

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

PRINTED: 07/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER JEWISH HOME AT ROCKLEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 10 LINK DRIVE ROCKLEIGH, NJ 07647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 01/23/24 through 01/26/24 Survey Census: 185 Sample Size: 46 Supplemental Residents: none	F 000			

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

TITLE

(X6) DATE

Electronically Signed

02/01/2024

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: JZ240P	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/26/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

JEWISH HOME AT ROCKLEIGH

**10 LINK DRIVE
ROCKLEIGH, NJ 07647**

(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
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. The facility is actively working with CNA schools and programs for recruitment, frequently reviewing CNA rates to remain competitive, offering sign-on bonuses for incentive, and actively advertising through different channels. The facility is also utilizing agency staffing minimally, in instances where filling slots on shifts are necessary to meet appropriate staffing ratios. b. Interviews with residents pertaining to the day in which the staffing ratio was not met, did not result in any complaints or	2/15/24

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: JZ240P	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER JEWISH HOME AT ROCKLEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 10 LINK DRIVE ROCKLEIGH, NJ 07647		
(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
S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. Review of staffing from 01/07/2024 to 01/20/2024 for the 01/26/2024 Standard survey revealed the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: - 01/07/24 had 22 CNAs for 183 residents on the day shift, required at least 23 CNAs.	S 560	concerns that appropriate care was not rendered. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. The facility is actively working with CNA schools and programs for recruitment, frequently reviewing CNA rates to remain competitive, offering sign-on bonuses for incentive, and actively advertising through different channels. The facility is also utilizing agency staffing minimally, in instances where filling slots on shifts are necessary to meet appropriate staffing ratios. b. The DON or designee will do a staffing ratio review every 2 weeks to ensure ratios are met x 90 days. 4. How the facility plans to monitor its performance to make sure that solutions are sustained a. The Director of Nursing or designee will review the results of the biweekly staffing ratio review in the quarterly QAPI meeting x 90 days, and will be reevaluated thereafter.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER JZ24OP	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/22/2024
NAME OF FACILITY JEWISH HOME AT ROCKLEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 10 LINK DRIVE ROCKLEIGH, NJ 07647	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/15/2024	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/26/2024		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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NAME OF PROVIDER OR SUPPLIER JEWISH HOME AT ROCKLEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 10 LINK DRIVE ROCKLEIGH, NJ 07647		
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E 000	Initial Comments	E 000			
K 000	An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 01/23/24. The facility was found to be in compliance with 42 CFR 483.73. INITIAL COMMENTS A Life Safety Code Survey was conducted by the Health Care Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/23/24 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 18 NEW Taub building and chapter 19 EXISTING health care occupancy Legacy building. The Jewish Home at Rockleigh has two buildings. The original building or Legacy was first occupied in 2001 and consists of two stories, concrete flooring, roofing, and bearing walls which are fire resistive. The building has a 700 KW (kilowatt) diesel generator. The second building or Taub building was first occupied in 2021 and consists of two stories with concrete flooring, concrete roofing, and block bearing walls which are fire resistive. The building has a 480 KW diesel generator. The complex has 185 occupied beds.	K 000			
K 925 SS=E	Gas Equipment - Respiratory Therapy Sources CFR(s): NFPA 101 Gas Equipment - Respiratory Therapy Sources of	K 925			2/15/24

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

TITLE

(X6) DATE

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02/01/2024

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K 925	Continued From page 1 Ignition Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility's policy, the facility failed to ensure residents who used supplemental oxygen were prohibited from entering and using beauty shop hair dryers in accordance with NFPA 99 (2012 edition) section 11.3.2.7. The deficient practice had the potential to affect 15 residents that use oxygen throughout the buildings. Findings include: A review of the facility's policy titled "Oxygen," dated 08/2019, stated" ...when oxygen is not in use, "return the tank to oxygen supply room." An observation on 01/23/24 at 1:45 PM of the beauty shop/salon in the Legacy building revealed two large commercial hair dryers used for residents located in the salon/beauty shop. The area contained no prohibitions signs for use of oxygen cylinders while using large commercial hair dryers or while in the room. The hair dryers	K 925	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice a. The oxygen cylinder was immediately removed from the beauty salon space. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. 15 residents who use oxygen in the building, were identified as having the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. The Director of Maintenance or designee will place a prohibition sign for the use of oxygen cylinders in the beauty salon at the entrance to the beauty salon.		

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K 925	Continued From page 2 had heated electrical coils in the headset used for drying residents' hair. One oxygen compressed cylinder was in the room near the entrance within five feet of the hair dryers. During an interview on 01/23/24 at 1:45 PM, when asked why the compressed oxygen tank was in the beauty salon room, the [U.S. FOIA (b)(6)] stated, "to use for residents that are getting their hair done." During an interview at the time of the observation, the [U.S. FOIA (b)(6)] verified the compressed tanks placement and indicated he would remove the tank from the room immediately. NJAC 8:39-31/2(e) NFPA 99	K 925	b. The Director of Maintenance or designee will in-service all members of the beauty salon team, as to the prohibited use of oxygen cylinders in the beauty salon. c. The Director of Maintenance or designee will conduct a random weekly audit of the beauty salon to ensure free of any oxygen cylinders x 90 days, and submit to the Administrator for review. 4. How the facility plans to monitor its performance to make sure that solutions are sustained a. The Administrator or designee will report on the results of the random weekly audit at the quarterly QAPI meeting x 90 days, and will reevaluate thereafter.		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315473	MULTIPLE CONSTRUCTION A. Building 01 - JEWISH HOME AT ROCKLEIGH B. Wing	DATE OF REVISIT 2/22/2024
NAME OF FACILITY JEWISH HOME AT ROCKLEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 10 LINK DRIVE ROCKLEIGH, NJ 07647

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. #	Completed	Reg. #	Completed
LSC K0925	02/15/2024	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/26/2024		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			