New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CP07001	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SENIOR RESIDENCE	71 CHRISTOPHER STREET MONTCLAIR, NJ 07042

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: On 4/4 and 4/5/2023 an initial inspection of a conversion of a Skilled Nursing Facility licensed for 29 residents to a Comprehensive Personal Care Home (CPCH) with exisiting construction of a 14 Residential Unit building for a total of 26 CPCH beds. CENSUS: 21 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 783	8:36-7.5(e) Resident Assessments and Care Plans (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing. This REQUIREMENT is not met as evidenced	A 783		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/04/23

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A 783	Continued From page 1 by: Based on observations, interview, and record review, it was determined that the facility failed to provide documented evidence of a physician's certification to confirm residents needs were met and adequately provided at the Comprehensive Personal Care Home (CPCH) facility for 4 of 4 sampled residents, Resident #'s 1, 2, 3 and 4. This deficient practice was evidenced by the following: On 04/04/2023, the surveyors conducted a conversion survey. The facility applied to the Department of Health (DOH) to convert from a licensed nursing home to a CPCH licensed facility. On 4/4/2023 at 11:00 a.m., during surveyors (Surveyor #'s 1, 2, 3, and 4) tour of the facility, the surveyors observed some residents who were still in bed and in their rooms. There were also residents that were observed on a continuous Ex Order 26. 4B1 use. Surveyors also observed a Ex Order 26. 4B , a Ex Order 26. 4B1 to transfer residents from bed to chair and vice versa, in the hallway by a resident's room. At 12:00 p.m., during meal service observation in the dinng room, surveyors (Surveyor #'s 1, 2, 3, and 4) observed facility staff physically assisted and spoon fed residents who required total assistance with feeding. Review of 4 of 4 residents' medical records on 4/4/2023 and 4/5/2023, revealed that the following residents required NJ Ex Order 26.4b1 with their Activities of Daily Living (ADL) activities: 1. Surveyor #3 reviewed the medical record (MR)	A 783		

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A 783	Continued From page 2 of Resident #3 who had a move-in date of NJ Ex Order 26.4b1, with diagnoses which included *Ex Order 26. 4B1* . A review of the MR revealed that Resident #3 received *Ex Order 26. 4B1* four times a day and had NJ Ex Order 26.4b1. A review of the Minimum Data Set (MDS), a facility utilized tool to assess the resident, revealed that Resident #3 was NJ Ex Order 26.4b1 on staff for Activities of Daily Living (ADL), including bed mobility, transfer to/from bed, chair, wheelchair, bathing/toilet, mobility, dressing, eating, and personal hygiene. The MDS further indicated that Resident #3 was *Ex Order 26. 4B1* and *Ex Order 26. 4B1*. Resident #3 had NJ Ex Order 26.4b1 per Primary Care Plan dated NJ Ex Order 26.4b1. Resident #3 had a NJ Ex Order 26.4b1 on his/her *Ex Order 26. 4B1* which required NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 every two hours. Resident #3 was NJ Ex Order 26.4b1. Further review of the resident's MR revealed that there was no documented evidence of a physician's certification that the resident's needs did not exceed what the facility was able to provide. There was no certification to confirm that the CPCH was an appropriate facility to meet the resident's current needs. 2. Surveyor #3 reviewed the MR of Resident #4, who had a move-in date of NJ Ex Order 26.4b1, with diagnoses which included *Ex Order 26. 4B1* . A review of the MR revealed that Resident #4 required continuous *Ex Order 26. 4B1* via *Ex Order 26. 4* at NJ Ex Order 26.4b1. It was also indicated that Resident #4 required *Ex Order 26. 4B1* consistency intake. Review of the MDS, a facility utilized tool to assess the resident, revealed that Resident #4 required NJ Ex Order 26.4b1 Resident #4 is *Ex Order 26. 4B1* and was NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1. *Ex Order 26. 4B1* was in place. Resident #4	A 783		

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A 783	Continued From page 3	A 783		

required assistance with dressing and personal hygiene. Resident #4 was NJ Ex Order 26.4b1 with a NJ Ex Order 26 and required NJ Ex Order 26.4b1 per Primary Care Plan dated NJ Ex Order 26.4b1. There was no documented evidence in the MR to certify that the CPCH was appropriate to meet the resident's current needs.

3. Surveyor #2 reviewed the medical record (MR) of Resident #1 who moved into the facility on NJ Ex Order 26.4b1, with diagnoses which included Ex Order 26 . A further review of the MR indicated Resident #1 receives continuous Ex Order 26. 4B1 by Ex Order 26. 4 and has *Ex Order 26. 4B1* NJ Ex Order 2 on the *Ex Order 26. 4B1*. A review of the Minimum Data Set (MDS), a facility utilized tool to assess the resident, revealed Resident #1 is NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 on staff for bed mobility, transfer to/from bed, chair, wheelchair, bathing/toilet, mobility, dressing, eating and personal hygiene. The MDS further indicated Resident #1 is *Ex Order 26. 4B1* and Ex Order 26. 4B1, NJ Ex Order 26.4b1 during meals or when NJ Ex Order 26.4b1, and requires a *Ex Order 26. 4B1* diet. Further review of the resident's medical record revealed that there was no documented evidence in the MR to certify that the CPCH was able to meet the resident's current needs.

