New Jersey Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		C	
		908116	B. WING			; 2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
2ND HOM	E SWEET HOME OPERA	ITIONS, LLC	I BROAD STR I, NJ 07208	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
М 000	Initial Comments		M 000			
	Type of Survey: Com	nplaint				
	Complaint #: NJ00171679					
	Census: AM: 132 PM: 71					
	Sample Size: 4					
	The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.					
M 223	8:43F-3.1(b)(1-7) Adr	ministration	M 223			
	(b) The administrator not limited to, the follo	shall be responsible for, but owing:				
	and	development, enforcement of all policies uding participant rights;				
	2. Planning and a managerial, operation components of the facility;	administering the nal, fiscal, and reporting				
	Participating ir program for participal performance;	n the quality improvement nt care and staff				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
		908116	B. WING		C 04/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	- ZIP CODE	
		550 NOR	TH BROAD STRE		
2ND HOM	E SWEET HOME OPERA	TIONS, LLC	TH, NJ 07208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
M 223	Continued From page	÷ 1	M 223		
	4. Ensuring that a duties based upon the competencies, and 5. Ensuring the p staff education, and of accordance with 6. Establishing an relationships and comstaff and services provand their caregivers; and their caregivers; and their caregivers; at the adult day heat the participant is eligible that the participant's entry purposes of this shall be entitled to religible to the performed by the	all personnel are assigned eir education, training, and job descriptions; erovision of staff orientation, engoing staff training in N.J.A.C. 8:43F-6.3; and maintaining liaison amunication between facility eviders and with participants			
	This REQUIREMENT by: NJ00171679	is not met as evidenced			
	pertinent facility docu that the facility failed t procedures titled, "Ad	ecord review, and review of ments, it was determined to implement its policy and mission/Visitors and Use of sure participant safety while			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 NORTH BROAD STREET ELIZABETH, NJ 07208 (MA) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECIDED BY FULL TAG STREET ADDRESS, CITY, STATE, ZIP CODE 550 NORTH BROAD STREET ELIZABETH, NJ 07208 DEPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION ADOLLO BE CROSS-REFERREDCED TO THE APPROPRIATE DATE DATE M 223 Continued From page 2 in the care of the facility for 1 of 4 participants, Participant #1. This deficient practice was evidenced by the following: On 2/27/24 the Department of Health (DOH) conducted a survey at the facility regarding a Facility Reportable Event (FRE) which was received on the survey or interviewed the Administrator regarding the FRE sent to the DOH on participant #1. NJ ex order 26.4b1 The Administrator stated on and NJ ex order 26.4b1 The Administrator stated on and NJ ex order 26.4b1 The Administrator stated on and NJ ex order 26.4b1 The CNA then left the restroom area to escort another participant to the same restroom. The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated the CNA then informed the Marketer and the Administrative staff that the Participant #1 NAME OF THE CONA THE CONA STATE THE ADMINISTRATOR STATE THE ADMINISTRATO	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY ETED	
NAME OF PROVIDER OR SUPPLIER 2ND HOME SWEET HOME OPERATIONS, LLC (X4) ID PREFIX TAG (X4) ID PREFIX TAG (X5) CONTRIBOAD STREET ELIZABETH, NJ 07208 CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CACH CORRECTIVE ACTION ADUID BE CROSS-REFERRECOED TO THE APPROPRIATE DATE	908116			B. WING		1		
ELIZABETH, NJ 07208 (A)1 D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) M 223 Continued From page 2 In the care of the facility for 1 of 4 participants, Participant #1. This deficient practice was evidenced by the following: On 2/27/24 the Department of Health (DOH) conducted a survey at the facility regarding a Facility Reportable Event (FRE) which was received on page 1 At 10:30 a.m., the surveyor interviewed the Administrator regarding the FRE sent to the DOH on page 3 Participant #1. My ex order 26.4b1 The Administrator stated on page 4 Participant #1 was a page 5 Participant #1 The Administrator stated on page 6 Participant #1 The Administrator stated on page 7 Participant #1 Page 7 Participant #1 Page 7 Page	NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) M 223 Continued From page 2 in the care of the facility for 1 of 4 participants, Participant #1. This deficient practice was evidenced by the following: On 2/27/24 the Department of Health (DOH) conducted a survey at the facility regarding a Facility Reportable Event (FRE) which was received on received on received on regarding the FRE sent to the DOH on regarding Participant #1's The Administrator regarding the FRE sent to the DOH around 11:50 a.m., a Certified Nurse Assistant (CNA) NJ ex order 26.4b1 The Administrator stated on around 11:50 a.m., a Certified Nurse Assistant (CNA) NJ ex order 26.4b1 The Administrator stated on around 11:50 a.m., a Certified Nurse Assistant (CNA) NJ ex order 26.4b1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated upon return, the CNA noticed Participant #1	2ND HOM	E SWEET HOME OPERA	TIONS, LLC			EET		
in the care of the facility for 1 of 4 participants, Participant #1. This deficient practice was evidenced by the following: On 2/27/24 the Department of Health (DOH) conducted a survey at the facility regarding a Facility Reportable Event (FRE) which was received on received on received on received the Administrator regarding the FRE sent to the DOH on regarding Participant #1, NJ ex order 26.4b1 At 10:30 a.m., the surveyor interviewed the Administrator regarding the FRE sent to the DOH on regarding Participant #1's Participant #1's Participant #1 was a NJ ex order 26.4b1 The Administrator stated on around 11:50 a.m., a Certified Nurse Assistant (CNA) NJ ex order 26.4b1 The CNA then left the restroom area to escort another participant to the same restroom. The Administrator stated upon return, the CNA noticed Participant #1 The Administrator stated and the Administrator stated the CNA then informed the Marketer and the Administrative staff that the Participant #1 The Administrator stated the CNA then informed the Marketer and the Administrative staff that the Participant #1	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	COMPLETE
The Administrator further stated all staff NJ ex order 26.4b1 The Administrator stated the participant approximately between 4:45 p.m. and 4:57 p.m. The Administrator added the participant was NJ ex order 26.4b1	M 223	in the care of the facil Participant #1. This devidenced by the follow on 2/27/24 the Department on Participant #1, NJ expression on	ity for 1 of 4 participants, eficient practice was bying: Interest of Health (DOH) to the facility regarding a vent (FRE) which was by exercised and vent (FRE) which was been dead on the participant was been dead and the participant was been dead and dead and dead and the participant was been dead and dead an	." OH 4b1 nt left t to	M 223			

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New Jersey Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __

		908116	B. WING		04/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	
OND HOM	E CWEET HOME OPERA	TIONS LLC 550 NOI	RTH BROAD STREE	ET .	
ZND HOM	E SWEET HOME OPERA	ELIZAB	ETH, NJ 07208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 223	Continued From page	3	M 223		
	The CNA stated NJ ex order control of the participant of the program. The participant of the program. The participant of the program of the program of the program of the participant of the program. The participant of the program of the program of the program of the program. The participant of the program of the p	the CNA stated she notified administrative staff that the der 26.4b1 During the ated she was by ex order 26.4b1 To attending the procedure for attending the procedure for attending the program. The gathered medical caregiver or the client prior marketer #1 explained der 26.4b1 The Jex order 26.4b1 The Jex order 26.4b1 The Jex order 26.4b1 Tand was unable to provide rds to the surveyor. The eters were responsible for all potential participants			
	At 2:00 p.m., the surv	eyor interviewed Marketer			

PRINTED: 12/18/2024 FORM APPROVED New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ С B. WING 908116 04/12/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **550 NORTH BROAD STREET** 2ND HOME SWEET HOME OPERATIONS, LLC ELIZABETH, NJ 07208 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) M 223 M 223 Continued From page 4 #2 via interpreter regarding Participant #1's NJ ex order 26.4b1 . Marketer #2 stated the participant attended the program on During the interview, Marketer #2 and the Administrator both stated on NJ ex order 26.4 an interview was conducted with Participant #1's spouse regarding the participant's NJ ex order 26.4b Administrator and Marketer #2 both stated the participant's spouse NJ ex order 26.4b1 ANJ ex order 26.4b1

During continued interview, Marketer #2 provided the surveyor with Participant #1's "Intake Record" which revealed a documented History and Physical dated "". The surveyor identified the physician documented mental status

Marketer #2 also stated on

informed by the CNA that Participant #1

However, the Administrator/Marketer #2 NJ ex order 26.4b1

At 2:15 p.m., the surveyor reviewed the facility policy and procedure titled, "Admission/Visitors," noted in "Procedure: ...Potential client will be evaluated by the registered nurse to ensure he/she meets the eligibility criteria 2. An H&P will be obtained from the physician..."

In addition, the surveyor reviewed the facility policy and procedure titled, "Use of Wonder Guard ...The registered nurse will assess all participants who have a diagnosis, which relates

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STATE ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STATE ADDRESS, CITY ADDRESS, CITY ADDRESS, CIT		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2ND HOME SWEET HOME OPERATIONS, LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) M 223 Continued From page 5 to cognitive impairment and for the possibility of elopementIf the registered nurse deems the patient at risk for elopement, she will notify the family and receive consent for the wonder guard to place on the client." STREET ADDRESS, CITY, STATE, ZIP CODE STATE				A. BUILDING: _			
2ND HOME SWEET HOME OPERATIONS, LLC X44 ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) M 223 Continued From page 5 to cognitive impairment and for the possibility of elopementIf the registered nurse deems the patient at risk for elopement, she will notify the family and receive consent for the wonder guard to place on the client." SONORTH BROAD STREET ELIZABETH, NJ 07208 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE			908116	B. WING		1	
2ND HOME SWEET HOME OPERATIONS, LLC ELIZABETH, NJ 07208 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DATE M 223 Continued From page 5 to cognitive impairment and for the possibility of elopementIf the registered nurse deems the patient at risk for elopement, she will notify the family and receive consent for the wonder guard to place on the client."	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) M 223 Continued From page 5 to cognitive impairment and for the possibility of elopementIf the registered nurse deems the patient at risk for elopement, she will notify the family and receive consent for the wonder guard to place on the client." M 223 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE M 223 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON 223	2ND HOM	IE SWEET HOME OPERA	ATIONS, LLC		EET		
to cognitive impairment and for the possibility of elopementIf the registered nurse deems the patient at risk for elopement, she will notify the family and receive consent for the wonder guard to place on the client."	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
plan from the administrator for the facility registered nurse not completing an assessment and/or evaluation for a NJ ex order 26.4b1 participant who NJ ex order 26.4b1 which placed the participant is additionally, the facility failed to provide documentation to support Participant #1's NJ ex order 26.4b1 On 3/5/24 the surveyor reviewed the which revealed Participant #1 was NJ ex order 26.4b1 The report further indicated the police contacted the emergency medical services and the participant NJ ex order 26.4b1 at 5:04 p.m., Na order 26.4b1 at 5:04	M 223	to cognitive impairme elopementIf the rec patient at risk for elop family and receive co to place on the client. At 2:30 p.m., the surve plan from the administregistered nurse not consider and/or evaluation for participant who NJ ewhich placed Addition provide documentation. At 2:30 p.m., the survey which placed Addition provide documentation. Addition provide documentation. On 3/5/24 the survey which was NJ ex order 2 a.m., and NJ ex order 2 a.m., a	ent and for the possibility of gistered nurse deems the pement, she will notify the onsent for the wonder guard." veyor requested a removal strator for the facility completing an assessment a NJ ex order 26.4b1 ex order 26.4b1 d the participant NJ ex order 26.4b1 onally, the facility failed to on to support Participant #1's b1 or reviewed the NJ ex order 26.4b1 at 5:04 p.m., NJ ex order 26.4b1 dicated the police contacted cal services and the order 26.4b1 .m., the facility provided the oval plan via email which was export conducted a follow-up dicated the police of the eval plan via email which was export conducted a follow-up dicated the police of the eval plan via email which was export conducted the surveyor observed dipants wore safety vests, by staff. Additionally, the ne visiting participant wore a strator provided the surveyor ords on the facility's policy isiting participants. The	M 223			

INCW JCIS	ey Department of Fleat	IUI				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			1		_	
			D 14//10			
		908116	B. WING		04/1	2/2024
NAME OF D	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	ATE ZID CODE		
TVAINE OF T	TO VIDER OR OUT LIER					
2ND HOM	E SWEET HOME OPERA	TIONS, LLC	H BROAD STR	EEI		
		ELIZABET	H, NJ 07208			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(IATE	DATE
				52.18.2.18.17		
M 223	Continued From page	e 6	M 223			
	. •					
		facility's procedures for				
	elopement risk partici	pants, and assessments for				
	visiting participants.					
M 367	8:43F-5.3(b) Participa	ant Assessment and Plan of	M 367			
	Care					
	Guio					
	An initial assessment shall be completed for each					
participant on the day of admission and shall						
include at least personal hygiene, immediate dietary needs, medications, ambulation and						
	•					
		this initial assessment, a				
		care shall be developed				
		ays of the date the initial				
	assessment is perforr	med.				
	This REQUIREMENT	is not met as evidenced				
	by:					
	NJ00171679					
	Based on interview, re	ecord review, and review of				
	facility policy and prod	cedure, it was determined				
	that the facility failed t	to perform a participant				
	_	ment or a nursing evaluation				
		ndance to the facility for 1 of				
		pant #1. This deficient				
	practice was evidence	•				
	practice was evidence	ed by the following.				
	On 2/27/24 at 10:30 a	am the surveyor				
		nistrator regarding a facility				
		E) sent to the Department of				
		garding Participant #1's				
	elopement. The Admi					
	Participant #1 was a	^{U ex order 26.4} and NJ ex order 26.4b1				
		The Administrator stated on	1			I I

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					C
		908116	B. WING		04/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		550 NOR	TH BROAD STR	EET	
2ND HOM	E SWEET HOME OPERA	TIONS, LLC ELIZABE	TH, NJ 07208		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE
M 207	0 " 15	7	M 207		
M 367	Continued From page	e /	M 367		
	2/20/24 around 11:50	a.m., a NJ ex order 26.4b1			
	ONIA 41 1- ft 414	. The troom area to escort another			
	participant to the sam				
		upon return, the CNA noticed			
	Participant #1 NJ ex				
		he CNA then informed the			
	Marketer and the Adn				
	Participant #1 NJ ex orde	r 26.4b1			
	A1 44 00 II				
		veyor reviewed the facility ad transportation logs dated			
		which revealed Participant			
		ex order 26.4b1			
	W T	7 CX 31431 23. 15 1			
		keter's "Intake Record," the			
		NJ ex order 26.4b1			
	noted Participant #1's	NJ ex order 26.4b1			
	At 11:36 a.m., the sur	veyor interviewed the			
	Director of Nursing (D				
	procedure for potentia	al participants enrollment			
		DON stated the potential			
	participant came in fo	rNJ ex order 26.4b1			
		Additionally the			
	DON stated she was	Additionally, the			
		history until enrollment			
		leted for the program. The			
	•	d that she did not assess			
	nor evaluate Participa	ant #1 and was unable to			
	· ·	ited medical records to the			
		tated the Marketers were			
	•	ocumentation of all potential			
	participants during the	eii visils.	1		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		908116	B. WING		04/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
2ND HOM	E SWEET HOME OPERA	TIONS, LLC	TH BROAD STR TH, NJ 07208	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE	
M 367	Continued From page	e 8	M 367			
	policy and procedure noted in "Procedure:	reyor reviewed the facility titled, "Admission/Visitors"Potential client will be stered nurse to ensure ibility criteria"				
	Reference: M-0223, 8	3:43F-3.1(b)(1-7)				

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7 50.25 10.			R-C	
908116			B. WING			/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
2ND HOM	E SWEET HOME OPERA	TIONS LLC	RTH BROAD STR	EET			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ETH, NJ 07208	PROVIDER'S PLAN OF CO	ORRECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
{M 000}	Initial Comments		{M 000}				
	Type of Survey: Com	nplaint					
	Complaint #: NJ0017	71679					
	Census: AM: 132 PM: 71						
	Sample Size: 4						
	all of the standards in Administrative Code, for Licensure of Adult facility must submit a a completion date, for that the plan is impler deficiencies may resu	Chapter 8:43F, Standards Day Health Services. The plan of correction, including r each deficiency and ensure mented. Failure to correct alt in enforcement action in provisions of New Jersey Title 8, Chapter 43E,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/26/24

			ST/	TE EODM: DE	EVISIT REPORT			
	R / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS A. Building B. Wing		ATE FORM. RE	EVISII REPORT		DATE _{Y2} 4/12/2	OF REVISIT
	FACILITY ME SWEET HOME O				STREET ADDRESS, CIT 550 NORTH BROAD ST ELIZABETH, NJ 07208			, c
corrective	e action was accompli tion prefix code previo	shed. Each deficien	cy should be	fully identified us	ly reported that have bee sing either the regulation des shown to the left of e	or LSC provision no	umber and the	
ITE	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	M0223	Correction	ID Prefix	M0367	Correction	ID Prefix		Correction
Reg.#	8:43F-3.1(b)(1-7)	Completed	Reg.#	8:43F-5.3(b)	Completed	Reg. #		Completed
LSC		04/19/2024	LSC		04/19/2024	LSC		= ' =
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		_
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#		Completed	Reg. #		Completed	Reg. #		Completed
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Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		_
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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 O	OMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				

EVENT ID: Page 1 of 1 PZ5E12

YES NO

STATE FORM: REVISIT REPORT

4/12/2024

	STATE FORM: REVISIT REPORT							
	R / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS A. Building B. Wing	STRUCTION			DATE OF REVISIT		
	FACILITY	Y1 B. Willy		STREET ADDRESS	CITY STATE ZID CODE	Y2 4/12/2024 Y3		
	ME SWEET HOME OP	ERATIONS, LLC		550 NORTH BROAD	CITY, STATE, ZIP CODE STREET			
				ELIZABETH, NJ 0720				
corrective	e action was accomplis tion prefix code previou	hed. Each deficier	cy should be fully	es previously reported that have lidentified using either the regulation to the left of	on or LSC provision nun	nber and the		
ITEI	M	DATE	ITEM	DATE	ITEM	DATE		
Y4		Y5	Y4	Y5	Y4	Y5		
ID Prefix	M0223	Correction	ID Prefix	Correction	ID Prefix	Correction		
Reg.#	8:43F-3.1(b)(1-7)	Completed	Reg. #	Completed	Reg. #	Completed		
LSC		04/19/2024	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			
REVIEWE	D BY REVI	EWED BY	DATE	SIGNATURE OF SURVEYOR		DATE		

Page 1 of 1 EVENT ID: PZ5E12

DATE

YES NO

FOLLOWUP TO SURVEY COMPLETED ON

REVIEWED BY

CMS RO

4/12/2024

REVIEWED BY

(INITIALS)

DATE

TITLE

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?