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 _____	12/31/2024

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 000	INITIAL COMMENTS Survey Date: 12/31/24 Census: 21 Sample: 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 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to document weekly weights as ordered in accordance with professional standards of practices. This deficient practice was identified for 1 of 12 residents reviewed for professional standards of practice (Resident #10). The deficient practice was evidenced by the following: 1. On 12/26/24 at 10:35 AM, during initial tour of the facility, the surveyor observed resident #10 in their bedroom seated in their wheelchair. At the time Resident #10 had a visitor present and	F 658	CORRECTIVE ACTION: The Interdisciplinary Care Team (IDCT) re-assessed Resident #10 on NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 for resident #10. The nurses assigned to Resident #10 NJ ex order 26.4b1 [redacted] resident□s NJ ex order 26.4b1 and Vital Summary section of the electronic medical record (EMR) on NJ ex order 26.4b1 and NJ ex order 26.4b1. In addition, the facility□s US FOIA (B) (6) [redacted] was instructed to review the resident□s medical record weekly and document the review to	2/14/25

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

Electronically Signed — 01/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 658	Continued From page 1 reported [NJ Exec Order 26.4b1]. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but not limited to; [NJ ex order 26.4b1] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [NJ ex order 26.4b1] reflected the resident had a Brief Interview for Mental Status (BIMS) score of [NJ ex] out of 15, which indicated a [NJ Exec Order 26.4b1] A review of the Order Summary Report dated active orders as of [NJ ex order 26.], included a physician's order (PO) dated [NJ ex order 26.], for [NJ ex order 26.4b1] A review of the corresponding [NJ ex order 26.4b1], and [NJ ex order 26.4b1] Treatment Administration Records (TAR) revealed the weekly [NJ Exec Order 26.] were signed off as completed on [NJ ex order 26.4b1], [NJ ex order 26.4b1] A further review of the [NJ ex order 26.4b1] and [NJ ex order 26.4b1] [NJ ex order] TAR revealed that weekly [NJ Exec Order 26.] were blank on [NJ ex order 26.4b1] A review of the [NJ Exec Order 26.4b] and Vitals Summary provided by the [US FOIA (B) (6)] revealed weekly [NJ Exec Order 26.] were not documented for [NJ ex order 26.4b1] [NJ ex order 26.4b1]	F 658	ascertain that the weight was completed and properly recorded. Any significant weight change will be addressed by the IDCT. The facility□s EMR system was modified to address the deficient practice. Nurses shall be required to enter weights when due, and that the weights must be entered properly in order for a nurse to complete an acknowledgement in the EMR. The facility conducted a root cause analysis (RCA) to determine the cause of the deficient practice on 01/09/2025. The RCA revealed that the main causes of the deficiency were that several nursing staff lacked the knowledge and understanding of the facility□s documentation policies causing inconsistencies in the recording of weights. The RCA also revealed a lack of communication between the nursing staff and the RD. IDENTIFICATION OF OTHER RESIDENTS: Residents who have their weights monitored daily or weekly have been identified to have the potential to be affected by this deficient practice. Nursing administration conducted an audit on residents□ weight recordings including those residents that have weights recorded monthly, weekly and daily. 20 of 21 resident records were found to be compliant with physician□s orders and with weights recorded properly in the EMR. The audit was completed	

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F 658	Continued From page 2 and [NJ ex order 26.4b1]. On 12/27/24 at 12:57 PM, the surveyor interviewed the [US FOIA (B)], who stated she [NJ ex order 26.4b1]. The [US FOIA (B)] stated that the nurse completes weekly weights, signs it off on the TAR and then will document it under the [NJ Exec Order 26.] tab in the electronic medical record (eMR). On 12/20/24 at 11:50 AM, the surveyor interviewed the US FOIA (B) (6) who stated that the [US FOIA (B)] or US FOIA (B) (6) can obtain weekly [NJ Exec Order 26.4b] The [US FOIA (B)] also stated that the weights order will show up on the TAR to initial off, but they also document the [NJ Exec Order 2] under the [NJ Exec Order 26.] and vitals tab. On 12/30/24 at 12:18 PM, the surveyor interviewed the US FOIA (B) (6) who stated that she was unaware that Resident #10 NJ ex order 26.4b1 The [US FOIA] also stated that when Resident #10 was admitted to the facility NJ ex order 26.4b1 The [US FOIA] further stated she had been monitoring the residents' [NJ ex order 26.4b1]. On 12/30/24 at 1:21 PM, the US FOIA (B) (6), in the presence of the US FOIA (B) (6), and survey team, confirmed that Resident #10's NJ ex order 26.4b1 The [US FOIA (B)] stated that weekly [NJ Exec Order 26.4] should be documented in the eMR under the weights tab. The [US FOIA (B)] acknowledged that the NJ ex order 26.4b1. A review of the facility's "Weight Monitoring"	F 658	12/30/2024. PREVENTIVE MEASURES: On 01/09/2025, based on the findings of the RCA, the facility□s Administrator and Director of Nurses (DON) reviewed its policies for weight monitoring and charting and documentation. Based upon this review and with staff discussions, the facility revised its weight monitor policy so that all required weekly weights shall be completed on a consistent basis. Commencing immediately, all weekly weights will be completed and recorded in the medical records via the EMR every Wednesday. In addition to the policy review, the DON provided in-service education training to all nurses on 01/09/2025 regarding the facility□s weight monitoring and documentation policies. Nurses were instructed that all weights must be recorded in the resident□s medical record through the EMR. Nurses were notified of the modification changes in the EMR requiring that the weights are entered prior to signing off on the task. The RD was instructed by the DON and Administrator to maintain a listing of residents requiring daily and weekly weights. The RD is to inspect the list weekly and confirm that the necessary weights were recorded properly in the EMR. The RD will be responsible for obtaining any missing weights with the nursing staff. The RD will then report weekly to the DON the status of the residents□ weights, and any	

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F 658	Continued From page 3 policy dated reviewed and updated 11/19/24, included residents that are on weekly weights should be weighed on the day of the week ordered ... All weights will be reported to the nurse and documented in the resident's chart ...RD will monitor resident's weights for any weight loss/gain. A review of the facility's "Charting and Documentation" policy dated reviewed and updated 11/20/24, included all services provided to the resident, progress toward the care plan goal, or any changes in the resident's medical, physical, functional of psychological condition, shall be documented in the resident's medical record ...Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. NJAC 8:39-27.1(a)	F 658	recommendations. Communication between the DON, nursing staff, and RD shall be verbal and supported in writing. The communicating party must confirm receipt of the information through follow-up efforts with the receiving party. The DON will monitor the communication between the nursing staff and RD. QUALITY ASSURANCE: Weekly for 4 weeks, the DON will randomly select 10 residents requiring daily and/or weekly weights and verify that the residents□ weights were recorded properly in the EMR. Findings shall be reported to the Administrator for any additional corrective action. The Administrator shall review monthly for three months, the RD□s weekly reports to ascertain that residents□ weights are properly recorded in accordance with facility policies. Thereafter, the Quality Assurance (QA) committee shall review residents□ weights as part of the facility□s ongoing Quality Assurance and Performance Improvement (QAPI) program.	

New Jersey Department of Health

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	62207	A. BUILDING: _____ B. WING _____	12/31/2024

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

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency 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		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 1 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	CORRECTIVE ACTION: On 01/09/2025, the Administrator and DON along with the Unit Secretary reviewed the daily staffing reports for 12/16/2024. The review revealed that the day shift for 12/16/2024 required a minimum of 3 CNAs, however only 2 CNAs were assigned. The review also revealed that the remaining shifts for 12/16/2024 had excess CNAs for the 3-11 and 11-7 shifts. The Unit Secretary was instructed to review the daily schedules and to staff each shift to meet the minimum CNA requirements. When	2/14/25

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

Electronically Signed | 01/10/25

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor reviewed the facility completed Nurse Staffing Reports which revealed the following: For the 2 weeks of staffing prior to survey from 12/08/2024 to 12/21/2024, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -12/16/24 had 2 CNAs for 22 residents on the day shift, required at least 3 CNAs. On 12/30/24 at 11:40 AM, the surveyor interviewed the Unit Secretary who was able to verbalize the regulations. The Unit Secretary also stated that when staffing deficient they contact per diem nurses and agency nurses to fill any call outs. The Unit Secretary further stated that they have weekend incentives to help with staffing the weekends.	S 560	appropriate, CNAs should be re-assigned from other shifts so that minimum staffing requirements are met throughout the day. In the event of call-outs, the Unit Secretary may offer overtime shifts and incentives to CNAs as well as using nursing agencies to cover call-outs. When necessary, the Unit Secretary can replace CNA call-outs using professional nurses. The nurses must be signed in as CNAs and perform CNA assignments. The facility continues its recruitment efforts for both professional and non-professional nursing staff. The facility uses help wanted advertisements and works directly with nursing agencies to obtain staff. The facility offers referral and sign-on bonuses for employee referrals and new employees, and provides employees with cash incentives and gift incentives for accepting additional shifts. IDENTIFICATION OF OTHER RESIDENTS: All residents were identified to have the potential to be affected by this deficient practice. PREVENTIVE MEASURES: On 01/09/2025, the facility□s Administrator and Director of Nurses (DON) reviewed its policy for Staffing. No modifications were made to the policy based on this review. The DON was instructed by the Administrator to collaborate closely with the Unit Secretary in reviewing the CNA daily schedules to	

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S 560	Continued From page 2	S 560	ensure that the facility is compliant with the minimum staffing requirements. The DON shall review the daily staffing with the Administrator. QUALITY ASSURANCE: Daily for the next 3 months the DON shall review the daily staffing schedule to ascertain compliance with the minimum staffing requirements. Findings shall be reported to the Administrator daily. The Administrator shall review weekly for the next three months the daily staffing schedules reported to NJDOH to determine the effectiveness of the preventive measures. Thereafter, the Quality Assurance (QA) committee shall review daily staffing as part of the facility□s ongoing Quality Assurance and Performance Improvement (QAPI) program.	
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation 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	S1405		2/14/25

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S1405	Continued From page 3 employees. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documentation, it was determined that the facility failed to ensure that employees received a health examination by a physician, an advanced practice nurse, or a licensed physician assistant within two weeks prior to the first day of employment or upon employment. This deficient practice was identified for 3 of 5 employee files reviewed (Employee #3, #4, and #5), and was evidenced by the following: During entrance conference on 12/26/24 at 09:41 AM, the surveyor team requested from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to provide the survey team with a list of employees newly hired since last standard survey. On 10/1/24 at 1:30 PM, the surveyor reviewed the employee files which revealed the following: Employee #3, a Registered Nurse (RN), was hired on [NJ ex order 26.4b1], the Employee Physical form was dated [NJ ex order 26.4b1] Employee #4, a Certified Nursing Assistant (CNA), was hired on [NJ ex order 26.4b1] the Employee	S1405	CORRECTIVE ACTION: The Administrator in-serviced the Director of Nurses on the New Jersey state regulations pertaining to the completion of a health history and physician examination for new employees (NJAC 8:39-19.59(a)). The DON was instructed to complete a nursing assessment upon the employment of a new hire. The nursing assessment shall be completed by a registered nurse (RN). The DON would then be responsible for scheduling the physician examination for completion within 30 days of the first day of employment. The physician examination shall be completed by the facility□s Medical Director. The physical examination shall be documented and retained in the employee□s file. IDENTIFICATION OF OTHER RESIDENTS: All residents and staff were identified to have the potential to be affected by this deficient practice. The DON reviewed the remaining employee files of employees	

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S1405	Continued From page 4 Physical form was dated 12/5/24. Employee #5, a Licensed Nursing Home Administrator (LNHA), was hired on [NJ ex order 26.4b1], the Employee Physical form was dated [NJ ex order 26.4b1]. On 12/30/24 at 11:35 AM, the surveyor interviewed the DON regarding the facility's hiring practices. The DON stated that she was responsible for obtaining all new hires physicals. The DON stated that the employee should have a physical upon hire, or if there was a Registered Nurse (RN) assessment upon hire, the physician nurse needed to complete the physical within thirty days. On 12/30/24 at 1:21 PM, the DON in the presence of the LNHA and survey team, acknowledged that the [NJ ex order 26.4b1] for Employee #3, Employee #4 and Employee #5 [NJ ex order 26.4b1]. The DON confirmed the facility did not have a RN assessment upon hire, and the physical should have been completed upon hire. A review of the facility's "Orientation Process for Newly Hired Employee" policy dated reviewed and updated 11/20/24, included nursing assessment may be done upon hire and must be completed before receiving an assignment or completion of orientation. A physical from the Medical Director within 30 days of the RN assessment.	S1405	hired since the last standard survey (5 additional files). The review revealed that all employees reviewed had a completed physical examination; however, 3 additional physician examinations and/or RN nursing assessment were not timely completed in accordance with NJAC 8:39-19.59(a). PREVENTIVE MEASURES: On 01/10/2025, the facility□s Administrator and Director of Nurses (DON) reviewed its policy for newly Hired Employees. No modifications were made to the policy based on this review. The Administrator instructed the DON that all new employees must have a nursing assessment completed upon hire and prior to receiving a work assignment. The newly hired employee must then have a physician examination completed by the facility□s Medical Director within the first 30 days of employment. An in-service is scheduled for 01/13/2025 for all department supervisors. The Administrator shall conduct the in-service and provide instructions to all department supervisors on the facility□s policy for newly Hired Employees. The department supervisors will be instructed that newly hired employees will require a completed RN nursing assessment by a facility RN upon their date of hire and prior to any assignments. In addition, the department supervisors will be responsible for scheduling with the DON a physician examination to be completed by the facility□s Medical Director for all newly	

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S1405	Continued From page 5	S1405	hired employees within the employees first 30 days of employment. Employees not meeting these requirements will be removed from the schedule. QUALITY ASSURANCE: Monthly for the next 4 months, the DON shall review the employment files for all newly hired employees to ascertain the facility s compliance with its Newly Hired Employee policy, as well as NJAC 8:39-19.599(a). Findings shall be reported to the Administrator for any additional corrective actions. Thereafter, the Quality Assurance (QA) committee shall confidentially review employment files for recent new hires as part of the facility s ongoing Quality Assurance and Performance Improvement (QAPI) program.	

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	2/20/2025 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 F0658	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/14/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/31/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62207 Y1	A. Building B. Wing Y2	2/20/2025 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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. #	Completed
LSC	02/14/2025	LSC	02/14/2025	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	
12/31/2024	☐ 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 _____	**12/31/2024**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/30/24, the facility is NOT 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		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal,	E 004		2/14/25

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

Electronically Signed | 01/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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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E 004	Continued From page 1 State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 12/30/24 in the presence of the US FOIA (B) (6) [redacted] and US FOIA (B) (6), it was determined the facility failed to review and update their emergency preparedness plan annually in accordance with CFR 483.73, Requirements for Long Term Care Facilities. A documentation review at 11:48 AM revealed the last annual review and update of the facilities emergency preparedness plan was August 17, 2023, over 16 months ago. In an interview at 1:55 PM the US FOIA (B) (6) and US FOIA confirmed the documentation review. The US FOIA (B) (6) [redacted] was informed of the deficient practice at the Life Safety Code exit	E 004	CORRECTIVE ACTION: The Administrator and Maintenance Director (MD)reviewed the facility□s Emergency Plan (EP) on 01/02/2025. The review resulted in a revision in the EP to include an updated listing of current employees along with their contact information. The employee contact listing shall be updated monthly by the facility□s business office with copies filed in the EP by the MD. The Administrator and Maintenance Director shall conduct the subsequent annual review of the EP during August 2025, at which time the annual Facility Assessment shall be completed along	

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E 004	Continued From page 2 conference. N.J.A.C. 8:39-31.6 (i)(.1)	E 004	with an annual facility wide hazard and vulnerability assessment (HVA). Modifications to the EP shall be based upon the findings of the HVA, the Facility Assessment and any additional requirements established by governing authorities. An electronic copy of the EP shall be maintained as well as hard copies, in order to accommodate necessary modifications. IDENTIFICATION OF OTHER RESIDENTS: All residents were identified to have the potential to be affected by this deficient practice. A review of facility records and documents as well as staff interviews revealed that there were no emergency incidents that occurred at the facility from the date of the last documented review of the EP (08/17/2024) to the EP□s most recent review day of 01/02/2025. PREVENTIVE MEASURES: On 01/09/2025, the facility□s Administrator met with the Maintenance Director (MD). The MD was instructed to update the employee contact list monthly in the EP. The MD was also instructed to report any necessary changes required in the EP based on routine inspections, record reviews, and results of quality assurance analyses. In addition, the MD and Administrator shall develop an annual calendar of events. The calendar will include mandatory events that must occur during the year such as monthly fire drills, semi-annual	

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E 004	Continued From page 3	E 004	disaster drills, inspections, and the annual review of the facility□s EP. Events shall be scheduled in a manner that provides sufficient time for planning and conducting drills, inspections, and the review and any required modifications of the EP. QUALITY ASSURANCE: Monthly, for the next three months, the Administrator shall review the annual calendar of events and determine that the facility completed the events as scheduled. Any events not completed shall be addressed immediately. Thereafter, the Quality Assurance (QA) committee shall review the calendar of events as part of the facility□s ongoing Quality Assurance and Performance Improvement (QAPI) program.	
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 12/27/2024 and 12/30/2024, 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		

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K 000	Continued From page 4 The facility has 32 licensed beds and the census was 21 at the time of survey.	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/30/24 in the presence of the US FOIA (B) (6) [redacted], it was determined that the facility failed to maintain a stable, level walking surface at exit discharge for 2 of 8 exterior exits observed in accordance with NFPA 101:2012 Edition, Section 7.7 and 7.1.7. This deficient practice had the potential to affect 21 residents and was evidenced by the following: An observation at 10:30 AM revealed that the dining room exterior exit and kitchen back hall exterior exit shared an exit discharge path to a public way which posed a trip hazard in the path of egress for evacuation. Where the concrete slab against the building met the concrete slab leading to the parking lot there was a hole across the path 13 foot long and from 5 inches to 11 inches wide. In addition where the concrete sidewalk from the dining room exit met the concrete slab in front of the kitchen exit there was a 2 foot long by 5 inches wide hole in the	K 271	CORRECTIVE ACTION: The exit discharge path shared by the dining room exterior exit and the kitchen back hall exterior exit is scheduled to be repaired the week of January 13, 2025, depending upon the weather. The repair work shall provide a stable walking surface for the exit discharge path leading to and from the two identified exterior exits. IDENTIFICATION OF OTHER AFFECTED AREAS: The Maintenance Director inspected all exit discharge paths leading from exterior exit doorways. One additional exit discharge path is in need of repair. The repair work has been scheduled for the week of January 13, 2025, depending upon the weather. All other exit discharge paths were found to be in safe order. A	2/14/25

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K 271	Continued From page 5 concrete slab. The measurements were taken with a standard tape measure. In an interview at the time, the [US FOIA] confirmed the observations. The [US FOIA (B) (6)] was informed of the deficient practice at the Life Safety Code exit conference at 1:55 PM. NJAC 8:39-31.2 (e) NFPA 101	K 271	review of the facility incident reports revealed that there were no incidents related to the damaged exit discharge paths. PREVENTIVE MEASURES: On 01/09/2025, the facility□s Administrator met with the [US FOIA (B) (6)] [redacted]. The [US FOIA] was instructed to include the inspection of all exit discharge paths to the monthly inspection rounds of the building□s exterior. Exit paths requiring repairs shall be reported to the [US FOIA (B) (6)] immediately. QUALITY ASSURANCE: Monthly, for the next three months, the Administrator shall review the Maintenance Director□s monthly inspection logs of the building□s exterior to ascertain that the inspections were completed appropriately. The Administrator shall also visually inspect all exit discharge paths for a period of three months to determine the effectiveness of the preventive measures. Thereafter, the Quality Assurance (QA) committee shall review the monthly inspection logs and the exit discharge paths as part of the facility□s ongoing Quality Assurance and Performance Improvement (QAPI) program.	
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	K 353		2/14/25