4. Surveyor #2 reviewed the MR of Resident #2, who moved into the facility on NJ Ex Order 26.4b1 with diagnoses which included *Ex Order 26. 4B1* . A further review of the MR revealed Resident #2 was NJ Ex Order 26.4b1, required *Ex Order 26. 4B1* and had a *Ex Order 26. 4B1* of the *Ex Order 26. 4B1* of back. A review of the MDS indicated Resident #2 is NJ Ex Order 26.4b1 of staff for dressing, eating, and personal hygiene. The MDS further indicated Resident #2 is *Ex Order 26. 4B1* and Ex Order 26. 4B1.

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A 783	Continued From page 4 There was no documented evidence in the MR to certify that the CPCH was appropriate to meet the resident's current needs. Later that day on 4/5/2023 at 2:00 p.m., Surveyor #1, in the presence of Surveyor #'s 2, 3, and 4, shared the above findings with the Administrator, who stated he had not been approved yet [for CPCH] and that he will comply with all the regulations once he has been approved. Residents' medical records did not include documentation of a physician's certification to confirm that residents' needs could be met and adequately provided at the CPCH, including residents assessed with higher level of care and require total assistance from staff to perform their ADLs.	A 783		
A1027	8:36-14.1(c) Emergency Services and Procedures (c) At least one employee trained in cardiopulmonary resuscitation and the Heimlich maneuver shall be available in the facility at all times. This REQUIREMENT is not met as evidenced by: Based on interview and review of staffing schedules provided by the facility, it was determined that the facility's Administrator failed to ensure that at least one employee who was certified and trained in cardiopulmonary resuscitation (CPR) was available and on duty in the facility at all times. This deficient practice was	A1027		

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A1027	Continued From page 5 evidenced by the following: On 4/4/2023, the surveyor reviewed the staffing schedule provided by the facility's Administrator from 4/6/2023 to 4/14/2023 which did not indicate which staff member was certified in CPR on each shift. On 4/4/2023 at 12:52 p.m., the surveyor interviewed the facility's Administrator who stated the facility's Director of Nursing (DON) who is a Professional Registered Nurse, was the only facility employee who was certified in CPR at the time of the survey. The Administrator also stated he did not necessarily have an employee who was CPR certified on duty, every shift. The Administrator also stated that all the facility's nurses were not CPR certified. At 12:59 p.m., the surveyor interviewed the facility's DON who stated at the time of the survey she was the only facility employee who was CPR certified. On 4/5/2023, during the survey entrance conference, the facility's DON provided the surveyor team with a CPR certification for the facility's staff nurse. The surveyor requested the staffing schedule for 3/23/2023 to 4/5/2023. On 4/5/2023, the surveyor reviewed the facility's employee files and staffing schedule from 3/23/2023 to 4/5/2023 which revealed that all shifts were not staffed with a CPR certified staff member in the facility. The facility did not ensure that a CPR certified staff member was scheduled and on duty in the facility on the following days and shift: 3/23/23: 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m.	A1027		

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A1027	Continued From page 6 3/24/23: 4 p.m., to 12 a.m. and 12 a.m. to 8 a.m. 3/25/23: 8 a.m. to 4 p.m., 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 3/26/23: 8 a.m. to 4 p.m., 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 3/27/23: 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 3/28/23: 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 3/29/23: 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 3/30/23: 12 a.m. to 8 a.m. 3/31/23: 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 4/1/23: 8 a.m. to 4 p.m., 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 4/2/23: 8 a.m. to 4 p.m., 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 4/3/23: 4 p.m. to 12 a.m. and 12 a.m. to 8 a.m. 4/4/23: 4 p.m. to 12 a.m. and 12 a.m. to 7 a.m. 4/4/23: 4 p.m. to 12 a.m. and 12 a.m. to 7 a.m. The facility Administrator failed to ensure that the facility had a CPR certified staff member scheduled and on duty at their facility at all times.	A1027		
A1169	8:36-16.15(a) Physical Plant (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101. This REQUIREMENT is not met as evidenced by: Based on observation on 04/04/2023 in the presence of facility management, it was	A1169		

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A1169	Continued From page 7 determined that the facility failed: 1) To install 2 of 11 portable fire extinguishers with in the required height, 2) Perform and document a monthly visual examination on the tag attached to the extinguisher for 1 of 11 fire extinguishers, in accordance with the requirements of National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. The evidence includes the following: Reference #1: NFPA 10 Standard for portable fire extinguishers reads, " 6.1.3.8 Installation Height ... - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor ... - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches." Reference #2: NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, "4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require ... - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a	A1169		

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A1169	Continued From page 8 tag or label attached to the fire extinguishers ... - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification." The findings include the following, On 04/04/2023, starting at approximately 10:21 AM, during a tour of the facility, in the presence of the facility's Administrator (Admin) the surveyor observed and inspected eleven (11) portable fire extinguishers that were last annually inspected June 2022 in following various locations: 1) At approximately 10:26 AM, the surveyor observed on the 3rd. floor one (1) ABC type fire extinguisher last annually inspected June 2022, no monthly examination performed and document on the tag attached to the extinguisher for July 2022, August 2022, September 2022, October 2022, November 2022, December 2022, January 2023, February 2023, and March 2023. 2) At approximately 11:22 AM, the surveyor observed in the Kitchen area one (1) ABC type and one (1) class "K-Type" wet chemical fire extinguisher that appeared to be mounted too high. At this time the surveyor measured and recorded the two fire extinguishers, as follows: - One ABC type extinguisher was mounted 5'-4" to the center of the pressure gauge. - One class K-Type wet chemical extinguisher was mounted 5'-5" to the center of the pressure gauge. The Admin, in the presence of the surveyor, confirmed the findings at the time of observations.	A1169		

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A1169	Continued From page 9 The facility did not meet the NFPA -10 requirement as referenced above.	A1169		
A1179	8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance (a) The facility shall provide and maintain a sanitary and safe environment for residents. This REQUIREMENT is not met as evidenced by: Based on observation on 04/04/2023, in the presence of facility management, it was determined the facility failed to provide and maintain a safe environment for the residents. The evidence includes the following, During the building tour in the presence of the facility's Administrator (Admin) the following building safety hazards were observed: 1. At approximately 11:10 AM, during an inspection in the basement, the surveyor observed a laundry chute door in the corridor. When the door was opened and allowed to self-close, the door did not positive latch as required for fire rated doors. This test was repeated two additional times with the same results. This would allow fire, smoke and poisonous to pass from the basement to the floors above in the event of a fire. 2. At approximately 11:36 AM, the surveyor observed inside the first floor 20" deep by 4' wide	A1179		

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A1179	Continued From page 10 Clean Linen closet a down pendant fire sprinkler head. At this time, the surveyor measured and recorded the sprinkler head to be 22 inches down from the decking above. Code requires an upright sprinkler head installed within 12 inches from the decking above. Fire Safety Hazards.	A1179		

Id Prefix Tag	What corrective action will be accomplished for those residents affected by the deficient practice	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. What Q.A. program will be put into place to monitor the continued effectiveness of the systemic change.	Completion date
A783	No resident has been negatively affected by this practice. All residents of the facility have had physician certifications issued confirming that the resident does not have needs which exceed the level of care that a Comprehensive Personal Care Home is capable of providing. Resident #2 NJ Ex Order 26.4b1 since the time of the survey. Residents #4 was NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1, providing a similar level of care. Residents #1 and #3 NJ Ex Order 26.4b1 and all required services have been provided.	All residents have the potential to be affected, however, all residents were assessed by a physician, and based upon the facility's current nurse staffing levels and the requirement to provide nursing home level of care in a CPCH, they were all certified as not having clinical care needs that exceed the levels of care that will continue to be available upon conversion of the facility to a Comprehensive Personal Care Home.	The facility has updated its policies and procedures to require that a certification by a physician, advanced practice nurse or a physician assistant will be performed annually or upon any significant change in their medical condition, confirming that each residents' needs can be met and adequately provided at the facility as a Comprehensive Personal Care Home. Residents assessed with a higher level of care and who require total assistance from staff to perform their Activities of Daily Living will be checked at least quarterly. The certification will be included in the resident's medical record.	On a weekly basis the Director of Nursing will audit all resident medical records to ensure proper implementation of our updated policy and procedures. The DON will review all resident medical records as well as staffing reports, weekly, to ensure that the facility will provide all necessary nursing services to maintain residents, including residents who require skilled nursing home level care with high acuity levels. The DON will review staffing levels weekly to ensure that the facility employs both professional and unlicensed staff in sufficient number and sufficient ability and training to provide all necessary resident care, assistance and supervision required, based on an assessment of the acuity of residents' needs.	05/19/23.

LICENSING

NJ Ex Order 26.4b1 8/3/23

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
CP07001 Y1	A. Building B. Wing Y2	8/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SENIOR RESIDENCE	71 CHRISTOPHER STREET MONTCLAIR, NJ 07042

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 A0783	Correction	ID Prefix A1027	Correction	ID Prefix A1169	Correction
Reg. # 8:36-7.5(e)	Completed	Reg. # 8:36-14.1(c)	Completed	Reg. # 8:36-16.15(a)	Completed
LSC	04/14/2023	LSC	04/14/2023	LSC	04/14/2023
ID Prefix A1179	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/14/2023	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	
4/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO