STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING ______ B. WING ______	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ00163064 Survey Date: 1/26/24 Census: 33 Sample: 12 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with Federal guidelines for 1 of 15 residents, Resident #8 reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following:	F 641	All residents have the potential to be affected by this deficient practice. A MDS modification was completed and submitted with the correct NJ Exec Order 26 information for resident #8 This deficient practice had the potential to affect all residents. All other residents MDSs were reviewed	3/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/15/2024

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.

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F 641	Continued From page 1 On 1/22/24 at 11:41 AM, the surveyor observed Resident #8 sitting in a wheelchair with other residents in the day room for recreational activity. The resident was resting in the wheelchair with there eyes closed. There was NJ Exec Order 26.4b1 observed. On 1/24/24 at 9:40 AM, the surveyor reviewed the electronic and paper medical record for Resident #8. An Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, NJ Exec Order 26.4b1 A review of a Quarterly MDS assessment, dated NJ Exec Order 26.4, Resident #8 was documented as "NJ Exec Order 26.4b1" and the resident was NJ Exec Order 26.4b1 a Brief Interview for Mental Status (BIMS). In NJ Exec Order 26.4b1 of the MDS, under NJ Exec Order. Appliances, Resident #8 was coded as having an NJ Exec Order 26.4b1". A review of the Order Summary Report for Resident #8 revealed there were no physcian orders for NJ Exec Order 26.4b1. On 1/24/24 at 12:40 PM, the surveyor interviewed a US FOIA (b)(6) who cared for Resident #8 about the resident having a NJ Exec Order 26.4 The US FOIA stated the resident previously had a NJ Exec Order 26.4b1	F 641	to ensure section H0100 was completed accurately. They were all coded correctly. US FOIA (b)(6) was re-inserviced to ensure accuracy when completing and submitting resident MDSs. The DON and/or MDS Coordinator will conduct monthly audits to ensure section H0100 is completed accurately. These audits will continue until 100% compliance has been achieved for 3 consecutive months. The findings of these audits will be reported to the DON monthly and, at a minimum, to be reviewed at the quarterly QAPI committee meeting to ensure that the solutions are sustained.	

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F 641	Continued From page 2 NJ Exec Order 26.4b1 from your NJ Exec Order 26.4b1. The US FOIA reviewed Resident #8's medical record and explained the resident last had a NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 which was removed in NJ Exec Order 26.4b1. The US FOIA stated the resident did not have a NJ Exec Order 26.4b1 NJ Exec O or other NJ Exec Order 26.4b1 since that time. On 1/24/24 at 12:56 PM, the surveyor interviewed the US FOIA (b)(6)) about the above concerns. The US FOIA (b) confirmed that Resident #8 previously had a NJ Exec Order 26.4b1 and did not have an NJ Exec Order 26.4b1 at the time of the MDS assessment. The US FOIA (b) stated she would review the resident's medical records and follow up with the MDS coordinator who was currently not on-site at the facility. On 1/24/24 at 1:21 PM, the US FOIA (b) informed the surveyor that she spoke to the MDS coordinator and acknowledged that the resident should not have been coded for an NJ Exec Order 26.4b1. The US FOIA (b) further stated it was a data entry error by the MDS coordinator and the MDS assessment would be modified. On 1/24/24 at 2:30 PM, the surveyor informed the US FOIA (b)(6)) and US FOIA (b) about the above concerns. The US FOIA (b) and US FOIA (b)(6) acknowledged MDS assessments should be coded accurately. No further information was provided. NJAC 8:39-33.2 (d)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		3/26/24

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F 658	Continued From page 3 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to follow professional standards of practice by a.) not acquiring physician's order (PO) for the administration of NJ Exec Order 26.4 b.) not administering the medication as ordered by the Physician and c.) by not following the facility's policy for NJ Exec Order 26.4b1 medication administration. This deficient practice was observed for 1 of 15 residents reviewed, Resident #19, Resident #5 and Resident #127 as evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 1/22/24 at 11:35 AM, the surveyor observed Resident #19 lying on the bed in the resident's room. The surveyor inspected the NJ Exec Order 26.4b1 dated NJ Exec Order 26 and the NJ Exec Order 26.4b1 which was NJ Exec Order 26.4b1 On 1/23/24 at 8:40 AM, the surveyor observed	F 658	1) All residents have the potential to be affected by this deficient practice. The Physician order for Resident #19 was immediately recorded in the EMR. This deficient practice had the potential to affect all residents. All other residents that were receiving oxygen were checked to ensure there was a PO for the oxygen that was being administered. All other residents had the correct PO in their EMR. All RN's and LPN's were re-inserviced to ensure there are PO for all areas of care that are being provided including oxygen orders. The DON and/designee will conduct monthly audits to ensure there are PO for all residents receiving oxygen. These audits will continue until 100% compliance has been achieved for 3 consecutive months. The findings of these audits will be reported to the DON monthly and, at a minimum, to be reviewed at the quarterly QAPI committee meeting to ensure that the solutions are sustained. 2) All residents have the potential to be affected by this deficient practice. The Physician order(PO) for Resident #5	

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F 658	Continued From page 4 Resident #19 awake, lying on bed. The surveyor inspected the NJ Exec Order 26.4b1 which was set at NJ Exec Order 2. The NJ Exec Order 2 was delivered continuously NJ Exec Order 26.4b1 The surveyor reviewed Resident #19's hybrid medical records. The admission record (AR) reflected that Resident #19 was admitted to the facility with medical diagnoses which included but was not limited to NJ Exec Order 26.4b1 . A review of the Admission Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 indicating that the resident was NJ Exec Order 26.4b1 On 1/24/24 at 10:50 AM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN #1) assigned to Resident #19 who stated that for any resident who was on NJ Exec Order 26 it must be documented in the electronic treatment administration record. The surveyor interviewed the facility's US FOIA (b)(6)) who stated that there was no Physician's Order (PO) for Resident #19's continuous use of NJ Exec Order 26 A review of the facility's Policy and Procedure titled, "Oxygen Administration" reflected under preparation, "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." On 1/24/24 at 2:50 PM, the surveyor met with the facility's US FOIA (b)(6)	F 658	was corrected to accurately reflect the NJ Ex Order 26.4b1 being given. This deficient practice had the potential to affect all residents. All other residents that were receiving OTC vitamins were checked to ensure the PO matched the vitamins being given. All RN's and LPN's were re-inserviced to ensure that the PO for all OTC vitamins accurately reflect what is being given to the residents. The DON and/designee will conduct monthly audits to ensure there are accurate PO orders for all residents receiving OTC vitamins. These audits will continue until 100% compliance has been achieved for 3 consecutive months. The findings of these audits will be reported to the DON monthly and, at a minimum, to be reviewed at the quarterly QAPI committee meeting to ensure that the solutions are sustained. 3) All residents receiving IV medications have the potential to be affected by this deficient practice. An RN immediately assessed resident #127 to ensure that he and his NJ Ex Order 26.4b1 were OK. This deficient practice had the potential to affect all residents with PICC lines. All other residents with PICC lines were checked along with their PICC lines to see that they were OK.	

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F 658	Continued From page 5	F 658		

and US FOIA (b)(6) acknowledged that there was no PO for Resident #19 who was on NJ Exec Order 26.4b1.

2. On 1/23/24 at 8:40 AM, the surveyor observed LPN #2 administer medication to Resident #5. The surveyor observed LPN #2 dispensed 2 tablets from a bottle labeled, "NJ Exec Order 26.4b1."

The surveyor reviewed Resident #5's hybrid medical records. The AR reflected that Resident #5 was admitted to the facility with medical diagnoses which included but was not limited to NJ Exec Order 26.4b1.

The resident had a current PO which reflected in the NJ Exec Order 26.4b1 electronic Medication Administration Record for "NJ Exec Order 26.4b1 give 2 tablet by mouth one time a day for NJ Exec Order 26.4b1" with an order date of NJ Exec Order 2

The surveyor observed LPN #2 dispensed 2 tablets from a bottle with a label indicating, NJ Exec Order 26.4b1

On 1/23/24 at 10:05 AM, the surveyor interviewed LPN #2 who acknowledged that the medication she administered did not match the current PO for Resident #5. No further information was provided.

3. On 1/22/24 at 11:50 AM, the surveyor observed Resident #127 lying on the bed in the resident's room.

The surveyor reviewed Resident #127's hybrid medical records. The AR reflected that Resident

Provider's Plan of Correction (F 658):

The facility reviewed and updated the policy and procedure for PICC lines to ensure they were in accordance with all Federal and State guidelines.
All RN's and LPN's were re-inserviced with the updated policy and procedure to ensure that PICC line care will be administered in accordance to Federal and State guidelines.
All RN's and LPN's caring for PICC lines will be observed to ensure they have the skills required to care for PICC lines.

The DON and/designee will conduct monthly audits to ensure only trained staff will be caring for the PICC lines. These audits will continue until 100% compliance has been achieved for 3 consecutive months.
The findings of these audits will be reported to the DON monthly and, at a minimum, to be reviewed at the quarterly QAPI committee meeting to ensure that the solutions are sustained.

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F 658	Continued From page 6 #127 was admitted to the facility with medical diagnoses which included but were not limited to NJ Exec Order 26.4b1 . A review of the A/MDS, an assessment tool used to facilitate the management of care, dated NJ Exec Order 26 reflected that the resident had BIMS score of NJ Exe out of 15 indicating that the resident was NJ Exec Order 26.4b1. A review of the progress notes dated NJ Exec Order 26.4b1 which documented that Resident #127 had an NJ Exec Order 26.4b1 A review of the electronic Medication Administration Record (eMAR) reflected a PO dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 Use NJ Exec Order 26.4b1 one time a day for NJ Exec Order care for NJ Exec Order ." The medication was administered by LPN #2 as reflected in the eMAR. Further review of the eMAR reflected a PO dated NJ Exec Order 26 to, " F NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every night shift for NJ days." The medication was administered from NJ Exec Order 26 through NJ Exec Order 26.4b1 by a LPN. The surveyor reviewed the facility's policy and procedure titled, "PICC Medication Administration Policy" with a review date of 7/7/23 which reflected under Policy, "The catheter must be flushed after each use by an Registered Nurse (RN) only. Further review of the policy indicated, "Note: Only RN's with IV certification can access a PICC line, infuse medications, care for and maintain it.	F 658		

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F 658	Continued From page 7 However, an LPN can prepare IV medication, spike and hang the medication on the pole, but will not connect it to PICC." The surveyor interviewed the facility's US FOIA (b)(6) who confirmed that the LPNs who administered the NJ Ex medication through NJ Exec Order 26.4b1 were not NJ Ex certified. On 1/24/24 at 2:50 PM, the surveyor met with the facility's US FOIA (b)(6) and US FOIA (b)(6) agreed that the medication should not have been administered by a non NJ Ex certified LPN. NJAC 8:39- 29.2 (d)	F 658		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 163054 Based on interview and review of the Nurse	F 727	All residents have the potential to be affected by the RN Nursing staffing requirements.	3/26/24

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F 727	Continued From page 8 Staffing Report it was determined that the facility failed to ensure that a required Registered Nurse (RN) was present at the facility 7 days a week for at least 8 consecutive hours a day for 4 of 14 days reviewed. This deficient practice was evidenced by the following: Per the Interpretive Guidance §483.35(b) Facilities are responsible for ensuring they have an RN providing services at least 8 consecutive hours a day, 7 days a week. However, per Facility Assessment requirements at F838, §483.70(e), facilities are expected to identify when they may require the services of an RN for more than 8 hours a day based on the acuity level of the resident population. If it is determined the services of an RN are required for more than 8 hours a day. Facilities may choose to have differing tours of duty (e.g. 8 hour- or 12-hour shifts) for their licensed nursing staff. Regardless of the approach, the facility is responsible for ensuring the 8 hours worked by the RN are consecutive within each 24-hour period. Review of the Nurse Staffing Report completed by the facility for the week of 3/12/23 to 3/25/23 revealed the facility had no RN coverage on any shift for the following days: 3/12/23, 3/18/23, and 3/19/23. Review of the Nurse Staffing Report completed by the facility for the week of 1/14/24 to 1/20/24 revealed the facility had no RN coverage on any shift for 1/15/24. On 1/24/24 at 2:15 PM, during an interview with the surveyors, the US FOIA (b)(6))	F 727	US FOIA (b)(6) was re-in serviced on the RN staffing requirements on 2/1/24 Facility RN starting hourly rates were increased to attract hiring of RN's. Additional pay/gift cards will be offered on an as needed basis to provide required RN staffing. Facility administrator reviewed with the DIRECTOR OF NURSING the facilities hiring and staff retention program. Facility increased the number of RN's on staff and a number of LPN's currently employed at Clover are working towards their RN. Facility intends to continue to employ them when they achieve RN status. The administrator and or designee will perform monthly audits to review the previous months compliance. Findings identifying staffing concerns will be addressed upon completion of the audits. These audits will continue until at least 95% compliance is achieved for 3 consecutive months. The administrator and or the management designee will report the findings of the staffing audits and corrective actions to the quarterly QAPI committee.	

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F 727	Continued From page 9 agreed that there should be a RN in the facility daily for 8 consecutive hours. The [US FOIA (b)] stated that she was previously the only RN employed by the facility. No further information was provided. NJAC 8:39-25.2(h)	F 727		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices to prevent food borne illness. This deficient practice was observed and evidenced by the following:	F 812	All residents have the potential to be affected by this deficient practice. The microwave was cleaned immediately. the 2 air conditioning units had the air outlet grills cleaned immediately. This deficient practice had the potential to affect all residents.	3/26/24

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F 812

Continued From page 10

On 1/22/24 at 9:10 AM, the surveyor in the presence of the US FOIA (b)(6)), observed the following during the kitchen tour:

1. In the food preparation area, the surveyor observed the microwave with a white and yellowish debris throughout the microwave.

2. Next to the refrigerator/freezer the surveyor observed an Air Condition (AC #1) unit with a heavy buildup of a brown colored dust-like debris on the air outlet grill of the AC.

3. Above the 3 compartment sink, the surveyor observed AC #2 with a heavy buildup of a brown colored dust-like debris on the air outlet grill of the AC.

The US FOIA (b) explained that the debris in the microwave was from the weekend staff, unable to state why nobody had cleaned the microwave.

The US FOIA (b) revealed that the microwave should be cleaned after each meal and/or when visibly soiled.

The US FOIA (b) verified that the maintenance department is responsible for maintaining and cleaning the AC units.

On 1/22/24 at 10:30 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that cleaning should be performed monthly but did not have a documented schedule. The US FOIA revealed that the ACs where cleaned last month but could not provide any documented proof that this occurred.
On 1/24/24 at 9:55 AM, the US FOIA (b) provided the surveyor with a facility policy titled, "Clover Rest

F 812

All other small appliances in the kitchen were checked to see that they were clean. The US FOIA (b)(6) and kitchen staff & housekeeping were re-inserviced to ensure that properly cleanliness of all appliances is maintained and who is responsible to clean each item/area.
a daily check list was posted in the kitchen area to ensure that the appliances that were found to be not clean are clean.

The DOM/designee will conduct daily audits to ensure that the microwave and AC air outlet grills are clean. These audits will continue until 90% compliance has been achieved for 3 consecutive months. The findings of these audits will be reported to the administrator monthly and, at a minimum, to be reviewed at the quarterly QAPI committee meeting to ensure that the solutions are sustained.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET COLUMBIA, NJ 07832**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 11 Home Sanitation of Small Equipment", no created or revised date noted. Under the policy section it states, "Small equipment will be cleaned and sanitized as needed to maintain good sanitation and prevent foodborne illness." Under the procedure section of the policy it states, "Nonfood contact surfaces will be cleaned & wiped with a sanitizing solution ...Microwave will be cleaned as needed, a minimum of once daily. Inside and outside will be cleaned & wiped with a sanitizing solution." On 1/24/24 at 2:15 PM, the survey team met with the US FOIA (b)(6) and US FOIA (b)(6)). The US FOIA (b)(6) acknowledged that all equipment in the kitchen should be cleaned and sanitized when visibly soiled. No further information was provided. NJAC 8:39-17.2(g)	F 812		
F 912 SS=F	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observations and interview on 01/25/2024 and 01/26/2024, it was determined that the facility failed to provide at least 80-square feet per Resident bed in multi-bedded rooms or 100-square feet in a single bedded room as evidenced by the following: On 01/25/2024 during the survey entrance at approximately 10:01 AM, a request was made to	F 912	Building was built approx. 1920's as a 3 story boarding home for the Aged. In late 1970's NJDOH converted building into SNF allowing Residents to live only on main floor. All 33 Residents only live on main floor with existing rooms as built. Both the NJDOH team leader and physical plant surveyor noted that they	3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING ______ B. WING ______	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

(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 912	Continued From page 12	F 912		

the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility is a three-story (3) building with a basement. There are eighteen (18) Resident sleeping rooms and common areas on the first floor.

Starting on 01/25/2024 at approximately 10:40 AM, in the presence of the facility's US FOIA (b), the surveyor observed, measured and recorded the following Resident rooms:

A-Wing Resident rooms:
A-1 measured 61 square feet per resident bed
A-2 measured 91.54 square feet per single bedded room
A-3 measured 63.5 square feet per resident bed
A-4 measured 47.5 square feet per resident bed

B-Wing Resident rooms
B-1 measured 75.7 square feet per resident bed
B-2 measured 74.57 square feet per resident bed
B-3 measured 73.2 square feet per resident bed
B-4 measured 72.7 square feet per resident bed
B-5 measured 63.85 square feet per resident bed
B-6 measured 58.23 square feet per resident bed

found rooms in good condition, homelike, free of clutter and accommodating the needs of all Residents. The rooms have proper lighting, clear means of egress and easy access to bathrooms.
Residents and families survey indicated they are extremely satisfied and happy with their rooms, care and environment. They feel comfortable in their rooms and its size. Easy mobility, sufficient living space and ability to freely ambulate was noted including
Nurse call system, fire safety and emergency egress systems were all in compliance.

Residents currently residing in the effected rooms do not want to leave and therefor we are requesting a variance to allow the residents to remain in their rooms.
should any of the residents be discharged from the facility the room will not be refilled until it meets the size requirements,

24 residents have the potential to be affected by the room size.

Facility has interviewed and engaged an architect/engineering company to do a design and reconfiguration assessment in order to reconfigure the other rooms and bring them up to code.

Facility will conduct quarterly audits of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING ______ B. WING ______	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

(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 912	Continued From page 13 B-7 measured 58.35 square feet per resident bed B-8 measured 58.6 square feet per resident bed The facility's US FOIA (b) confirmed the findings at the times of inspection. The US FOIA (b)(6)r (via telephone) and US FOIA (b) was informed of the deficiency during the Life Safety Code survey exit on 01/26/2024 at approximately 12:05 PM. NJAC 8:39 -31.2	F 912	rooms and residents of the rooms that are not 80 square feet per resident to ensure that they are free of clutter and that the residents are satisfied with the size of the rooms. These Audits will be presented to the QAPI/Safety Committee for the quarterly meetings	

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
	62104	A. BUILDING: ____ B. WING ____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET COLUMBIA, NJ 07832**

(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 was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Complaint # NJ00163064 Based on observation, interview, and 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. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes	S 560	1. US FOIA (b)(6) was re-in serviced on the required staffing ratios on 02/1/24. 2. All residents have the potential to be affected by the NJ Nursing staffing ratios requirement. 3. Facility CNA Minimum hourly rates were increased significantly to attract hiring of CNA□s. Additional pay/gift cards will be offered on an as needed basis to provide required staffing ratios. Facility administrator reviewed with the DIRECTOR OF NURSING the facility's hiring and staff retention program. Ongoing posting of available jobs	3/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62104	A. BUILDING: ______ B. WING ______	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

(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 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the	S 560	reflecting rate increases. Referral bonuses of $2400 were reposted in facility and reviewed with staff. The administrator and or designee will perform monthly audits to review the previous months compliance. Findings identifying staffing concerns will be addressed upon completion of the audits. These audits will continue until 100% compliance is achieved for 3 consecutive months. 4. The administrator and or the management designee will report the findings of the staffing audits and corrective actions to the quarterly QAPI committee.	

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
	62104	A. BUILDING: ______ B. WING ______	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET COLUMBIA, NJ 07832**

(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 2 midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 3/12/23 and ending 3/25/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 1 of 14 day shifts. The facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -03/12/23 had 3 CNAs for 31 residents on the day shift and required at least 4 CNAs. On 2/5/23 at 11:42 AM , the surveyor discussed the lack of required staff with the Licensed Nursing Home Administrator who did not provide any further information.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING ______ B. WING ______	R-C **05/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An offsite/desk review was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities, specifically F912.	{F 000}		

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315429	A. Building B. Wing	5/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

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 F0727 Reg. # 483.35(b)(1)-(3) LSC	Correction Completed 03/26/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315429	A. Building B. Wing	5/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

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 F0641 Reg. # 483.20(g) LSC	Correction Completed 03/26/2024	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 03/26/2024	ID Prefix F0727 Reg. # 483.35(b)(1)-(3) LSC	Correction Completed 03/26/2024
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 03/26/2024	ID Prefix F0912 Reg. # 483.90(e)(1)(ii) LSC	Correction Completed 03/26/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
1/26/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62104 (Y1)	A. Building B. Wing (Y2)	5/9/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/26/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ___	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

(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 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/25/2024 and 01/26/2024 and Clover Rest Home was found to be in noncompliance 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. Clover Rest Home is a three story Type IV heavy timber building with the residents located on the 1st floor. The building is entirely protected by an automatic sprinkler system and fire alarm/detection. The facility has a 30 KW Propane Gas Emergency Generator.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories	K 161		3/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/08/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

(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 161	Continued From page 1 sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/2024, it was determined that the facility failed to comply with the construction requirements of the National Fire Protection Association (NFPA) 101:2012. The building exceeded the two story height requirement for Type IV wood-frame structures with a sprinkler system. This had the potential to affect all residents who resided in the facility. Findings included: 1. A tour of the nursing facility on 01/25/2024, in the presence of the US FOIA (b)(6)	K 161	K161 Plan of Correction for affected areas The facility has a time-limited waiver to remove all storage and vacate the 3rd floor. The waiver expires on 8/31/2024. The facility has removed all storage and vacated the 3rd floor. The facility permanently sealed off the access to the 3rd floor from inside the building allowing no access. The third floor is fully sprinklered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING 01 B. WING ______	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

(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 161	Continued From page 2 US FOIA (b)(6)), revealed the building was a three story wood-frame structure. The building exceeded the two story height requirement for Type IV wood-frame structures with a sprinkler system. During the survey entrance on 01/25/2024 at 10:01 AM, the US FOIA (b)(6) acknowledged the above concern. The US FOIA (b)(6) (via telephone) and US FOIA (b)(was informed of the deficiency during the Life Safety Code survey exit on 01/26/2024 at approximately 12:05 PM. New Jersey Administrative Code § 8:39-31.1(c)	K 161	The facility completed an FSES Equivalency calculation for the basement through second floor dated 3/08/24 showing that all these floors achieve fire safety equivalent that is required by NFPA 101, Life Safety Code, 2012 Edition (NFPA101-2012). The facility meets the requirement of a two-story Type IV wood-frame structure with a sprinkler system. Plan of Correction to identify other areas potentially affected The facility acknowledges that all residents have the potential to be affected by this practice. The facility has permanently sealed off the access to the 3rd floor from inside the building allowing no access. Plan of Correction for system measures to prevent reoccurrence The Director of Maintenance will inspect the permanent barrier sealing off the 3rd floor monthly. The Director of Maintenance will utilize an audit tool to document the findings and report the audit findings to the QAPI Committee monthly for a period of six (6) months. Plan of Correction for monitoring corrective actions The Director of Maintenance or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ____	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

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K 161	Continued From page 3	K 161	will review monthly audits for any cases of non-compliance. The Director of Maintenance or Designee will report the result of the audits to the QAPI committee on a monthly basis for 6 months, as well as correction plan if warranted. Responsibility: Administrator	
K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/2024 and 01/26/2024, it was determined that the facility failed to provide a corridor which was at least four feet wide. This had the potential to affect all residents residing in the facility. Findings included: On 01/25/2024 during the survey entrance at approximately 10:01 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.	K 232	K232 Plan of Correction for affected areas The facility will maintain the current corridor free of obstructions that the residents transverse with walkers and wheelchairs. The facility will also permanently provide a 48" wide access walkway through the main sitting room adjacent to the identified corridor as an alternate access. The FSES completed 3/08/24 indicates the corridor on the main floor of the building in which the deficiency is located achieved a passing FSES score. The	3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ____	**01/26/2024**

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K 232	Continued From page 4 A review of the facility provided lay-out identified the facility is a three-story (3)building. Starting at 10:15 AM on 01/25/2024 and continued on 01/26/2024 in the presence of the [US FOIA (b)] a tour of the building was conducted. At approximately 10:51 AM on 01/26/2024, the surveyor observed, measured and recorded a section of exit access corridor next to the kitchen measured 39 inches in clear width. The [US FOIA (b)] confirmed the finding that the section of the corridor was less than four feet in width at the time of observation. The [US FOIA (b)(6)]r (via telephone) and [US FOIA (b)] was informed of the deficiency during the Life Safety Code survey exit on 01/26/2024 at approximately 12:05 PM. New Jersey Administrative Code § 8:39-31.1(c)	K 232	residents are kept safe as evidenced by the passing FSES score. Plan of Correction to identify other areas potentially affected The facility acknowledges that all residents have the potential to be affected by this practice. The Director of Maintenance inspected all areas throughout the facility for same deficiency. None were identified. Plan of Correction for system measures to prevent reoccurrence All staff will receive additional education and all participants will understand the life safety issues with maintaining the existing corridor free of obstructions and providing an alternative 48" wide access walkway through the main sitting room. The Director of Maintenance has been assigned the responsibility for the education of all staff. This education will be provided to all new staff and will be reviewed when concerns are identified. The Director of Maintenance or Designee will check the identified corridor and alternative access walkway monthly for compliance. The Director of Maintenance will utilize an audit tool to document the findings and report the audit findings to the QAPI Committee monthly for a period of six (6) months. Plan of Correction for monitoring corrective actions The Director of Maintenance or Designee will review monthly audits for any cases of non-compliance. The Director of Maintenance or Designee will report the result of the audits to the QAPI committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ______	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

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K 232	Continued From page 5	K 232	on a monthly basis for 6 months, as well as correction plan if warranted. Responsibility: Administrator	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/25/2024 in the presence of facility management, it was determined that the facility failed to: 1) To provide one (1) illuminated exit sign to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3,	K 293	K293 Plan of Correction for affected areas The facility contracted company will permanently install an illuminated exit sign at the identified fire rated corridor door (next to Resident room #B-2) to clearly identify the exit access route to reach an exit. Plan of Correction to identify other areas potentially affected The facility acknowledges that all residents have the potential to be affected by this practice. The Director of Maintenance inspected all areas throughout the facility for same deficiency. None were identified. Plan of Correction for system measures to prevent reoccurrence The Director of Maintenance will receive additional education and all participants	3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 293	Continued From page 6 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 01/25/2024 (day one of survey) during the survey entrance at approximately 10:01 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6) provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3) building with six (6) designated exit (illuminated exit signs above the doors) discharge doors on the first floor that Resident, Staff and Visitors could use in the event	K 293	will understand the life safety issues with NFPA Life Safety Code 2012 7.10.1.5.1. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. The Life Safety Consultant has been assigned the responsibility for the education of Director of Maintenance. The Director of Maintenance or Designee will check exit signage monthly for compliance with NFPA Life Safety Code 2012 7.10.1.5.1. The Director of Maintenance will utilize an audit tool to document the findings and report the audit findings to the QAPI Committee monthly for a period of six (6) months. Plan of Correction for monitoring corrective actions The Director of Maintenance or Designee will review monthly audits for any cases of non-compliance. The Director of Maintenance or Designee will report the result of the audits to the QAPI committee on a monthly basis for 6 months, as well as correction plan if warranted. Responsibility: Administrator	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

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K 293	Continued From page 7 of an emergency. Starting at 10:15 AM on 01/25/2024, in the presence of the US FOIA (b) a tour of the building was conducted. During the building tour at approximately 11:58 AM, the surveyor observed above the 1-1/2 fire rated corridor door (next to Resident room #B-2) no evidence of an illuminated exit sign to clearly identify the exit access route to reach an exit. The US FOIA (b) confirmed the findings at the time of observation. The US FOIA (b)(6) (via telephone) and US FOIA (b)(was informed of the deficiency during the Life Safety Code survey exit on 01/26/2024 at approximately 12:05 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 01/25/2024 and 01/26/2024 in the presence of facility management, it was	K 355	K355 Plan of Correction for affected areas The Director of Maintenance or Designee	3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING 01 B. WING ____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 355	Continued From page 8 determined that the facility failed to: 1) Install portable fire extinguishers with-in the required height for 4 of 18 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 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 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. Reference #2 NFPA 10 Edition 2010 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	K 355	will permanently remount the identified fire extinguishers so that the top of type fire extinguisher is not more than 5 feet above the floor and no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. Plan of Correction to identify other areas potentially affected The facility acknowledges that all residents have the potential to be affected by this practice. The Director of Maintenance inspected all areas throughout the facility for same deficiency. None were identified. Plan of Correction for system measures to prevent reoccurrence The Director of Maintenance will receive additional education and all participants will understand the life safety issues with NFPA 10 Edition 2010 6.1.3.8 Installation Height. The Life Safety Consultant has been assigned the responsibility for the education of Director of Maintenance. The Director of Maintenance or Designee will check all fire extinguishers monthly for compliance with NFPA 10 Edition 2010 6.1.3.8 Installation Height. The Director of Maintenance will utilize an audit tool to document the findings and report the audit findings to the QAPI Committee monthly for a period of six (6) months. Plan of Correction for monitoring corrective actions The Director of Maintenance or Designee will review monthly audits for any cases of non-compliance. The Director of Maintenance or Designee will report the	

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	315429	A. BUILDING **01** B. WING ______	**01/26/2024**

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K 355	Continued From page 9 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. The findings include the following, On 01/25/2024 (day one of survey) during the survey entrance at approximately 10:01 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3)building with a basement. Starting at 10:15 AM on 01/25/2024 and continued on 01/26/2024 in the presence of the US FOIA (b) an inspection of the building was conducted.. During the two (2) day tour of the facility the surveyor observed and inspected eighteen (18) portable fire extinguishers in various locations with the following issues that were identified: On 01/25/2024: 1) At approximately 10:30 AM, the surveyor observed on the 3rd. floor near room #8 one (1) ABC-Type fire extinguisher that appeared to be mounted too high. At this time the surveyor measured and recorded the fire extinguisher to be 5'-3-1/4" to the center of the pressure indicating needle gauge. 2) At approximately 11:10 AM, the surveyor observed on the basement level near the Laundry area one (1) ABC-Type fire extinguisher that	K 355	result of the audits to the QAPI committee on a monthly basis for 6 months, as well as correction plan if warranted. Responsibility: Administrator	

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	315429	A. BUILDING **01** B. WING	**01/26/2024**

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K 355	Continued From page 10 appeared to be mounted too high. At this time the surveyor measured and recorded the fire extinguisher to be 5'-3-3/4" to the center of the pressure indicating needle gauge. 3) At approximately 11:55 AM, the surveyor observed on the 1st. floor near the "B" Nursing station one (1) ABC-Type fire extinguisher that appeared to be mounted too high. At this time the surveyor measured and recorded the fire extinguisher to be 5'-2-1/4" to the center of the pressure indicating needle gauge. 4) At approximately 12:11 PM, the surveyor observed on the 1st. floor in the corridor next to the stairwell leading up to the second floor one (1) ABC-Type fire extinguisher that appeared to be mounted too high. At this time the surveyor measured and recorded the fire extinguisher to be 5'-5" to the center of the pressure indicating needle gauge. The US FOIA (b)(confirmed the findings at the time of observation. The US FOIA (b)(6) r (via telephone) and US FOIA (b)(was informed of the deficiency during the Life Safety Code survey exit on 01/26/2024 at approximately 12:05 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke	K 363		3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ___	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

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K 363	Continued From page 11 and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 01/25/2024 and 01/26/2024, in the presence of facility management it was determined that the facility failed to ensure that 6	K 363	K363 Plan of Correction for affected areas 1. The Director of Maintenance or Designee will permanently install a fire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ____________	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

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K 363	Continued From page 12 of 21 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 01/25/2024 during the survey entrance at approximately 10:01 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3)building with a basement There are eighteen (18) Resident sleeping rooms and common areas on the first floor. During the two (2) day tour of the facility the surveyor performed closure tests of the twenty-one (21) doors in the corridors with the following results, On 01/25/2024: 1) At approximately 11:11 AM, during a closure test of Basement level Commercial Laundry room door was closed into its frame had a 1-3/4 inch under cut along the bottom edge of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 11:49 AM, during a closure test of Resident room #B-1 had a 1/4 inch gap at the top of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.	K 363	rated extension to the Basement level Commercial Laundry room door to provide an undercut less than 1 inch. 2. The facility will permanently repair Resident room #B-1 corridor door assembly to resist the passage of smoke. 3. The facility will permanently repair Resident room #B-8 corridor door assembly to resist the passage of smoke. 4. The facility will permanently repair Resident room #B-7 corridor door assembly to resist the passage of smoke. 4. The facility will permanently repair Resident room #B-6 corridor door assembly to resist the passage of smoke. 4. The facility will permanently repair Resident room #B-2 corridor door assembly to resist the passage of smoke. Plan of Correction to identify other areas potentially affected The facility acknowledges that all residents have the potential to be affected by this practice. The Director of Maintenance or Designee checked all doors for gaps exceeding NFPA requirements to resist the passage of smoke and in good repair. Any deficiencies were corrected immediately. Plan of Correction for system measures to prevent reoccurrence The Director of Maintenance will receive additional education and all participants will understand the life safety issues with NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, and 19.3.6.5. The Life Safety Consultant has been assigned the responsibility for the education of Director of Maintenance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 13 3) At approximately 12:01 PM, during a closure test of Resident room #B-8 had a 5/8 inch gap at the top of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 4) At approximately 12:03 PM, during a closure test of Resident room #B-7 had a 1/4 inch gap at the top of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 5) At approximately 12:05 PM, during a closure test of Resident room #B-6 had a 1/2 inch gap at the top of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 6) At approximately 12:09 PM, during a closure test of Resident room #B-2 had a 1/4 inch gap at the top of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. Review of two (2) emergency evacuation diagrams posted on the corridor walls identify that you would need to pass these rooms to reach an exit discharge door in the event of a fire. The US FOIA (b)(confirmed the finding at the time of observation. The US FOIA (b)(6) (via telephone) and US FOIA (b)(6) was informed of the deficiency during the Life Safety Code survey exit on 01/26/2024 at approximately	K 363	The Director of Maintenance or Designee will check all corridor doors monthly for compliance with NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, and 19.3.6.5. The Director of Maintenance will utilize an audit tool to document the findings and report the audit findings to the QAPI Committee monthly for a period of six (6) months. Plan of Correction for monitoring corrective actions The Director of Maintenance or Designee will review monthly audits for any cases of non-compliance. The Director of Maintenance or Designee will report the result of the audits to the QAPI committee on a monthly basis for 6 months, as well as correction plan if warranted. Responsibility: Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING 01 B. WING ____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 14 12:05 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 01/25/2024 and 01/26/2024, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 4 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for	K 911	K911 Plan of Correction for affected areas The facility contractor will permanently install a ground-fault circuit- interrupter receptacle in place of the identified electrical receptacle in the Residents Salon located 5 feet 2 inches to the left of the hair washing sink. Plan of Correction to identify other areas potentially affected The facility acknowledges that all residents have the potential to be affected by this practice. The Director of Maintenance inspected all areas throughout the facility for same deficiency. None were identified. Plan of Correction for system measures to prevent reoccurrence The Director of Maintenance will receive additional education and all participants will understand the life safety issues with	3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ______	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

(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 911	Continued From page 15 personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 01/25/2024 (day one of survey) during the survey entrance at approximately 10:01 AM, a request was made to the US FOIA (b)(6) [redacted]) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3)building with a basement. There are 18 Resident sleeping rooms and common areas on the first floor. Starting at 10:15 AM on 01/25/2024 and continued on 01/26/2024 in the presence of the facility US FOIA (b) an inspection tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested four (4) electrical outlets in wet (with-in 6 feet of a sink) locations with one (1) electrical outlet that failed to de-energize when tested in the following location, On -1/25/202412/18/2023: 1. At approximately 11:26 AM, inside the Residents Salon, one Duplex electrical outlet	K 911	NFPA 70, 210.8 (5). The Life Safety Consultant has been assigned the responsibility for the education of Director of Maintenance. The Director of Maintenance or Designee will check GFCI receptacles monthly for compliance with NFPA Life Safety Code 2012 7.10.1.5.1. The Director of Maintenance will utilize an audit tool to document the findings and report the audit findings to the QAPI Committee monthly for a period of six (6) months. Plan of Correction for monitoring corrective actions The Director of Maintenance or Designee will review monthly audits for any cases of non-compliance. The Director of Maintenance or Designee will report the result of the audits to the QAPI committee on a monthly basis for 6 months, as well as correction plan if warranted. Responsibility: Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING 01 B. WING	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

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K 911	Continued From page 16 located 5 feet 2 inches to the left of the hair washing sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The US FOIA (b)(6) confirmed the finding at the time of observation. The US FOIA (b)(6) (via telephone) and US FOIA (b)(6) was informed of the deficiency during the Life Safety Code survey exit on 01/26/2024 at approximately 12:05 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ___________	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

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K 918	Continued From page 17 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and document review on 01/19/2024 and 01/22/2024, it was determined the facility failed to: 1) Document the time needed by the generator to transfer power to the building was within the 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. 2) Ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. Findings included: On 01/25/2024 (day one of survey) during the survey entrance at approximately 10:01 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6) if the facility had an emergency generator, what type of fuel and how often does the facility run the emergency generator. The US FOIA (b)(6) told the surveyor, yes we have a	K 918	K918 Plan of Correction for affected areas The facility Emergency Generator vendor will permanently install a remote shut off switch for the emergency generator. The Director of Maintenance or Designee will continue to document the transfer time of the monthly load test of the emergency generator in the Records & Logs book. Plan of Correction to identify other areas potentially affected All residents have the potential to be affected by this practice. The facility will permanently install a remote shut off switch on the emergency generator. Plan of Correction for system measures to prevent reoccurrence The Director of Maintenance provided an Emergency Generator Emergency Shut off button Policy and Procedure. The Director of Maintenance will receive additional education and all participants	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315429	A. BUILDING **01** B. WING ______	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	**28 WASHINGTON STREET** **COLUMBIA, NJ 07832**

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K 918	Continued From page 18 Propane Gas Emergency Generator, we run it weekly, it runs under a load monthly and we keep a logbook. The surveyor asked the [US FOIA] to provide the logs for the last 24 months (01/01/2022 through 12/31/2023) for review later. Starting at approximately 10:15 AM on 01/25/2024 in the presence of the facility's [US FOIA (b)] a tour of the building was conducted. At approximately 10:55 AM, an inspection outside of the building, where the Propane Gas Emergency Generator was located was performed. The surveyor observed the emergency stop button was located inside the generator metal housing on the control panel on the generator. At this time the surveyor asked the [US FOIA (b)], "Do you have a remote emergency stop button for the generator." The [US FOIA (b)] told the surveyor, no. On 01/26/2024 (day two of survey) at approximately 9:59 AM a review of the "Emergency Generator Monthly Log" for the previous 24 months identified the following documented monthly load dates with the transfer times, - 11/27/2023, Transfer Time to Emergency Power: 4 seconds. - 12/18/2023, Transfer Time to Emergency Power: 5 seconds. The monthly generator load transfer logs identified 2 of 24 months had the transfer times documented on the monthly load log sheets. There was no documented Transfer times for following months: 01/2022, 02/2022, 03/2022, 04/2022, 05/2022, 06/2022, 07/2022, 08/2022, 09/2022, 10/2022.	K 918	will understand the life safety issues with NFPA 99 and NFPA 110. The Life Safety Consultant has been assigned the responsibility for the education of Director of Maintenance. The Director of Maintenance or Designee will inspect the emergency generator remote shut off switch monthly. The Director of Maintenance or Designee will document the transfer time during the monthly load test and document in the Records & logs book. The Director of Maintenance will utilize an audit tool to document the findings and report the audit findings to the QAPI Committee monthly for a period of six (6) months. Plan of Correction for monitoring corrective actions The Director of Maintenance or Designee will review monthly audits for any cases of non-compliance. The Director of Maintenance or Designee will report the result of the audits to the QAPI committee on a monthly basis for 6 months, as well as correction plan if warranted. Responsibility: Administrator	

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	315429	A. BUILDING **01** B. WING ______	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 19 11/2022, 12/2022,01/2023, 02/2023, 03/2023, 04/2023, 05/2023, 06/2023, 07/2023, 08/2023, 09/2023 and 10/2023. At approximately 10:20 AM, the surveyor asked the US FOIA (b)(6) if he could provide the emergency generator transfer times for the 22 monthly load dates. The US FOIA (b)(6) told the surveyor that he just started to document the transfer times on the log sheets. The US FOIA (b)(6) confirmed the finding at the time of interview and review of log. The US FOIA (b)(6) (via telephone) and US FOIA (b)(6) was informed of the deficiency during the Life Safety Code survey exit on 01/26/2024 at approximately 12:05 PM. NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NJAC 8:39-31.2(g)	K 918		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315429	A. Building 01 - MAIN BUILDING 01 B. Wing	5/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER REST HOME	28 WASHINGTON STREET COLUMBIA, NJ 07832

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 Reg. # NFPA 101 LSC K0161	Correction Completed 03/26/2024	ID Prefix Reg. # NFPA 101 LSC K0232	Correction Completed 03/26/2024	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 03/26/2024
ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 03/26/2024	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 03/26/2024	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 03/26/2024
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 03/26/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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