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K 353	Continued From page 6 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 observation, documentation review and interview on 12/27/24 and 12/30/24 in the presence of the US FOIA (B) (6) it was determined the facility failed to inspect and test its dry valve fire sprinkler system and fire hydrant in accordance with NFPA 25: 2011 Edition, Sections 7.2.2.4, 7.3.2, 7.4.2, and 13.4.4.2.9. This deficient practice had the potential to affect 21 residents and was evidenced by the following: A documentation review on 12/27/24 at 10:55 AM revealed there was a dry valve sprinkler system that serves the entire facility and there was no document of an air leak test performed on the dry sprinkler system in the past 3 years. In an interview on 12/30/24 at 2:40 PM, the US FOIA stated that he spoke with the facilities fire sprinkler service representative and the service had no knowledge of the air leak test requirement	K 353	CORRECTIVE ACTION: The dry valve sprinkler air leak test is scheduled to be performed the week of January 13, 2025. Results of the test will be reviewed by the Maintenance Director and Administrator. Any required repairs shall be addressed immediately. The fire hydrant located in front of the building is scheduled for inspection and testing the week of January 13, 2025, depending upon the weather. Results of the inspection and test will be reviewed by the Maintenance Director and Administrator. Any required repairs shall be addressed immediately. The facility□s fire sprinkler service provider was instructed by the Maintenance Director to add the annual	

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K 353	Continued From page 7 and had therefore not performed the test. The surveyor provided the code at the time and the US FOIA confirmed the documentation review. An observation on 12/27/24 at 9:00 AM revealed a fire hydrant in front of the building. A documentation review on 12/27/24 between 9:30 AM and 1:00 PM revealed no documentation of annual inspection and testing of the fire hydrant. In an interview on 12/27/24 at 1:27 PM the US FOIA stated that the facility maintains the one dry barrel fire hydrant and did not keep records of the annual inspection, testing and maintenance of the hydrant at this time. The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code exit conference on 12/30/24 at 1:55 PM. N.J.A.C. 8:39-31.2 (e) NFPA 25	K 353	inspections of the air leak test and the fire hydrant testing and inspection to the facility□s annual service contract. IDENTIFICATION OF OTHER AFFECTED AREAS: All residents and all areas of the facility have the potential to be affected by these deficiencies. The facility has one dry valve sprinkler system for the entire building as well as one fire hydrant that serves the facility. A review of the facility□s records and staff interviews revealed there were no incidents involving either the dry valve sprinkler system or the fire hydrant. PREVENTIVE MEASURES: On 01/09/2025, the facility□s Administrator met with the US FOIA (B) (6) . The US FOIA was instructed to include the air leak test for the dry valve fire sprinkler system and the inspection and testing of the fire hydrant to the facility□s annual service contract with the facility□s fire system inspection provider. In addition, the MD and Administrator shall develop an annual calendar of events. The calendar will include mandatory events that must occur during the year such as monthly fire drills, semi-annual disaster drills, inspections, and the annual review of the facility□s EP. Included on the calendar will be all required inspections of the fire prevention system including the annual air flow test and the annual inspection and test of the fire hydrant. Events shall be scheduled in a	

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K 353	Continued From page 8	K 353	manner that provides sufficient time for planning and conducting drills and inspections. Any deviations from the schedule inspections shall be reported to the Administrator immediately. QUALITY ASSURANCE: Monthly, for the next three months, the Administrator shall review the annual calendar of events and determine that the facility completed the events as scheduled. Any events not completed shall be addressed immediately. Thereafter, the Quality Assurance (QA) committee shall review the calendar of events as part of the facility□s ongoing Quality Assurance and Performance Improvement (QAPI) program.	
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. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/30/24 in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that the Class K portable fire extinguisher was provided with an instructional placard conspicuously placed near the extinguisher in accordance with NFPA 101: 2012 Edition, Sections 9.7.4, NFPA 10: 2010 Edition, Sections 5.5.5.3, A 5.5.5.3 and NFPA 96: 2011 Edition,	K 355	CORRECTIVE ACTION: The required instructional placard for the Class K fire extinguisher was installed on 01/06/2025. All dietary staff members received in-service training regarding the instructions pertaining to the proper use of the Class K fire extinguisher as described on the newly installed placard. The	2/14/25

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K 355	Continued From page 9 Sections 10.2.2. This deficient practice had the potential to affect 21 residents and was evidenced by the following: An observation at 10:35 AM revealed the Class K fire extinguisher in the kitchen was not provided with an instruction placard that stated the fire protection system shall be actuated prior to using the portable fire extinguisher. In an interview at the time, the [redacted] confirmed the observation. The [redacted] was informed on the deficient practice at the Life Safety Code exit conference at 1:55 PM. N.J.A.C 8:39-31:2(e) NFPA 10, 96	K 355	in-service was conducted [redacted] by the facility's [redacted] IDENTIFICATION OF OTHER AFFECTED AREAS: All residents and all areas of the facility have the potential to be affected by these deficiencies. The facility has one Class K fire extinguisher located in the facility's kitchen. A review of the facility's records and staff interviews revealed there were no incidents involving the use of the Class K fire extinguisher. PREVENTIVE MEASURES: On 01/09/2025, the facility's Administrator met with the [redacted]. The [redacted] was instructed to include a visual inspection of the Class K fire extinguisher instructional placard during the monthly inspection of fire extinguishers located throughout the building. The placard shall be replaced if damaged or missing immediately. QUALITY ASSURANCE: Monthly, for the next three months, the Administrator shall review the Maintenance Director's monthly inspection logs of the building's fire extinguishers to ascertain that the inspections were completed appropriately and included the instructional placard for the Class K fire extinguisher. The Administrator shall also visually inspect the instructional placard for a period of	

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K 355	Continued From page 10	K 355	three months to determine the effectiveness of the preventive measures. Thereafter, the Quality Assurance (QA) committee shall review the monthly inspections logs for fire extinguishers and the instructional placard as part of the facility□s ongoing Quality Assurance and Performance Improvement (QAPI) program.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the	K 363		2/14/25

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K 363	Continued From page 11 smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/30/24 in the presence of the US FOIA (B) (6) [redacted], it was determined the facility failed to ensure a hazardous area used for combustible material storage was protected by a corridor door that positively latched when closed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect 21 residents and was evidenced by the following: An observation at 10:50 AM revealed a double corridor doors to a garage storage area containing combustible materials that had a fixed door leaf with the other door leaf closing to it. The swinging door leaf equipped with a self closing device did not positive latch when opened to 90 degrees and released to the fully closed position. The test was repeated and an attempt to pull the door to latch was made with the same result. In an interview at the time, the [redacted] confirmed the observation. The facilities US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference at 1:55 PM.	K 363	CORRECTIVE ACTION: The corridor door leading to the garage storage area was repaired and tested on 01/02/2025. The door now functions properly and latches when opened to 90 degrees and released. IDENTIFICATION OF OTHER AFFECTED AREAS: All residents and all areas of the facility have the potential to be affected by this deficiency. The facility□s Maintenance Director inspected the remaining corridor doors on 01/03/2025. All doors inspected were found to work properly and latching in their door frames. PREVENTIVE MEASURES: On 01/09/2025, the facility□s Administrator met with the US FOIA (B) (6) [redacted]. The [redacted] was instructed to begin a quarterly inspection of corridor doors. Doors inspected are to be recorded	

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 _____	**12/31/2024**

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
K 363	Continued From page 12 N.J.A.C. 8:39-31.2 (e) NFPA 101	K 363	in a log indicating whether the doors functioned properly or required repairs. The log will be reviewed with the Administrator upon the completion of the quarterly inspection. Doors requiring repairs shall be addressed immediately. QUALITY ASSURANCE: Monthly, for the next three months, the Administrator shall inspect and test 10 randomly selected corridor doors to determine that the doors function properly and latch in their door frames. The Administrator shall also inspect quarterly the MD□s door inspection log to determine the effectiveness of the preventive measures. Thereafter, the Quality Assurance (QA) committee shall review the monthly inspections logs and inspect and test doors as part of the facility□s ongoing Quality Assurance and Performance Improvement (QAPI) program.	

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	2/20/2025 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 K0271	02/14/2025	LSC K0353	02/14/2025	LSC K0355	02/14/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0363	02/14/2025	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	
12/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO