STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 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 CENSUS: 76 SAMPLE SIZE: 18 + 16=34 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		9/15/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/16/2023

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F 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to report a [redacted] of unknown origin to the New Jersey Department of Health (NJDOH) for 1 of 1 resident reviewed for [redacted] of unknown origin (Resident #21). Findings included: On 08/02/23 at 10:00 AM, the surveyor toured the 200 unit of the facility and observed Resident #21 seated in the bed, watching television. The surveyor observed a NJ Exec. Order 26:4.b.1 to the resident's [redacted]. When asked about the NJ Exec. Order 26 4.b.1, the resident replied, "I don't know." On 08/02/23 at 12:01 PM, the surveyor returned to the unit to observe the lunch meal. The surveyor heard some noise and profanities coming from Resident #21's room and the curtain was drawn. The surveyor knocked at the door	F 609	1. The two missing statements for resident #21 for this deficient practice were obtained. The Unit Manager's conclusion that the [redacted] areas line up directly with the resident's drinking cup remain unchanged. 2. All residents have the potential to be affected. 3. The DON/designee will re-educate the nursing staff on the CMS definition and facility policy of abuse or injuries of unknown origin. In addition, the policy will be rewritten to eliminate the word [redacted]. All incidents will be discussed at the following morning meeting with the team and if statements are not obtained a call will be made to the off-shift staff member by either the Unit Manager or DON.	

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F 609	Continued From page 2 and the staff prompted the surveyor to enter the room. The surveyor observed Resident #21 seated on the bed. The surveyor also observed two Certified Nursing Assistants (CNAs) at the resident's bedside. The CNAs were about to transfer Resident #21 to the [redacted] and the resident kept repeating, "No." Resident #21 was [redacted], and was using [redacted] towards the CNAs. On 08/03/23 at 11:30 AM, the surveyor reviewed Resident #21's electronic medical record which revealed: The Admission Face Sheet (an admission summary) reflected that Resident #21 was admitted to the facility with diagnoses which included but were not limited to, [redacted] Review of the Admission Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care dated 06/19/23, reflected that Resident #21 was [redacted] and scored [redacted] 15 on the Brief Interview for Mental Status (BIMS). Resident #21 required [redacted]. Section E of the MDS which addressed behavior, indicated on E 0200 (section A) that Resident #21 exhibited some [redacted] symptoms directed at [redacted] A review of the 24-hour Report dated 07/27/23, from 11:00 PM-07:00 AM revealed the following: [redacted] A review of a Progress notes dated 07/28/23 timed 07:41 AM, indicated the following: Note: Daily Skin Observation Note. Affected area	F 609	4. The Assistant Administrator/DON will review all incident reports daily after morning meeting of unwitnessed incidents to determine if it meets the criteria for injury of unknown origin. Reports will be discussed at the quarterly QA meeting.	

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Status: New. Comment: EX Order 26 § [redacted] to resident's left side of EX Order 26 § 4b1 [redacted] noted during rounds. Unable to explain what happened. Family informed. MD (medical doctor informed).

On 08/04/23, the surveyor requested all investigative reports for Resident #21 for review.

On 08/04/23 at 11:15 AM, the Director of Nursing (DON) provided 2 Incident/Accident Investigation reports. Review of the Incident/accident Investigation dated 07/12/23 timed 9:30 AM, revealed during a NJ Exec. Order 26:4.b.1, Resident #21 sustained an NJ Exec. Order 26:4.b.1 [redacted]

Another Incident/Accident Investigation dated 07/27/23 timed 11:30 PM, indicated, EX Order 26 § 4b1 [redacted] noted during rounds by assigned Aide. Assessed, Denies EX Order [redacted], Resident unable to explain what happened due to EX Order 26 § 4b1 [redacted]" The surveyor reviewed the incident report dated 07/27/23, and noted that four statements were attached to the incident investigation report. One statement was from the RN who worked the 11:00 PM- 07:00 AM shift dated 07/27/23 timed 11:30 PM, revealed the following: "EX Order 26 § 4b1 [redacted]. Went into resident's room with outgoing nurse to assess. EX Order 26 § [redacted] noted to EX Order 26 § 4b1. Resident unable to explain what happened. No NJ Exec. O[redacted] to touch. Family notify....MD (Medical Doctor) office made aware. Assistant Director of Nursing notified. Another statement from the CNA who first identified and reported the EX Order 26 § [redacted] indicated the following: "EX Order 26 § 4b1 [redacted]

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The CNA assigned to Resident #21 on the 07:00 AM-3:00 PM shift, wrote: "Yesterday I was assigned to Resident #21 I did not noticed any [EX Order 26 § 4b1] on her/him."

A statement from the RN Nursing Supervisor, who worked on 07/27/23, the 3:00 PM-11:00 PM shift indicated the following:

"I worked the shift as a supervisor and as a floor nurse on the 3rd floor. When I saw Resident #21 in the day room at approximately at 8:00 PM, Resident #21 did not have a [EX Order 26 § 4b1]. Later, when assigned nurse gave me report, she told that [EX Order 26 § 4b1]."

Another statement from another RN dated 07/29/23, revealed that she worked on 07/27/23 during the day shift and there was [EX Order 26 § 4b1] on the resident's face. She observed the resident in the dayroom listening to music around 3:30 PM.

The surveyor reviewed the nursing assignment from 07/25/23 to 07/29/23. The facility did not provide any statement from the staff assigned to Resident #21 on 07/27/23 for the 3:00 PM-11:00 PM shift.

The surveyor then asked the DON what is the process to investigate an [EX Order 26] of unknown origin. The DON stated the facility would collect statement from all staff involved in the resident care for 24 to 48 hours. The DON also added the incident of 07/27/23 was not an [EX Order 26] of unknown origin.

The surveyor asked the DON for any reportable incident that was reported to NJDOH. The DON

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informed the surveyor that this incident was not reported to NJDOH since the Registered Nurse Unit Manager (RN/UM) concluded what had happened.

On 08/10/23 at 09:30 AM, the surveyor conducted a telephone interview with the CNA who first observed and reported the EX Order 26 § on 07/27/23 at 11:10 PM. She confirmed that she observed the EX Order 26 § during round and reported it to the nurse immediately.

On 08/10/23 at 10:30 AM, the surveyor conducted a telephone interview with the RN who wrote the incident report. The RN confirmed she was the nurse who observed the EX Order 26 § to Resident #21's EX Order 26 § 4b1 and completed the incident report on 07/27/23 at 11:30 PM. The RN indicated that when she entered the resident's room with the Licensed Practical Nurse (LPN) who worked the 3:00 PM-11:00 PM shift, the resident was in bed. She assessed the EX Order 26 § 4b1 which was not there the day before. The RN indicated that she assessed the area, assessed the resident for EX Order 26. She asked the resident what happened, the resident was EX Order 26 § 4b1 and could not provide any information. She reported to the Nursing Supervisor, and called the physician and the responsible party in the morning. She informed the UM and the DON also in the morning.

On 08/10/23 at 12:01 PM, the surveyor conducted a face to face interview with the RN Unit Manager who concluded that the EX Order 26 § was from the drinking cup. The Unit Manager stated she stood at the door and observed the resident eating while watching television. She stated she "assumed" that the EX Order 26 § could be from the

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drinking cup and the [EX Order 26 § 4b1] was an [EX Order 26 § 4b1] of unknown origin and should be further investigated to rule out [EX Order 26 § 4b1].

On 08/11/23 at 11:30 AM, an interview was conducted again with the DON, the DON stated that the RN/UM's conclusion seemed logical so she did not consider the EX Order 26 § 4b1 of unknown origin and did not report it to the NJDOH [Department of Health].

On 08/14/23 at 10:09 AM, the surveyor interviewed the Assistant Administrator. She indicated that she reviewed all investigations in conjunction with the Administrator. The DON was responsible to complete the investigation and submitted it for review. She was told in the morning meeting that the [EX Order 26 § 4b1] was from the drinking cup. She did not review the investigation. The team then asked the Assistant Administrator to elaborate on the process for an [NJ Exec. Order] of unknown origin. She stated that "We have to investigate. The supervisor will inform the DON who will follow the process. The components of the investigation protocol must be followed. The facility must obtained statements from all staff involved in the resident's care for 24-48 hours. We need the statements and then we review the statements."

The Assistant Administrator further stated "They [the facility] have to get the statements." The Assistant Administrator stated "to be honest, in morning meeting they told me that they already knew the cause of the [EX Order 26 § 4b1], I never reviewed it." The survey team then asked the Assistant Administrator if she had reviewed the investigation, would she have told them that statements were missing? She replied, "I would

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have told them to get the statements."

The survey team then asked the Assistant Administrator what the facility's definition was of an injury of unknown origin. The Assistant Administrator stated, "when we don't know the origin."

On 08/14/23 at 10:22 AM, the Assistant Administrator showed the surveyor that she did not sign the investigation nor review the summary provided by the UM. She stated clearly that although she was responsible to determine the causal factor after reviewing all statements, she did not make nor sign the determination that the [redacted] was from the drinking cup. Her expectation was that the facility would thoroughly investigate [redacted] of unknown origin and complete the required documentation per the facility policy.

On 08/14/23 at 11:42 AM, the LPN who worked the 3:00 PM - 11:00 PM shift on 07/27/23, returned the call and informed the survey team that she did not write a statement on 07/27/23. The LPN further stated that when she returned to work on 07/28/23, the DON stated that the issue with the [redacted] was resolved, she was not asked to provide a statement. When asked to elaborate regarding the incident, she stated she could not remember if she went to the room with the RN and observed the [redacted].

A review of the facility abuse policy last revised 2023, indicated the following:
Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met:
The source of the injury was not observed by any person or the source of the injury could not be

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F 609	Continued From page 8 explained by the resident. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Under Reporting and Response, it is stated that all alleged violations involving abuse, or mistreatment including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made and no later that 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. NJAC 8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		8/31/23

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F 610	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate a [redacted] of unknown origin that was identified on 07/27/27. This deficient practice was identified for 1 of 1 resident (Resident #21) reviewed for a [redacted] of unknown origin and was evidenced by the following: On 08/02/23 at 10:00 AM, the surveyor observed Resident #21 with a EX Order 26 § 4b1 to the [redacted]. The surveyor inquired about the [redacted], the resident stated, "I don't know." On 08/02/23 at 1:15 PM, the surveyor interviewed a CNA about Resident #21. Upon inquiry, the CNA informed the surveyor that Resident #21 could be [redacted] with care, but if you explained what you were about to do the resident would cooperate. On 08/03/23 at 11:30 AM, the surveyor reviewed Resident #21's electronic medical record which revealed: The Admission Face Sheet (a summary document) reflected that Resident #21 was admitted to with diagnoses which included but were not limited to, EX Order 26 § 4b1 [redacted] Review of the Admission Minimum Data Set (MDS) dated 06/19/23, an assessment tool used by the facility to prioritize care, reflected that Resident #21 scored [redacted] /15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was EX Order 26 § 4b1 [redacted] Resident #21 required NJ Exec. Order 26:4.b.1	F 610	1. All missing statements were completed for resident #21 for the 7/27/2023 incident/accident report. 2. All residents have the potential to be affected by the deficient practice. 3. The policy on incident reporting was revised to specifically address the timeline of statement collection. All statements will be completed within 24 to 48 hours. If a staff member does not complete a statement before the end of their shift, a call will be made to them by the Unit Manager/ supervisor for a verbal statement. All statements will be reviewed at the following morning meeting with the team. All nursing staff will be educated on the policy change and time-line of statements. 4. The DON will provide a monthly QA report on the completion times for all incident investigations to the Assistant Administrator for 6 months.	

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NJ Exec. Order 26:4.b.1

A review of Resident #21's Plan of Care (PC) initiated on 06/27/23, reflected a care plan with a EX Order 26 § 4b1. The goal was for staff to approach the resident calmly and unhurriedly, explain all procedures and reason before performing. Encourage Resident #21 to make choices in the timing of care.

The interventions included:
If possible-stop giving care when resident is NJ Exec. Order 26:4.b.1 and try later.
Attempt to refocus behavior to something positive when the resident is exhibiting NJ Exec. Order 26:4.b.1.
Acknowledge and validate feelings.
Monitor behaviors target behaviors.
2 staff assist during NJ Exec. Order 26:4.b.1.
Provide NJ Exec. Order 26:4.b.1 during resident care and transfers to help alleviate NJ Exec. Order 26:4

Review of an Incident/Accident investigation dated 07/27/23, timed 11:30 PM and signed by the Registered Nurse (RN) assigned to the 200's Unit, revealed that Resident #21 was noted with a EX Order 26§ to the EX Order 26 § 4b1. There was no measurement documented for the EX Order 26§ and the RN indicated that the resident was unable to explain what had happened due to NJ Exec. Order 26:4.b.1 The incident report listed the immediate actions taken were an assessment was completed, the EX Order 26§ was noted, vital signs were taken and the physician and responsible party were notified.

A review of the Progress Notes dated 07/28/23 timed 07:41 AM, revealed the following under Daily Skin Observation: "Status: New. Comment:

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EX Order 26 § 4b1 noted during rounds. Unable to explain what happened."

A review of the conclusion Incident/Accident Investigation report dated 07/27/27 provided by the DON revealed that the Unit Manager (UM) concluded on 07/28/23 that the EX Order 26 § was from the drinking cup. The Assistant Administrator did not sign to indicate that she reviewed and agreed with the conclusion. The Unit Manager did not interview the staff who provided care to Resident #21 on the 3:00 PM-11:00 PM shift

A review of the assignment sheets from 07/25/23 to 07/29/23, revealed that the staff assigned to Resident #21 on 07/27/23 for the 3:00 PM-11:00 PM shift were not included to provide statements. There was not a statement from the Licensed Practical Nurse (LPN) who cared for Resident #21. The Certified Nursing Aides (CNAs) involved with the resident's care during the 3:00 PM-11:00 PM shift were not interviewed, nor asked to provide statements. According to the Plan of Care, Resident #21 required NJ Exec. Order 26:4.b.1

The surveyor reviewed a nursing note dated 07/28/23 time 07:41 AM. The note was signed by the RN who wrote the incident report. The note revealed: EX Order 26 § 4b1

The physician's Order sheet was reviewed and there was no new orders. There were no entries from the Nurse Practitioner or the physician regarding the EX Order 26 §.

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The nursing Progress notes for 07/28/23 during the 3:00 PM-11:00 PM shift entered at 4:12 PM, failed to document anything regarding the resident's [redacted]. The nursing progress note documented no [redacted]. The nursing progress notes dated 07/29/23 timed 8:10 AM, documented the following: S/P [Status post] incident day 2/3. [redacted]. The nursing progress notes dated 07/29/23 timed 2:30 PM, indicated, [redacted] The facility failed to provide any [redacted] incident reports for review.

On 08/03/23 at 9:25 AM, the surveyor observed Resident #21 in bed and appeared more alert. The surveyor observed that the resident ate 100% of their breakfast and that the [redacted] was still visible to the [redacted]

On 08/10/23 at 12:30 PM the surveyor interviewed the Director of Nursing (DON) regarding the investigation provided. The surveyor reviewed the assignment sheet with the DON. The DON stated that the CNA assigned to the resident was an agency CNA and she confirmed that she did not get a statement. The DON further stated that the [redacted] was not identified as an [redacted] of unknown origin. The DON would not elaborate regarding the determination that was made by the UM.

On 08/10/23 at 1:15 PM, during an interview with the UM, she revealed that the same night [referring to 07/27/23] she received an email from the nurse regarding the incident. When asked to provide the email, she stated that she could not retrieve the email. The UM further added that on

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07/28/23 during the breakfast meal, she observed Resident #21 eating breakfast while watching television and she concluded that the [redacted] "could have been from the drinking cup." The UM added that she did not observe the [redacted], nor interview the resident and confirmed that the [redacted] was an [redacted] of unknown origin and should be investigated. The Surveyor then asked the UM to elaborate on the investigative process for an [redacted] of unknown origin. The UM added statements from all staff involved with the resident over a period of 24-48 hours should be obtained.

The surveyor again reviewed the Incident/Accident Investigation report dated 07/27/23, and noted that four statements were attached to the incident investigation report. One statement was from the RN who worked the 11:00 PM- 7:00 AM shift dated 07/27/23 timed 11:30 PM, revealed the following: "Notified by assigned Aide during change of shift that she noticed a [redacted] on the left side of resident's [redacted]. Went into resident's room with outgoing nurse to assess. [redacted] noted to left side of [redacted]. Resident unable to explain what happened. No [redacted] to touch. Family notify....MD (Medical Doctor) office made aware. Assistant Director of Nursing notified." Another statement from the CNA who first identified and reported the [redacted] indicated the following: "Around 11:10 PM, when I was doing my round, I noticed a [redacted], I went to tell the nurse." The CNA assigned to Resident #21 on the 7:00 AM-3:00 PM shift, statement indicated: "Yesterday I was assigned to Resident #21. I did not noticed any [redacted] on [her/him]."

A statement from the RN Nursing Supervisor,

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who worked the 3:00 PM-11:00 PM, shift indicated the following: "I worked the shift as a supervisor and as a floor nurse on the 3rd floor. When I saw Resident #21 in the day room at approximately at 8:00 PM, Resident #21 did not have a NJ Exec. Order 26 4.b.1. Later, when the assigned nurse gave me report, she stated that no incident, no EX Order change this shift."

Another statement from another RN dated 07/29/23, revealed that she worked on 07/27/23 during the day shift and there was no EX Order 26 § on the resident's face. She observed the resident in the dayroom listening to music around 3:30 PM.

On 08/10/23 at 11:30 AM, the surveyor conducted a face to face interview with the RN Unit Manager who concluded that the EX Order 26 § was from the drinking cup. The Unit Manager stated she stood at the door and observed the resident eating while watching television. She stated that she observed a line from the EX Order 26 § 4b1 . She did not have any input from the direct care staff regarding the resident's behavior the evening when the EX Order 26 § was discovered. She further stated that since no one knew what happened, she came to a reasonable conclusion the EX Order 26 § could have been from the drinking cup. The UM added that the EX Order 26 § was an injury of unknown origin and should be further investigated to rule out EX Order 26 §.

On 08/11/23 at 11:10 AM, the surveyor conducted a telephone interview with the CNA who first observed and reported the EX Order 26 § on 07/27/23 at 11:10 PM. She confirmed that she observed the EX Order 26 § during rounds and reported it to the nurse immediately.

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F 610	Continued From page 15 On 08/11/23 at 11:43 AM, the surveyor conducted a telephone interview with the RN who documented the incident report. The RN confirmed she was the nurse who observed the [redacted] to Resident #21's [redacted] and completed the incident report on 11/27/28 at 11:30 PM. The RN indicated that when she entered the resident's room with the Licensed Practical Nurse (LPN) who worked the 3:00 PM-11:00 PM shift, the resident was in bed. She assessed the [redacted] on the [redacted] which was not there the day before. The RN indicated that she assessed the area, assessed the resident for [redacted] She asked the resident what happened, the resident was confused and could not provide any information. She reported to the Nursing supervisor, and called the physician and the responsible party in the morning. She informed the UM and the DON also in the morning. There were no entries from either the physician or the Nurse Practitioner regarding the [redacted] dated 07/27/23 in the medical record. The surveyor attempted to interview the Nursing Supervisor on 08/10/23, 08/11/23 and 08/14/23. The Nursing Supervisor who worked the 3:00 PM-11:00 PM shift, returned the call on 08/14/23 but declined to comment on the incident. On 08/11/23 at 11:30 AM, an interview was conducted again with the DON, the DON stated that the RN/UM's conclusion seemed logical so she did not consider the [redacted] as an [redacted] of unknown origin and did not proceed further with the investigation. When asked about the staff statement from the staff that worked the 3:00 PM-11:00 PM shift, the DON stated that she stopped the investigation since she concluded what had happened.	F 610		

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F 610	Continued From page 16 On 08/14/23 at 09:18 AM, an interview was conducted with the DON regarding the investigation. The DON maintained that the [EX Order 26] was not an [NJ Exec. Orde] of unknown origin. The surveyor then reviewed the facility abuse policy which included the criteria that must be met for [NJ Exec. Order] of unknown origin which revealed: According to the facility's policy an injury should be classified as an injury of unknown source when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. 2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. On 08/14/23 at 10:09 AM, the survey team interviewed the Assistant Administrator in charge of the facility investigations. The Assistant Administrator stated that she was told that the staff observed a [EX Order 26] and the causal factor was identified. The Assistant Administrator further stated that she was not provided with the investigation for review and she had been informed by the DON that the investigation was completed. The Assistant administrator stated, "That was my mistake. I did not review the Incident/Accident Investigation. It is not a complete investigation, we need statements." On 08/14/23 at 10:22 AM, the Assistant Administrator showed the surveyor that she did	F 610		

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not sign the investigation nor review the summary provided by the UM. She stated clearly that although she was responsible to determine the causal factor after reviewing all statements, she did not make nor sign the determination that the [EX Order 26.3] was from the drinking cup. Her expectation was that the facility would thoroughly investigate [EX Order 26.3.1b] of unknown origin and complete the required documentation per the facility policy.

On 08/14/23 at 11:42 AM, the LPN who worked the 3:00 PM- 11:00 PM shift on 07/27/23 returned the call and informed the survey team that on 07/27/23, she did not write a statement regarding the [EX Order 26.3]. The LPN further stated that when she returned to work on 07/28/23, the DON stated that the issue with the [EX Order 26.3] was resolved and she was not asked to provide a statement. When asked to elaborate regarding the incident she stated she could not remember if she went to the room with the RN and observed the [EX Order 26.3]. The surveyor then asked the LPN if she was aware of the facility's process when an [NJ Exec. Orde] of unknown origin was identified. The LPN stated that whoever discovered the [EX Order 26.3] should write a statement. She could not provide the rationale for not writing a statement on 07/27/23 after she observed the [EX Order 26.3].

Review of the facility's administrative policy and procedures dated 02/2023 indicated the following:

Policy: It is the policy of the facility that all incidents are reported, recorded, and analyzed for causal factors and trends. Corrective and/or preventive measures will be implemented as indicated.

Incident Documentation:

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F 610	Continued From page 18 Each incident will be documented on the Incident Report form. All sections of the form wilt be completed. Incident Investigation An investigation will be initiated on all reported incidents. An incident Investigation Report form will be completed at the time of the incident. At the time of the incident, all nursing staff assigned to the unit will complete written statements regarding the incident when the incident is not witnessed. All nursing staff assigned to the unit during the previous two shifts will complete written statements when the incident is not witnessed. Additional statements may be warranted during the investigation. All statements must be signed by the writer, including any statements from everyone.	F 610		
F 804 SS=D	NJAC 8:39-4.1(a) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to serve foods at an acceptable temperature for 1 of	F 804	1. For the affected resident #67, a replacement meal tray was provided, with all cold foods served at 40 degrees F or	8/31/23

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F 804	Continued From page 19 18 residents reviewed (Resident #67) and for 1 of 3 resident units (2nd floor). The deficient practice was evidenced by the following: On 08/02/23 at 10:33 AM, during an interview with Resident #67, the resident expressed concerns over the meal temperature. On 08/04/23 at 7:24 AM, the surveyor observed the breakfast meal distribution from the 2nd floor remote food service kitchen. Three meal trucks left the kitchen at that time and arrived on A, B, C Wings and the surveyor observed the meal cart that arrived on the B Wing at 7:26 AM. The cart contained seven trays and was left on the unit for distribution. On 08/04/23 at 7:27 AM, one staff member removed a meal tray for service to a resident. On 08/04/23 at 7:31 AM, 4 trays remained and 1 staff delivered the meals. On 08/04/23 at 7:43 AM, the last tray (17 minutes from when the trays arrived on the unit) was to be served, and the surveyor proceeded to test the meal temperatures. 08/04/23 7:44 AM, in the presence of another surveyor, the test tray revealed the following food temperatures: scrambled eggs 119 degrees Fahrenheit (F), oatmeal 128 F, 4 ounces milk 63 F, 4 ounces juice 62 F. On 08/04/23 at 8:02 AM, the surveyor relayed the test tray food food temperatures to the Regional Director of Operations for the food management company (RDO). The RDO stated that the standard was 140 F for serving hot foods and 40 F for serving cold foods. The surveyor	F 804	below, and all hot food served 140 degrees F or higher. The root cause of the deficient practice was the untimely delivery of resident meal trays. 2. All residents who are provided meals at Reformed Church Home had the ability to be affected by this deficient practice, specifically those residents that prefer tray service in their rooms. The foodservice department will continue to prepare foods by methods that provide nutritive value, flavor, and appearance, while providing them at the proper holding temperatures. 3. The Dining Services Management Team will provide an In-Service to all foodservice personnel on appropriate temperatures for hot and cold holding of foods and beverages, and recording of these temperatures in the appropriate logs, prior to meal service. All foodservice personnel will be in serviced on how to prepare all hot foods and recording of hot foods in proper logs. All food service policies and procedures regarding hot and cold foods will be monitored and enforced. Continual Education and training will be provided to all foodservice personnel regarding hot and cold food standards, to ensure that these standards are met. 4. The Dining Services Management Team will do daily resident tray audits for 30 days and report the findings to the Administrator. Following the initial 30-day period, the team will conduct three meal tray audits weekly for 30 days and report the findings to the Administrator. Following that 60-day period the team will continue to perform one meal tray audit weekly, and the results will be brought to	

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F 804	Continued From page 20 showed the RDO the food temperatures and asked if they were acceptable and he stated, "no". On 08/04/23 at 8:05 AM, the surveyor requested a food temperature policy. On 08/04/23 at 9:40AM, the Food Service Director provided a Meal Temperature Policy dated January 1, 2021. the Temperature Records and Taste Panel Evaluation Form Revealed, 3. ...Recommended Service Temperatures, Cold Food 40 F or below, Other Entrees: 160 F ... NJAC 8:39-17.4 (a)2	F 804	the QAPI quarterly meetings. The Director of Dining Services will work with Nursing Management to ensure the prompt delivery of all resident meal trays and adherence to Meal Delivery and Retrieval Policies.	

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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: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to (a) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey and (b) ensure the required training for LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program, was provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+.	S 560	For LBGTQI+ training, the facility will provide education to the staff by the entity in the State of NJ that has identified has having the legal, social and medical expertise to create safe and affirming environments for LGBTQI+ and HIV+. The facility began the registration process for the current training cycle. The facility will continue to provide this training in orientation and biannually for all staff by the contracted entity identified by the State of NJ. The facility will contract with the entity identified by the State of NJ as having authority for training.	9/5/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/16/23

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S 560	Continued From page 1 This deficient practice was evidenced by the following: 1.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 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	S 560	Facility contracts are reviewed annually. The facility will monitor the engagement contract with the qualified entity to ensure it does not expire and all state regulation criteria are being met. For the five days identified as being short for CNAs, the facility provided additional nursing coverage to ensure residents needs were met. The nursing management team is called to the floor when this happens. The facility has never entered a day with the schedule below staffing minimums. Unfortunately illnesses and family situations sometime affect staffing unexpectedly. All residents have the potential to be affected by the lack on CNAs during the day. The facility has closed two units in order to keep the census low so that the CNA requirements can bet met. The facility has also contracted with Total Compensation Solutions to ensure that the hourly rates and benefits are very competitive. In addition, the facility signed a contract with United Methodist Healthcare Recruitment for 8 CNA visas. This contract was signed in August of 2022. We are awaiting the federal government to clear additional visas for healthcare workers. We also have contracts with four different staffing agencies to provide services. The facility monitors staff on a daily basis and if CNA numbers are below the minimum, additional nurses are scheduled	

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S 560	Continued From page 2 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 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 the facility provided staffing report from 07/16/2023 to 07/29/2023 for the 08/16/2023 Standard survey at Reformed Church Home revealed the following: The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -07/16/23 had 7 CNAs for 75 residents on the day shift, required at least 9 CNAs. -07/17/23 had 7 CNAs for 75 residents on the day shift, required at least 9 CNAs. -07/21/23 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. -07/23/23 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. -07/24/23 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs.	S 560	and primary care nursing is administered. If the trend continues, the facility will close another unit.	

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S 560	Continued From page 3 2. Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030709	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

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S 560	Continued From page 4	S 560		

room;

3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5);

4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity;

5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice;

6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices;

7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations;

8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
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S 560	Continued From page 5	S 560		

discomfort or unfairly demeans the resident's dignity; and

9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6).

Resident Records
Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.

Confidentiality
The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed.

Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties.

Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual

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	030709	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

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S 560	Continued From page 6	S 560		

barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility.

Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling.

Violations
A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action.

Training
Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey.

The required training shall address:
1. Caring for LGBTQI+ seniors and seniors living with HIV;

2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status;

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S 560	Continued From page 7 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. On 08/03/23 at 9:19 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the mandatory LGBTQI+ training. The LNHA provided documentation that both she and the Human Resources Director (HRD) attended the "Designated Representative" training on 03/04/22 and 03/18/ 22 respectively. When the LNHA was asked about the training that was provided to the employees, the LNHA	S 560		

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S 560	Continued From page 8 stated that since the LNHA and HRD attended the training, that the HRD developed a training from the training that they both recieved and trained the staff themselves. The LNHA was unable to provide documentation that the remaining staff were trained by a qualified entity. NJAC 8:39-5.1(a)	S 560		

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)
315417	A. Building B. Wing	10/16/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 09/15/2023	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 08/31/2023	ID Prefix F0804 Reg. # 483.60(d)(1)(2) LSC	Correction Completed 08/31/2023
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
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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	
8/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
030709		10/16/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

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 09/05/2023	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	
8/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING **01** B. WING _____	**08/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1990s with no current major renovations or noted additions. It is a two story building Type II (222) construction and is fully sprinklered. The facility has 17 smoke zones, 2-exterior diesel generators that do 100% of the building. Currently floor # 3 has the B and C wing closed, due to staffing as per the Maintenance Director. The building has a partial basement with no access to residents. The kitchen is located on floor #1 in the center core of the building. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 108 certified beds. At the time of the survey the census was 77. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		10/14/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/31/2023

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING **01** B. WING _____	**08/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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K 353	Continued From page 1 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/17/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. During a building tour from 9:30 AM to 12:25 PM, the Surveyor and MD, observed high-hat lighting installed in the drop ceiling tiles located in the facility exit/egress corridors on floors (1) one, (2) two, and (3) three. Each floor was observed to have approximately 38 high-hat light fixtures that were observed to have (2) two openings in each housing. the oval-like openings each measured approximately 2" x 3". The openings were observed to be open above the drop ceiling approximately 2'. The high-hat/recessed light fixtures did not have a fire rated recessed light cover to prevent smoke and heat from entering the ceiling above, delaying the activation of the fire sprinkler heads and smoke detectors in the event of a fire.	K 353	1. The Director of Maintenance has solicited 3 quotes from lighting companies to have the light fixtures replaced. He has also contacted a licensed electrical vendor to perform the installation. 2. All facility residents have the potential to be affected by the light fixtures. 3. The facility will have the identified recessed lighting replaced by 10/14/23. We will maintain records of all maintenance activities on lighting which will include assessments to ensure ongoing adherence to life safety regulations and compliance to NFPA 101.2012. Light fixtures will be approved by the facility engineer to ensure full compliance. 4. The facility will monitor recessed lighting and log monthly and report at the quarterly Safety Committee meeting.	

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K 353	Continued From page 2 The MD in an interview confirmed the above observations. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 08/17/23.	K 353		
K 363 SS=E	NJAC 8:39-31.2(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 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	K 363		8/22/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING **01** B. WING _____	**08/17/2023**

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K 363	Continued From page 3 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 interview on 08/17/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that corridor doors 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. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in 4 of 76 resident room (RR) doors observed and was evidenced by the following: During the building tour on 08/17/23 from 9:15 AM to 12:25 PM, the surveyor in the presence of the MD, toured the facility and observed the following compromised RR doors: RR # A-230 door does not fully close into its frame, spring in the hardware malfunction. RR # A-240 door does not fully close into its frame, spring in the hardware malfunction. RR # A-270 will not latch into its frame. RR # C-350 will not latch into its frame.	K 363	1. The facility Maintenance Director immediately removed the hardware (wreath hangers) and wreaths that interfered with the door closures in RR # A-230, RR # A-240, RR # A-270 RR # C-350. 2. All residents with wreath hangers have the potential to be affected. 3. 3M adhesive wreath hooks were purchased in lieu of the over door hangers. In addition, the facility Maintenance staff will conduct monthly inspections of all doors, door frames, door hardware for proper door closure and functioning Hardware. We will maintain a log of all monthly inspections and log the corrective actions taken. 4. The Maintenance Director will review the monthly inspections and perform monthly spot inspection to ensure accuracy. Findings will be discussed during the quarterly Safety Committee meetings.	

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K 363	Continued From page 4 At the time of observations, the surveyor interviewed the MD who confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code exit conference on 08/17/23. 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 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 08/16/23 in the presence of the Maintenance Director (MD), it was determined	K 531	1. The facility Maintenance Director was alerted that the facility was in non-compliance and instructed to the	8/25/23

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REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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K 531	Continued From page 5 that the facility failed to ensure that there was documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3). This deficient practice was evidenced by the following: At 10:30 AM, the surveyor reviewed all Life Safety Code (LSC) documentation provided by the MD. The monthly testing of the firefighters Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 was not provided. An interview was conducted with the MD during the record review. He confirmed there was no current firefighter's monthly service log for 4 of 4 elevator devices. During an interview with the Maintenance Director, the MD indicated that he called the "Elevator Construction Code Division department" and was informed that the city was short one elevator inspector and they were currently behind doing elevator inspections. The Administrator was informed of the findings at	K 531	proper procedure to test Fire fighter service requirements including Phase 1 and Phase 2 recall key operation for all 4 elevators, in the facility and follow the specifications by ASME/ANSI A17.3 The elevator contracted service, will do a monthly test for Phase 1 and Phase 2 recall key operation for code ASME/ANSI A17.3 all 4 elevators. This will be logged, and Documented ensuring that it is completed in a timely manner. 2. All residents could potentially be affected if the fire service in phase 1 or 2 was not working correctly and could cause a hold up in the elevator during an emergency. The maintenance director has been instructed to the proper procedure of testing Fire fighter service requirements specifications by ASME/ANSI A17.3 for all 4 Elevators. The contracted elevator service will complete all monthly inspections of fire fighter service. 3. The elevator contracted service, will do a monthly test for Phase 1 and Phase 2 recall key operation for all 4 elevators. This will be logged Documented ensuring that it is completed in a timely manner. and establish a comprehensive maintenance schedule. This will be Logged and available upon request for Administration, fire Marshall, State and District Manager per regulation ASME/ANSI A17.3 all issues identified will be promptly addressed documented and repaired immediately. 4. The contracted elevator service will do	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING **01** B. WING _____	**08/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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K 531	Continued From page 6 the Life Safety Code exit conference on 08/17/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3 & 9.4.3 Fire Fighters Emergency Operations: 9.4.3.2	K 531	a monthly test. This will be logged and documented for all 4 elevators, ensuring that has been completed for ASME/ANSI A17.3 The maintenance director will follow up to ensure it is done in a timely matter monthly. And monitor facility life safety logbook monthly.	
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 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	K 918		9/11/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING **01** B. WING _____	**08/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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K 918	Continued From page 7 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 observation and interview on 08/17/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure a remote manual stop station for one of one outside generators (750 KW), providing emergency power to 100% of the Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: On 08/17/23 at 1:05 PM, the surveyor and MD observed the exterior 750 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the MD, who stated and confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current generator in service. The Administrator was informed of the findings at the Life Safety Code exit conference on 08/17/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and	K 918	1. The facility will install a Remote Manual Stop Station for outside the generator location as required by NFPA 110,2010 edition. Electrician and generator techs have been contracted to set up install on 9/7/2023. 2. All residents have potential to be affected. 3. Once installed, all Maintenance staff, will be in-serviced for the proper use of the Remote Manual Stop Station. The facility Director of Maintenance has set up contracted services to install the electrical system as well as having the contracted service of the generator 750KW, on site during the installation to ensure the unit properly functions as per code NFPA 110,2010 editions. 4. In service logs of staff training will be discussed at quarterly Safety Committee.	

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	315417	A. BUILDING **01** B. WING _____	**08/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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K 918	Continued From page 8 5.6.5.6.1.	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315417 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	10/14/2023	LSC K0363	08/22/2023	LSC K0531	08/25/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	09/11/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO