STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A001	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE	338 CHESTNUT STREET PASSAIC, NJ 07055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard Survey CENSUS: 86 SAMPLE SIZE: 9 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A1097	8:36-16.6 Physical Plant All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by:	A1097		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A001	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE	338 CHESTNUT STREET PASSAIC, NJ 07055

(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
A1097	Continued From page 1 Based on observation and review of facility documentation, it was determined the facility failed to perform quarterly, every 3 months, inspections of the building's fire sprinkler system as required. This deficient practice was evidenced by the following: On 7/31/2019 during the entrance conference with the the facility's Executive Director (ED) and maintenance staff, the surveyor requested that they complete page 5, the "Physical Environment Inspections," of the Affidavit of Compliance document with inspection dates going back to January 1, 2018. During the tour of the building, in the presence of maintenance staff, at approximately 11:42 a.m., the surveyor inspected the sprinkler control valves and observed on the inspection tag attached to the control valves, that the last quarterly inspected was on 2/5/2018. Later at approximately 12:55 p.m., the surveyor reviewed the facility provided Physical Environment Inspections form and observed that the facility documented that quarterly, every 3 months, inspections of the buildings sprinkler system were performed on the following dates: 12/14/2017, 3/29/2018, 6/13/2018, 8/22/2018 and 12/12/2018. Surveyor review of the facility provided quarterly sprinkler inspections revealed that the facility had inspections on the following dates: 2/15/2018, 6/13/2018, 9/22/2018, 12/12/2018 and 3/26/2019. At approximately 12:45 p.m. the surveyor requested that the ED and maintenance staff provide any additional quarterly inspections of the sprinkler system for the year 2019. Both were	A1097		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A001	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE	338 CHESTNUT STREET PASSAIC, NJ 07055

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A1097	Continued From page 2 unable to provide any additional inspections. On 8/1/2019, day two of the survey, the ED provided the surveyor with an e-mail from the Contracted Sprinkler Inspection Company that read in part, Attachments: "Chestnut Hill Residence 8/22/2018 pdf." "Chestnut Hill Residence 2/15/2018 pdf." "Chestnut Hill Residence 12/12/2018 pdf." "Chestnut Hill Residence 6/13/2018 pdf." "Chestnut Hill Residence 3/26/2018 pdf." Also documented on the same email, hand written in, "3rd quarterly inspection performed 8/1/2019. I can forward documentation." The hand written comment was signed by the facility Executive Director The facility failed to inspect the sprinkler system quarterly, every 3 months, from 3/26/2019 to 8/1/2019.	A1097		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A001	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE	338 CHESTNUT STREET PASSAIC, NJ 07055

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A1249	Continued From page 3 by: Based on observations it was determined the facility failed to provide a safe and fire hazard free environment for the residents. This deficient practice was as evidenced by the following: On 7/31/2019 during the tour of the building, in the presence of the facility's maintenance staff, the surveyor observed the following safety and fire hazards: At 11:46 a.m. the surveyor inspected the [redacted] floor service corridor and observed one (1) [redacted] snow blower and one (1) [redacted] snow blower stored in the egress corridor. At that time the surveyor asked the maintenance staff if there was gasoline in the 2 snow blowers. The maintenance staff stated, "I don't know." The surveyor removed the gasoline caps from both snow blowers and observed that both tanks were full with gasoline. At that time the surveyor requested that the maintenance staff remove the snow blowers from the building. The MS complied with the request and removed the snow blowers.	A1249		
A1299	8:36-18.3(a)(5) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident;	A1299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A001	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE	338 CHESTNUT STREET PASSAIC, NJ 07055

(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
A1299	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure proper hand hygiene during medication administration when the surveyor observed one Certified Medication Aide (CMA #1), administer 13 doses of medications to [redacted] of [redacted] residents, Resident [redacted] and Resident [redacted]. This deficient practice was evidenced by the following: On 8/1/19, during the 9 a.m. medication pass, the surveyor observed CMA #1 prepare [redacted] medications for administration to Resident [redacted] CMA #1 did not use hand hygiene prior to removing the tablets from a Bingo card of medication (a unit dose medication delivery system). The CMA administered [redacted] doses of medications by mouth, and then administered an [redacted] to Resident [redacted] without wearing gloves or performing hand hygiene prior to or after the administration of the [redacted] The surveyor then observed the CMA #1 prepare [redacted] medications to administer to Resident [redacted]. The surveyor observed that CMA #1 did not perform hand hygiene prior to or after the administration of the medications. The surveyor then observed the CMA#1 prepare medications for another resident without performing hand hygiene. At 10:15 a.m. the surveyor interviewed CMA#1 who agreed that she should have performed hand hygiene between residents and during the administration of [redacted]. At 10:30 a.m., the surveyor interviewed the Director of Nursing who stated that the CMA should have used hand hygiene between residents during the	A1299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A001	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE	338 CHESTNUT STREET PASSAIC, NJ 07055

(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
A1299	Continued From page 5 administration of medications. The surveyor then reviewed the facility policy titled, "Hand Washing" which stated "Personnel, who have had contact with resident's excretions, secretions or blood, whether directly or indirectly...shall wear gloves and then wash their hands with soap and warm water for 20 seconds." In addition, the policy stated "Hand sanitizer can be used for each resident. After caring for 3 residents hands must be washed with soap and water." The surveyor reviewed a document titled, "Medication Pass Observation Worksheet" dated 6/20/19 which documented the observation on CMA #1 as she performed a medication pass on that date. According to the form, CMA performed hand washing appropriately. The facility failed to ensure hand hygiene was completed during medication pass in accordance with the facility policy and CMA training competencies.	A1299		
A1303	8:36-18.3(a)(7)(i-iv) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 7. Sterilization, disinfection, and cleaning practices and techniques used in the facility, including, but not limited to, the following: i. Care of utensils, instruments, solutions, dressings, articles, and surfaces;	A1303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A001	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE	338 CHESTNUT STREET PASSAIC, NJ 07055

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A1303	Continued From page 6 ii. Selection, storage, use, and disposition of disposable and nondisposable resident care items. Disposable items shall not be reused; iii. Methods to ensure that sterilized materials are packaged, labeled, processed, transported, and stored to maintain sterility and to permit identification of expiration dates; and iv. Care of urinary catheters, intravenous catheters, respiratory therapy equipment, and other devices and equipment that provide a portal of entry for pathogenic microorganisms; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to implement a policy for preventing the sharing of resident care devices, which expose residents to respiratory sections, in order to decrease the risk of the spread of infection by respiratory pathogens for [redacted] of [redacted] residents, Residents [redacted] Resident [redacted] and Resident [redacted] This deficient practice was evidenced by the following: On 7/31/19 at 11:00 a.m., the surveyor observed a [redacted], ([redacted]). The surveyor then observed separate plastic bags, each contained a face mask and were labeled with the names of Resident [redacted] Resident [redacted] and	A1303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1303	Continued From page 7 Resident [redacted] During interview, LPN#1 stated that each resident had their own face masks, however this device was shared among the 3 residents. The surveyor observed that the device was labeled with the name of Resident [redacted] and there was no [redacted] for Resident [redacted] or Resident [redacted] The surveyor reviewed the facility policy titled, "Equipment & Supplies for Administration of Medication," which documented, "All nebulizer machines must be labeled with resident name for specific use of that resident." At 11:15 a.m. the surveyor interviewed the Director of Nursing (DON) who stated that each resident should have their own equipment and that respiratory devices should not be shared among residents. The facility failed to implement its own policy for providing individual [redacted] machines to decrease the spread of respiratory pathogens.	A1303		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
16A001 Y1	A. Building B. Wing Y2	8/21/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE CARE	338 CHESTNUT STREET PASSAIC, NJ 07055

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 A1097	Correction	ID Prefix A1249	Correction	ID Prefix A1299	Correction
Reg. # 8:36-16.6	Completed	Reg. # 8:36-17.7	Completed	Reg. # 8:36-18.3(a)(5)	Completed
LSC	08/20/2019	LSC	08/01/2019	LSC	08/14/2019
ID Prefix A1303	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-18.3(a)(7)(i-iv)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/15/2019	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/1/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
	16A001	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCE	338 CHESTNUT STREET PASSAIC, NJ 07055

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

Executive Director | 8/20/19

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

A1097 8:36-16.6

Corrective action for the residents found affected by the alleged deficient practice:
Sprinkler Control Valves - (1) inspection tag stated last inspection was 2/5/2018 and (2) The facility failed to inspect the sprinkler system quarterly, every 3 months, from 3/26/19 to 8/1/19. No negative outcomes were noted from the alleged deficient practice.

Corrective Action Accomplished:
On July 31, 2019, the Executive Director contacted the contracted sprinkler inspection company and scheduled the 2nd quarterly sprinkler inspection and sprinkler valve inspection which was completed on August 1, 2019. There is no action that can be performed to address the inspection shortfall for 2019. The facility will perform and record a dry (churn) test on a monthly basis. An in-service on churn testing was given to all Maintenance staff and the Executive Director on 8/20/19 by the inspection vendor.

Identifying other residents/staff affected:
All Residents/Staff had the potential to be affected by this omission.

Systemic Changes:
Systemically, to prevent re-occurrence, the facility will perform and record a dry (churn) test on a monthly basis. An in-service on churn testing was given to all Maintenance staff and the Executive Director on 8/20/19 by the inspection vendor. In addition, the inspection vendor and/or Director of Maintenance/Designee will provide the Executive Director with a copy of quarterly and annual inspection reports as they occur.

Monitoring
To ensure on-going compliance, the Executive Director or Designee will attend at least 1 churn test quarterly, and will use the aforementioned quarterly inspection copy as a tickler. The churn test records, along with the sprinkler inspection records and sprinkler valve inspection records, will be reviewed as part of the community's quarterly QAPI program. The Maintenance Director/Designee will perform random inspections on valve tags to ensure compliance.

Completion Date: 8/20/19

A1303 8:36-18.3 (a) (7) (i-iv)

Sterilization, disinfection and cleaning practices and techniques used in the facility.

Corrective Action Accomplished:
Corrective action for the residents found to have been affected by the alleged deficient practice: For Resident [redacted] and [redacted] LPN #1 was re-educated by the Wellness Director on the same day of the infraction. The in-service focused on Equipment and Supplies for Administration of Medication. All Nebulizer Machines must be labeled with resident name for specific use of that resident. Wellness Director provided nebulizer machine for each resident affected immediately. No negative outcomes were noted from the alleged deficient practice.

Identifying other residents/staff affected:
All residents who received nebulizer treatments have the potential to be affected.

Systemic Changes:
Measures/Systemic changes put into place to ensure alleged deficient practice does no re-occur: Wellness Director/Designee will in-service LPN/CMA on the policy and protocol for Equipment and Supplies for Administration of Medication.

Monitoring:

Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The Wellness Director/Designee will conduct random audits of nebulizer machines twice a week for 4 wks on all medication room, then once a week x 4 wks, then once a month to ensure protocol is being followed. To ensure compliance resident nebulizer use will be included in the quarterly QAPI program.

Complete Date: 8/15/19

A1299 8:36-18.3 (a) (5)

Techniques to be used during each resident contact, including hand washing before and after caring for a resident.

Corrective Action Accomplished:
Corrective action for the residents found to have been affected by the alleged deficient practice: For Resident [redacted] and [redacted] CMA #1 was re-educated and observed by the Wellness Director on the same day of the infraction. The in-service focused on proper hand sanitation techniques, situations that would drive the need for hand sanitation and used of gloves. All other LPN/CMA were in-serviced. No negative outcomes were noted from the alleged deficient practice.

Identifying other residents/staff affected:
All residents who received medications by mouth and eye drop have the potential to be affected.

Systemic Changes:
Measures/Systems changes put into place to ensure alleged deficient practice does no re-occur. Wellness Director/Designee will in-service appropriate staff on the policy and protocol for hand washing and used of gloves with medication pass. Policies and procedures regarding Hand washing/sanitation was revised on 8/1/19, used of gloves for administering eye drop medication was revised on 8/1/19.

Monitoring
Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The Wellness Director/Designee will do random hand washing competencies on appropriate staff (LPN/CMA) monthly to ensure proper hand washing protocol is followed on all shifts and units during medication pass to ensure compliance. To ensure compliance hand washing competencies will be included in the quarterly QAPI program.

Complete Date: 8/14/19

A1249 8:36-17.7

Two snow blowers stored inside building with gasoline inside both tanks.

Corrective Action Accomplished:
On July 31, 2019, the two gas snow blowers were removed immediately from the facility and stored in a detached storage building on the property. Maintenance staff was in-serviced on proper storage of gas operated machinery on 8/1/19. No negative outcomes were noted from the alleged deficient practice.

Identifying other residents/staff affected:
All residents had the potential to be affected.

Systemic Change:
Systemically, to prevent re-occurrence, the maintenance director/designee and maintenance staff were in-serviced on the policy and procedure for storage of gas operated equipment on 8/1/19.

Monitor:
To ensure on-going compliance, daily environmental rounds will be conducted by the Maintenance Director/Designee daily x 2 weeks, then once a week x 2 weeks, then monthly to ensure compliance. The Executive Director will perform random inspections to ensure compliance.

Completion Date: 8/1/19