STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558**

(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 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 Survey Date: 2/6/2024 Census: 33 Sample: 13 + 3 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=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		3/11/24

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

Electronically Signed | 02/16/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 1 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility documentation it was determined that the facility failed to a.) label, date, and store potentially hazardous foods appropriately to prevent food borne illness; b.) maintain kitchen equipment in a manner to prevent microbial growth, and c.) maintain multiuse food-contact surface cutting board in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 1/30/24 at 9:54 AM, the surveyor, in the presence of a second surveyor and the [redacted] toured the kitchen, and observed the following: In walk-in freezer #1: 1. A 22-quart plastic food storage container containing, what was identified by the [redacted] as, rice soup. The container was not labeled or dated. At this time the [redacted] stated, "that should have been labeled." 2. One (1) opened 20-pound (lb) box of wax beans labeled with a received date of 1/15/24, containing a plastic bag of wax beans which was opened to air, to which the [redacted] stated it "should not be opened to air like that." On a drying rack adjacent to the dish washing area were two large stainless steel mixing bowls and two clear plastic food storage containers all	F 812	Element one: All residents had the potential to be affected by these practices. The unlabeled food items and box of wax beans open to air were discarded immediately, the cutting boards were replaced immediately, the stacked bowls and containers were removed from the drying rack and rewashed immediately. 1. Dietary Director or designee provided In-service to dietary staff on the policy and procedure of proper labeling and storage of frozen foods. 2. Dietary Director or designee provided In-service to dietary staff on the policy and procedure for maintaining kitchen equipment in a manner to prevent microbial growth. i.e wet nesting of mixing bowls and plastic containers. 3. Dietary Director or designee provided In-service to dietary staff on the policy and procedure for maintaining multiuse food-contact surface cutting board in a manner to prevent microbial growth. i.e cutting boards. 4. Dietary Director or designee provided In-service to dietary staff on the policy and procedure of proper labeling and storage of dry foods storage. Element two: 1. All residents had the potential to be affected. 2. All residents had the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 2 wet nested (stacked on top of each other while still wet). At that time, the [US FOIA (b)(6)] stated these "should not be stored like that." On a storage rack adjacent to the three-compartment sink were four cutting boards with scrapes, gouges, and black discoloration. The [US FOIA (b)(6)] stated there were new cutting boards on order and had a kitchen staff member remove these cutting boards from use. On 2/2/24 at 10:10 AM, the surveyor in the presence of a second surveyor and the [US FOIA (b)(6)] observed in the emergency food supply room a one-pound bag of cereal which was not in it's original shipping box and not labeled or dated. At this point the [US FOIA (b)(6)] stated it "should be labeled." On 2/6/24 at 10:01 AM, in the presence of the survey team, the [US FOIA (b)(6)] stated they had a new dining company and are "still working out the kinks." Review of the facility's policy titled "Food and Supply Storage" with revised date 1/22 included but was not limited to, "all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption ... cover, label and date unused portions and open packages." Review of the facility's policy titled "Storage of Pots, Dishes, Flatware, Utensils" with revised date 1/22 included but was not limited to, "air dry all food contact surfaces, including pots, dishes, flatware, and utensils before storage, or store in a	F 812	3. All residents had the potential to be affected. 4. All residents had the potential to be affected. Element three: 1. Daily checklist, completed by Dietary director or designee, will include monitoring all areas of proper covering, labeling, and dating. Monthly safety and sanitation audits will be completed Dietary director or designee. 2. Daily checklist and monthly safety and sanitation audits will be completed by Dietary director or designee. 3. Daily checklist and monthly safety and sanitation audits will be completed by Dietary director or designee. 4. Daily checklist and monthly safety and sanitation audits will be completed by Dietary director or designee. Element Four: All Daily audits and monthly sanitation audits will be reviewed and presented, by Dietary director or designee, at the quarterly QAPI meeting for the next two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 3 self-draining position. Do not stack or store when wet." Review of the facility's policy titled "Cutting Boards" with revised date 1/22 included but was not limited to, "replace all cutting boards with grooves and pits 1/8-inch or deeper that cannot be cleaned and sanitized using routine cleaning and sanitizing procedures." NJAC 8:39-17.2(g)	F 812		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315486 Y1	A. Building B. Wing Y2	4/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

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	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/11/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/6/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

(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 000	INITIAL COMMENTS Stonebridge Montgomery is a two story Type II (111) Un-Protected building that was built in November 2004. The facility is divided into 5-smoke zones for Health Care on floor #2. The facility utilizes two (2) diesel exterior generators: 1, interior (lower level) generator 250 KW does the red outlets. 2, exterior generator 450 KW does 100% of the building. The Health Center is located on the second floor of the building and utilizes 4-wings. The kitchen is located on the ground floor and attached to the independent living surroundings, including a dining room not used to serve the health care residents. The facility has 50 licensed health care beds, currently occupying 33 beds.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on	K 222		3/11/24

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

Electronically Signed | 02/16/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

(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 222	Continued From page 1 each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING 01 B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(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 222	Continued From page 2 ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interviews on 2/2/24, in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that the 15-second delayed egress feature on 1 of 4 exit discharge doors (with this feature), would activate properly when tested in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1. This deficient practice was evidenced by the following: At 10:10 AM, the surveyor, US FOIA (b) and Administrator observed that the stair #2 exit/egress door by HC-238 was labeled with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." The US FOIA (b)(6) attempted to activated the door with the 15-second delay feature as indicated on the sign and on all 3-attempts the door remained open and the delay feature did not engage. An interview was conducted with the US FOIA (b)(6) and US FOIA (b)(6) during the observation, where they indicated someone may have shut this feature off and both confirmed the door remained open on all 3-attempts. The US FOIA (b)(6) was notified of the finding at	K 222	K 222 Element one: All residents had the potential to be affected by this practice: 1. The 15-second delayed egress feature on 1 of 4 exit doors that failed on 2/2/24 was serviced and fixed on 2/5/24 by a service tech from ADT with an adjustment made to correct the alarm not working properly. Element two: 1. All residents had the potential to be affected by malfunctioning door alarm. Element three: 1. On a monthly basis, the maintenance director or designee, will audit the door alarms for proper functioning and any issue will be corrected immediately. Element Four: 1. All monthly audits will be reviewed and presented, by the maintenance director or designee, at the quarterly QAPI meeting for the next two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING 01 B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(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 222	Continued From page 3 the Life Safety Code exit conference on 2/2/24. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/2/24, in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide a battery back-up emergency light above the interior emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 1 interior transfer switch and was evidenced by the following: At 10:55 AM, the surveyor, US FOIA (b)(6) [redacted] in the lower level electrical room where the generator and transfer switch were located, that the room was not equipped with battery back-up emergency lighting of at least 1-1/2-hour duration and is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 At that time, the US FOIA (b)(6) [redacted] both confirmed the finding during the observation.	K 291	All residents had the potential to be affected by this: 1. The battery back-up emergency lighting above the interior emergency generator transfer switch has been installed by an ADT service tech on 2/21/24. Element two: 1. All residents had the potential to be affected. Element three: 1. The emergency back up lighting will be inspected and tested monthly, by maintenance director or designee, as part of our life safety program. Element Four: 1. Monthly audit will be reviewed and presented, by maintenance director or designee, at the quarterly QAPI meeting for the next two quarters.	3/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

(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 291	Continued From page 4 The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit on 2/2/24. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced	K 321		3/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING 01 B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(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 321	Continued From page 5 by: Based on observation and interview on 2/2/24, in the presence of the [redacted], it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in 4 of 10 hazardous storage areas observed in the facility and was evidenced by the following: 1.) At 10:20 AM, the surveyor, [redacted] observed in HC-249 that the room was being used for hazardous storage. The room was greater than 50 square feet in size and required an auto-close device installed on the door. The room was observed to have 5 mattresses, large combustible cardboard box, 10 wheel chairs with fabric seats and back, and 1-bed with a wooden headboard. The [redacted] confirmed that room HC-249 was converted into a temporary storage room and required a door with a self-closing device. 2.) At 10:49 AM, the surveyor, [redacted] that the double doors to the main fire panel room were not labeled to indicated the fire resistant rating of the doors. The right-door did not latch into its frame. 3.) At 11:18 AM, the surveyor, [redacted] observed that the door to the fire sprinkler room did not latch into its frame.	K 321	Element one: All residents had the potential to be affected by this practice: 1. Room 249 is larger than 50 sq ft in size and required an auto-close device installed on the door. Room 249 had an auto closing device installed immediately after the life safety survey to meet regulation. Element two: 1. All residents had the potential to be affected. Element three: 1. All rooms being used for storage will be inspected monthly, by the maintenance director or designee, as part of our life safety program to ensure proper auto closing devices as in place. Element Four: 1. Monthly audit will be reviewed and presented, by maintenance director or designee, at the quarterly QAPI meeting for the next two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING 01 B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(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 321	Continued From page 6 4.) At 11:28 AM, the surveyor, US FOIA (b)(6) [redacted] observed that the door to the resident storage room did not latch into its frame. The US FOIA (b)(6) [redacted] both confirmed the findings during the observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code Exit Conference on 2/2/24. NJAC 8:39-31.2(e)	K 321		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on surveyor observation on 2/2/24 in the presence of the US FOIA (b)(6) [redacted])	K 353	Element one: All residents had the potential to be	3/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING 01 B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(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 353	Continued From page 7 and US FOIA (b)(6) it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. This deficient practice was evidenced by the following: 1.) At 09:46 AM, the surveyor, US FOIA (b)(6) [redacted] observed 2 of 8 sprinkler heads in the resident dining room that were dirty with a coating of lint/dust. The sprinkler heads were observed by ceiling air vents. 2.) At 11:00 AM, the surveyor, US FOIA (b)(6) [redacted] observed in the back of the 4-commercial clothes dryers that 2 of 2 fire sprinkler heads were loaded with a coating of lint/dust. 2 of 10 fire sprinkler heads in the laundry room were observed to be dirty with a coating of lint/dust.The sprinkler heads were observed by ceiling air vents The US FOIA (b)(6) [redacted] both confirmed the findings during the laundry room observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 2/2/24. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	affected by this: 1. 2 of 8 fire sprinkler heads in resident dining room, 2 of 10 fire sprinkler heads in laundry room, and 2 of 2 fire sprinkler heads in back of the commercial clothes dryers were inspected and cleaned. Element two: 1. All residents had the potential to be affected. Element three: 1. All sprinkler heads will be inspected monthly, by the maintenance director or designee, as part of our life safety program to ensure all parts of the automatic sprinkler system are in optimal condition. Element Four: 1. Monthly audits will be reviewed and presented, by maintenance director or designee, at the quarterly QAPI meeting for the next two quarters.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		3/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

(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 8 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 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 2/2/24, in the presence of the US FOIA (b)(6) [redacted], it was determined that	K 363	Element one: All residents had the potential to be affected by this:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING 01 B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(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 9 the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring complete bedroom door closure for confinement of smoke/fire products was identified in three (3) of thirty four (34) resident rooms observed and was evidenced by the following: During the building tour on 2/2/24 from 9:15 AM to 01:45 PM, the surveyor, in the presence of the US FOIA (b)(6) toured the facility and observed the following compromised RR doors in the following areas: HC-203 door will not latch into its frame HC-233 door will not latch into its frame HC-242 door will not latch into its frame At the time of observations, the surveyor interviewed the US FOIA (b)(6) who both confirmed the above findings. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 2/2/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	1. The doors on 3 of 34 resident rooms, 203, 233, and 242, were adjusted to ensure complete bedroom door closure for proper confinement of smoke/fire products. Element two: 1. Three resident rooms, 203, 233, and 242, had the potential to be affected. Element three: 1. All bedroom doors will be inspected monthly, by maintenance director or designee, as part of our life safety program to ensure proper latching. Element Four: 1. Monthly audits will be reviewed and presented, by maintenance director or designee, at the quarterly QAPI meeting for the next two quarters.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		3/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

(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 918	Continued From page 10 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/2/24, in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure a remote manual stop station for there interior 250 KW generator was installed, providing emergency power to	K 918	Element one: All residents had the potential to be affected by this: 1.The remote manual-stop for the interior diesel generator was installed. Element two:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING 01 B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(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 918	Continued From page 11 approximately 60% of Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 1 of 2 generators by the following: At 10:40 AM, the surveyor, US FOIA (b)(6) observed the interior 250 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the US FOIA (b)(6) who both stated and confirmed that the interior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current interior generator in service. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 2/2/24. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	1.All residents had the potential to be affected. Element three: 1.Proper functioning of the remote manual-stop for the interior diesel generator will be inspected monthly, by the maintenance director or designee, as part of our life safety program. Element Four: 1.Monthly audits will be reviewed and presented, by maintenance director or designee, at the quarterly QAPI meeting for the next two quarters.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.	K 923		3/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	**100 HOLLINSHEAD SPRING ROAD** **SKILLMAN, NJ 08558**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 12 >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 2/2/24, in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to prohibit combustible storage within 5-feet of quantities of oxygen exceeding 300 cubic feet in accordance with NFPA 99.	K 923	Element one: All residents had the potential to be affected by this: 1.Items were removed from the oxygen room to create a 5-foot barrier between combustible items and the secured	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. BUILDING 01 B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 13 This deficient practice was identified for 18 of 18 portable oxygen cylinders and was evidenced by the following: At 10:08 AM, the surveyor, US FOIA (b)(6) observed in the floor #2 main oxygen storage closet for Health Care across from HC-234, that 18-portable oxygen cylinders were observed to be stored within 1' of combustible cardboard boxes, plastic bags and bins exceeding 300 cu. ft. to 3000 cu. ft. as per NFPA 99 2012 11.3.2.1 through 11.3.2.3 An interview was conducted with the US FOIA (b)(6) who stated that the cylinders must be separated by five-feet (5') from combustibles when an automatic fire sprinkler system is provided. The building has a fully functional sprinkler system. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 2/2/23. NJAC 8:39-31.2(e) NFPA 99	K 923	oxygen tanks. A maximum of 12 oxygen tanks will be in the oxygen room at any given time. Element two: 1.All residents had the potential to be affected. Element three: 1.Audit of the oxygen room will be completed monthly, by the director of nursing or designee, as part of our life safety program to ensure no more than 12 oxygen tanks are present and that a 5-foot barrier is maintained between combustible items and oxygen tanks. Element Four: 2.Monthly audits will be reviewed and presented, by the director of nursing or designee, at the quarterly QAPI meeting for the next two quarters.	

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
315486 Y1	A. Building 01 - STONEBRIDGE AT MONTGOMERY B. Wing Y2	4/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER	100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558

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 K0222	03/11/2024	LSC K0291	03/11/2024	LSC K0321	03/11/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	03/11/2024	LSC K0363	03/11/2024	LSC K0918	03/11/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	03/11/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO