

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

PRINTED: 11/12/2024
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 11/10/2022
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 TYPE OF SURVEY: New Construction and Renovation Project: 10 add-a-bed plus a six bed transfer to total 16 additional beds; New Subacute unit and Rehabilitation Facility. The survey team inspected staffing, the entrance canopy, lobby, electrical and mechanical closets, gas room, salon, Administrative offices, Administrative bathrooms, Kosher pantries on the first and second floors, non-Kosher microwaves on the first and second floors, central supply room, living rooms on the first and second floors, 60 resident rooms - including Bariatric resident rooms and Negative Pressure rooms, 60 resident bathrooms, therapy courtyard, garden courtyard, common areas on the first floor, common areas on the second floor, medication rooms on the first and second floors, elevator #6 and #7, vestibule, environmental closets on the first and second floors, laundry rooms on the first and second floors, outpatient rehab, Inpatient Rehabilitation rooms, nursing stations on the first and second floors, soiled utility rooms on the first and second floors, Activity of Daily Living suites, group fitness room, fitness storage, driver's assessment room, Occupational Therapy and Physical Therapy treatment and exam rooms, storage areas, Kosher kitchens, resident dining room areas on the first and second floors, aquatic center, and review of Administrative Outpatient Rehab Policies and Equipment. SURVEY DATE: 11/10/22 The facility was found to be in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities for this project survey.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

11/22/2022

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.

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

PRINTED: 11/12/2024
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 11/10/2022
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	Continued From page 1 THE BUILDING AS NOTED ABOVE MAY NOT BE OCCUPIED UNTIL YOU RECEIVE FORMAL NOTIFICATION FROM CERTIFICATE OF NEED AND LICENSING DIVISION.	F 000			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: JZ24OP	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
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 000	Initial Comments TYPE OF SURVEY: INITIAL SURVEY/ NEW CONSTRUCTION PROJECT: 10 add-a-bed plus a six bed transfer to total 16 additional beds; New Subacute unit and Rehabilitation Facility. The survey team inspected staffing, the entrance canopy, lobby, electrical and mechanical closets, gas room, salon, Administrative offices, Administrative bathrooms, Kosher pantries on the first and second floors, non-Kosher microwaves on the first and second floors, central supply room, living rooms on the first and second floors, 60 resident rooms - including Bariatric resident rooms and Negative Pressure rooms, 60 resident bathrooms, therapy courtyard, garden courtyard, common areas on the first floor, common areas on the second floor, medication rooms on the first and second floors, elevator #6 and #7, vestibule, environmental closets on the first and second floors, laundry rooms on the first and second floors, outpatient rehab, Inpatient Rehabilitation rooms, nursing stations on the first and second floors, soiled utility rooms on the first and second floors, Activity of Daily Living suites, group fitness room, fitness storage, driver's assessment room, Occupational Therapy and Physical Therapy treatment and exam rooms, storage areas, Kosher kitchens, resident dining room areas on the first and second floors, aquatic center, and review of Administrative Outpatient Rehab Policies and Equipment. SURVEY DATE: 11/10/22 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	S 000		

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

TITLE

(X6) DATE

Electronically Signed

11/22/22

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 11/10/2022
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 000	Continued From page 1 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. THE BUILDING AS NOTED ABOVE MAY NOT BE OCCUPIED UNTIL YOU RECEIVE FORMAL NOTIFICATION FROM CERTIFICATE OF NEED AND LICENSING DIVISION.	S 000		
S2235	8:39-31.6(c) Mandatory Physical Environment (c) Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility. This REQUIREMENT is not met as evidenced by: Based on observation on 11/09/2022 and 11/10/2022, interview and review of pertinent facility documents, it was determined that the facility failed to ensure evacuation diagrams which include the evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers were posted conspicuously on a wall on the 4 of 4 resident care units located on the first and second floor of the newly constructed building.	S2235	S-2235 1. Plan of Corrective Action On 11/17/22, the architect revised the evacuation diagrams to include the evacuation routes, location of the fire exits, alarm boxes/pull station and fire extinguishers. On 11/17/22, Maintenance staff posted the updated evacuation diagrams on 4 of the 4 resident care units in conspicuous locations on the first and second floors of the newly constructed	11/22/22

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 11/10/2022
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
S2235	Continued From page 2 This deficient practice was evidenced by the following: During the survey entrance on 11/09/2022 at 10:10 AM, the surveyor requested a copy of the of the facility lay-out which identified the various rooms and smoke compartments from the Director of Maintenance (DOM). A review of the facility provided lay-out identified there are two floors (First and Second floor) with two (2) Residential units (North and South Units) on each floor. During the tour of the building on 11/09/2022 in the presence of the DOM, an inspection of the Second Floor, North and South Units was performed. At approximately 12:00 PM, the surveyor observed no evidence of an emergency evacuation diagram posted on either of the two Resident Units on the Second Floor. The surveyor asked the DOM if any emergency evacuation diagrams were posted in the facility, and the DOM replied that he didn't know if any were posted. On 11/10/2022, the surveyor conducted an inspection of the First Floor North and South Units with the DOM. During the tour at approximately 12:01 PM, the surveyor observed one emergency evacuation diagram posted on the wall next to elevator #7. A review identified that there were no locations of the fire alarm pull stations and fire extinguishers on the diagram. The surveyor observed no evidence of an	S2235	building. 2. Identify Others. All residents in the facility can be affected by this practice. The Director of Maintenance reviewed each evacuation diagram to ensure it contained the evacuation routes, location of the fire exits, alarm boxes/pull stations and fire extinguishers. He then ensured that the evacuation diagrams were posted throughout the newly constructed building. 3. Measures or System Changes On 11/16/22, the Administrator, and Directors of Maintenance, Housekeeping, Rehab and Nursing Supervisor met with the local Fire Chief and Fire Captain to perform a table top fire safety and evacuation drill. The group reviewed possible types of fires that could take place, possible locations of fires, the evacuation procedures, evacuation routes, methods to evacuate residents, location of the fire doors, alarm/pull stations, fire extinguishers, room tags and the diagram. This information was provided to the architect to update the evacuation diagrams which are now posted on the units. The Evacuation/Shelter In Place policy was reviewed and revised. The Administrator, DOM and Director of Nursing inserviced the department heads, maintenance staff and nursing leadership team regarding the evacuation policy, evacuation diagram, evacuation procedure, fire exits, alarm boxes/pull stations and locations of fire extinguishers. 4. Monitor of Corrective Actions	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: JZ24OP	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
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
S2235	Continued From page 3 emergency evacuation diagram posted on either of the two Resident Units (North or South Units) on the First Floor. The surveyor informed the facility President and Chief Executive Officer (CEO) of the surveyor's findings at the Life Safety Code exit conference on 11/10/2022 at approximately 12:45 PM.	S2235	The DOM/designee/maintenance staff will conduct scheduled environmental rounds and will visually inspect the area to ensure the diagrams are posted. This information will be reported at the next monthly interdisciplinary Safety Committee meeting which is a subcommittee of the Quality Assurance Performance Improvement Committee. Responsible Person: Director of Maintenance Completion Date: 11/22/22	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER JZ24OP	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/28/2022
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 S2235	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-31.6(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/22/2022	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 11/10/2022		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

PRINTED: 11/12/2024
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 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2022	
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
K 000	INITIAL COMMENTS TYPE OF SURVEY: New Construction and Renovation Project: The following areas were inspected during the two-day survey: 1) Inspection of first (1st) floor to include: 15 Resident rooms 1st. floor North Unit, 15 Resident rooms 1st. floor South Unit, Lobby, Administrative offices, Salon, Therapy pool area, Mechanical rooms, 2 Unisex bathrooms, Therapy Court yard, 2 Laundry rooms, 2 Dens, 2 Mini Dens, Living room and 2 Kosher Pantries and Kitchen area. 2) Inspection of second (2nd.) floor to include: 15 Resident rooms 2nd. floor North Unit, 15 Resident rooms 2nd. floor South Unit, Activity room, Inpatient Therapy room, Group fitness room, OT/PT treatment rooms, Mechanical rooms, 2 Unisex bathrooms, 2 Laundry rooms, 2 Dens, 2 Mini Dens, Living room and 2 Kosher Pantries and Kitchen area. A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/9/2022 and 11/10/2022 and Jewish Home at Rockleigh was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies for the above mentioned project survey. The above noted areas may not be occupied until formal notification by the Certificate of Need and			K 000			

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

TITLE

(X6) DATE

Electronically Signed

11/22/2022

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.

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

PRINTED: 11/12/2024
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 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2022
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	
K 000	Continued From page 1	K 000			
K 324	Licensing Division has been received.	K 324			
SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation on 11/09/2022 and 11/10/2022, in the presence of facility management, it was determined that the facility failed to: a.) inspect 1 of 2 Kitchen range-hood fire suppression system semi-annually (every six		11/17/22		
			K-324 1. Plan of Corrective Action The facility hired a third party vendor to perform a semi-annual inspection of the 2nd floor kitchen range hood fire		

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

PRINTED: 11/12/2024
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 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2022
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	
K 324	Continued From page 2 months), and b.) ensure that 2 of 2 Kitchens were equipped with a Class "K-Type" fire extinguisher in accordance with NFPA 96 and NFPA 10. The deficient practice was evidenced by the following: During the survey entrance on 11/09/2022 at 10:10 AM, a request was made to the [U.S. FOIA (b) (6)] to provide a copy of the Certificate of Occupancy, all Sub-Code (Construction, Plumbing, Electrical, Fire Suppression and Fire Alarm and Detection system) Final Inspections and a copy of the facility lay-out which identified the various rooms and smoke compartments. A review of the facility provided lay-out identified there are two Kosher Kitchen's in the new building, one Kitchen on the first floor and one Kitchen on the second floor. On 11/09/2022 during the building tour with the [U.S. FOIA] at 12:24 PM, an inspection of the second floor Kitchen area was performed. The surveyor observed no evidence of a class "K-Type" fire extinguisher in the Kitchen area. The surveyor also observed on the inspection tag attached to the manual pull for the Kitchen's Ansul wet chemical fire suppression systems was last semi-annual (every 6 months) inspected January 2022. The surveyor pointed this out to the [U.S. FOIA (b) (6)]. At this time the [U.S. FOIA] told the surveyor that the system had just been inspected. The surveyor made a request to the [U.S. FOIA] to provide a copy of the inspection.	K 324	suppression system. This was completed on 11/10/22. They performed a visual inspection, hazard inspection, system function tests and system reactivation checked the cylinders and agent. No deficiencies were identified. They also checked to be sure the Class K portable extinguisher was installed and properly serviced in the kitchen areas on both the first and second floors. 2. Identify Others. All residents in the facility can be affected by this practice. The DOM and Maintenance Supervisor toured the building to ensure that fire extinguishers are located in both the first and second floor kitchens. 3. Measures or System Changes The DOM and maintenance staff will inspect all extinguishers and Ansul systems after each vendor visit to ensure they are in place. They will schedule a check of the Ansul system at least semi-annually for both the first and second floor kitchens and sign off on the inspections when received. An in-house audit form was updated to include the new fire extinguishers on 11/16/22. The audit forms are kept in the maintenance log book. 4. Monitor of Corrective Actions The DOM and maintenance staff will continue regularly scheduled checks of Ansul system and fire extinguishers. They will include these on appropriate forms. This will be reported at the next monthly		

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

PRINTED: 11/12/2024
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 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2022
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	
K 324	Continued From page 3 Later at approximately 1:30 PM, a review of the facility provided kitchen suppression systems inspection identified that there is "No class K fire extinguisher" in the kitchen. A review of the facility provided Contracted Vendors invoice reads, "Note: (2) wet Chemical fire extinguishers removed for hydrostatic and recharge." On 11/10/2022 at approximately 11:56 AM, an inspection of the first floor Kitchen was performed. The surveyor observed no evidence of a class "K-Type" wet chemical fire extinguisher in the kitchen. The surveyor informed the facility [U.S. FOIA (b) (6)] and [U.S. FOIA] of the deficiency at the Life Safety Code exit conference on 11/10/2022. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324	interdisciplinary Safety Committee meeting. Any findings and the report of these actions will be provided by the Director of Maintenance at the quarterly QAPI meeting. Responsible Person: Director of Maintenance Completion Date: 11/17/22		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315473	MULTIPLE CONSTRUCTION A. Building 01 - JEWISH HOME AT ROCKLEIGH B. Wing	DATE OF REVISIT 11/28/2022
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 K0324	11/17/2022	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 11/10/2022		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			