STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315354	A. BUILDING ______ B. WING ______	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE MANOR	**2500 RIDGEWOOD ROAD** **WALL, NJ 07719**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not 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		
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		9/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2022

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

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E 037	Continued From page 1	E 037		

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

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E 037	Continued From page 2 (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 3	E 037		

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

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E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of the Emergency Preparedness Program binder and interviews with facility leadership staff, it was determined that the facility failed to provide emergency preparedness training to all existing staff annually. The deficient practice was identified for 30 out of 84 long-term care staff members and evidenced by the following: On 8/4/22 at 11:00 AM, the surveyor reviewed the facility's Emergency Preparedness Program binder provided by the facility and the surveyor was unable to locate evidence that the facility was providing emergency preparedness training to all existing staff annually. A review of the facility provided "COVID-19 Staff Vaccination Status for Providers" which included	E 037	1. The facility LNHA reviewed Appendix-Z, Emergency Preparedness for LTC at 483.73 (d):] (1) Training Program on August 9, 2022 and found the facility policy/procedure and training materials to be up to date. Training in the facility's Emergency Preparedness and Response Plan was conducted by the LNHA's designee regarding policy, procedure, and verbal return demonstrations. This training was initiated on August 22, 2022 and completed for all existing staff August 30, 2022. Attendance was documented and records will be kept in the LNHA office. 2. All Residents have the potential to be affected during an emergency or evacuation.	

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E 037	Continued From page 5 only long-term care staff employees, reflected the facility currently had eighty-four staff members. On 8/4/22 at 1:45 PM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) who identified himself as in charge of emergency preparedness for the facility, for evidence that the facility was providing emergency preparedness training to all new and existing staff annually. The LNHA stated that the facility trained all new staff during their orientation and during the facility's emergency preparedness exercise on 12/15/22, he included emergency preparedness training but did not have a separate sign-in sheet. At this time, the surveyor with the LNHA reviewed the emergency preparedness 12/15/22 sign-in sheet that included thirty-two names. The LNHA confirmed that this did not include all staff. On 8/5/22 at 12:15 PM, the LNHA provided evidence of an additional seventeen new hires who received emergency preparedness training. On 8/8/22 at 9:28 AM, the surveyor reviewed an additional five Certified Nursing Aides education transcripts which included an additional five staff members who received emergency preparedness training. On 8/9/22 at 10:36 AM, the LNHA in the presence of facility administration and the survey team, confirmed there was no additional documentation that all staff members were trained annually on emergency preparedness. NJAC 8:39-31.2(e)	E 037	3. The facility LNHA, or his designee, will annually in August or more frequently in the event of substantial updates, changes, new hire, or an actual emergency conduct Emergency Preparedness Training to all individuals providing services under arrangement, and volunteers, consistent with their expected role. Documentation of the annual training will be reviewed by the LNHA for completeness. New hire documentation will be kept in the employee file and the annual documentation will be kept by the LNHA. 4. In order to ensure the deficient practice does not reoccur, the LNHA or his designee will review the Emergency Preparedness Plan annually within the first quarter at the time of the Policy and Procedure Manual updates and Facility Assessment reviews. Emergency Preparedness Training data will be brought to the Quality Assurance Committee for quarterly review or revisions. The Quality Assurance Performance Improvement process may be conducted more frequently in the event of an occurrence or identified training need.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 6 Survey Date: 8/10/22 Census: 36 Sample: 13 + 2 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to implement, reassess and/or discontinue a physician order for a NJ Exec. Order 26:4.b.1 of a resident with a history of NJ Exec. Ord in accordance with professional standard of practice. This deficient practice was identified for 1 of 2 residents (Resident #35) reviewed for accidents. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and	F 658	1. Resident #35's medical record, which includes the care plan, was reviewed for appropriateness for a Resident with a history for NJ Exec. Ord The care plan was found to be Resident centered and appropriate for Resident #35. The Resident's ability to NJ Exec. Order 26:4.b.1 necessitated deviation from the physician's order for a NJ Exec. Order 26:4.b.1 of a Resident in accordance with professional standard of practice. Subsequent to review by the IDC team and with an MD order the NJ Exec. Order 26:4.b.1 order was discontinued on August 8, 2022. Documentation was added to Resident	9/9/22

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F 658

Continued From page 7

treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

The evidence was as follows:

On 8/3/22 at 11:25 AM, during the initial tour, the surveyor observed Resident #35's room. The resident was not in the room and the surveyor observed a clean room, bed made, call bell was on the resident's bed, and no observed NJ Exec. Orde [redacted] in the room.

The surveyor reviewed the medical record for Resident #35.

A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility on in NJ Exec. Order 26:4.b.1 with diagnoses that included, NJ Exec. Order 26:4.b.1 [redacted]

F 658

medical record.

2. All Residents have the potential to be affected.

3. The ADON and the UM reviewed all Residents' Physician's Orders for assistive devices; i.e., crash pads, leg sleeves etc. to ensure compliance with professional standard of practice, to confirm appropriateness based on resident conditions, and to verify they were carried out and care planned accordingly to maximize Resident centered care. Nursing staff in-service was initiated, August 24, 2022 regarding the following: physician orders follow through, baseline care planning, comprehensive care planning and the process of performing chart checks by a nurse other than the admitting nurse or the transcribing nurse. This will provide a crosscheck, eliminate errors ensuring implementation, reassessment, physician's orders or discontinuation of a physician's order.

4. To ensure the problem does not reoccur the Director of Nursing or her designee will randomly select and audit one chart per week to check for compliance. Physician's Orders and interventions will be compared to identified care area assessment focus, and Resident changes in condition; compliance data and the results of the audits will be brought quarterly to the Quality Assurance Committee for review or revision. The Quality Assurance

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F 658	Continued From page 8	F 658		

NJ Exec. Order 26:4.b.1 .

A review of the admission Minimum Data Set (MDS), an assessment tool dated 7/15/22, reflected the resident had a brief interview for mental status (BIMS) score of NJ Ex out of 15, which indicated NJ Exec. Order 26:4.b.1 . The MDS further revealed in Section J. Health Conditions, the resident had a history of NJ Exec. O in the last month prior to admission and had a NJ Exec. Order 26:4.b.1 two to six months of admission.

A review of the Order Summary Report included a physician's order dated 7/9/22 for a NJ Exec. Order 26:4.b.1 .

A review of the Progress Notes included an Alert Note dated 7/9/22 at 10:24 PM, that the resident transferred him/herself to NJ Exec. Order 26:4.b.1 independently; was assisted to the NJ Exec. Order 26:4.b.1 by writer; education given but resident NJ Exec. Order 26:4.b.1 ; call bell placed in reach; new orders for NJ Exec. Order 26:4.b.1 to be placed bedside to decrease NJ Exec. Order 26; will continue checks for duration of shift.

A review of the Interdisciplinary Team (IDT) Care Conference Notes dated 7/19/22 did not include an assessment of the NJ Exec. Order 26:4.b.1 ordered by the physician.

A review of the resident's comprehensive care plan did not include a focused area or intervention for a NJ Exec. Order 26:4.b.1

Performance Improvement process may be conducted more frequently in the event of noncompliance.

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F 658	Continued From page 9	F 658		

A review of Resident #35's Kardex (a system in which nursing staff was given a brief overview of individual resident care needs) did not include the physician order for the NJ Exec. Order 26:4.b.1.

On 8/4/22 at 9:55 AM, the surveyor observed Resident #35's room. The resident was not in the room and the surveyor observed the resident's room was clean, bed made, call bell on the bed, and no NJ Exec. Order 26:4.b.1 observed in the room.

On 8/5/22 at 9:54 AM, the surveyor observed Resident #35's room. The resident was not in the room and the surveyor observed the resident's room was clean , bed made, call bell on the bed, and no NJ Exec. Order 26:4.b.1 observed in the room.

On 8/5/22 at 10:07 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who confirmed her assignment included Resident #35 and that the resident did not have a NJ Exec. Order 26:4.b.1

On 8/8/22 at 10:14 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who confirmed her assignment included Resident #35. The LPN also confirmed the resident was a NJ Exec. O and did not have a NJ Exec. Order 26:4.b.1

On 8/8/22 at 10:30 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who confirmed Resident #35 was a NJ Exec. Order 26. At this time, the surveyor and ADON reviewed the physician's order for a NJ Exec. Order 26:4.b.1 dated 7/9/22. The surveyor and the ADON then reviewed the comprehensive care. The ADON acknowledged the physician's order for the NJ Exec. Order 26:4.b.1 as well as the care plan did not include the NJ Exec. Order 26:4.b.1. The ADON stated the physician's order was not appropriate for Resident #35 since it was a

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F 658	Continued From page 10 NJ Exec. Order 26:4.b.1. The surveyor and the ADON then reviewed the IDT Care Conference Note dated 7/19/22, and the ADON confirmed the note did not include an assessment of the NJ Exec. Order 26:4.b.1 On 8/8/22 at 10:54 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who acknowledged that a physician's order should be followed. The LPN/UM further stated that the IDT team decided that the NJ Exec. Order 2 and confirmed there was no documentation to corroborate. The LPN/UM also confirmed the physician's order should have been discontinued and documented upon assessment of the IDT team. On 8/9/22 at 10:26 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), ADON, and survey team stated that the NJ Exec. Order 26:4.b.1 was a nursing intervention and that the NJ Exec. Order 26:4.b.1 was not appropriate since Resident #35 was able to NJ Exec. Order 26:4.b.1. The DON acknowledged there was an active physician order from 7/9/22 that was discontinued after surveyor inquiry for the NJ Exec. Order 2 The DON acknowledged that the nurse on duty failed to communicate to the NJ Exec. team or IDT team the physician order dated 7/9/22 that was added as a result of a NJ Exec. Order 26 event. The DON acknowledged physician order's should be carried out or reassessed by the nurses and discontinued if not appropriate because it was a professional standard of practice. A review of the undated facility provided "Physician's Orders" policy included medications/treatments shall be administered upon the written order of a person duty licensed and authorized to prescribe such	F 658		

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F 658	Continued From page 11 medications/treatment in this state...verbal orders must be signed by the prescriber at his or her next visit... NJAC 8:39-27.1	F 658		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315354		10/25/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE MANOR	2500 RIDGEWOOD ROAD WALL, NJ 07719

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 09/09/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/10/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315354	A. BUILDING **02** B. WING	**08/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE MANOR	**2500 RIDGEWOOD ROAD** **WALL, NJ 07719**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/10/2022 and Sunnyside Manor was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Sunnyside Manor is a single story, Type II Protected building that was built in January 2016. The facility is divided into 3 smoke zones.	K 000		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 8/10/22 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 7 of 7 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A.	K 521	1. A service call was placed to Sunnyside Manor's outside electrician on August 10, 2022 at 1:22 pm regarding facility Resident Bathroom Exhaust Fan outages. Sunnyside was advised that the root cause of the issue was likely blown fuses in the rooftop exhaust fans caused by the previous day's (8/9/22) power	9/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/01/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315354	A. BUILDING **02** B. WING	**08/10/2022**

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K 521 Continued From page 1

This deficient practice was evidenced by the following:

During the survey entrance conference on 8/10/22 at 9:05 AM, the surveyor requested the facility's Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms in the facility.

Starting at 9:36 AM, in the presence of the facility's DOM, an inspection of seven resident rooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 7 of 7 resident bathrooms in the following locations:

1. At 10:34 AM, inside Resident Room #163 bathroom, when tested the exhaust system did not function properly.

2. At 10:37 AM, inside Resident Room #165 bathroom, when tested the exhaust system did not function properly.

3. At 11:03 AM, inside Resident Room #183 bathroom, when tested the exhaust system did not function properly.

4. At 11:12 AM, inside Resident Room #186 bathroom, when tested the exhaust system did not function properly.

5. At 11:22 AM, inside Resident Room #174 bathroom, when tested the exhaust system did not function properly.

6. At 11:32 AM, inside Resident Room #168

K 521

outage. The fuses in the rooftop exhaust fans were replaced on 8/10/22, and Resident Bathroom Exhaust Fans #163, #165, #183, #186, #174 and #168 were subsequently tested and found to be in good working order. All Resident Bathroom Exhaust Fans were tested and functioning on 8/10/2022.

2. All Residents have the potential to be affected by a blown fuse that may cause a Resident Bathroom Exhaust Fan outage.

3. All Resident Bathrooms will be tested for function as part of the routine monthly maintenance, Resident room inspections and subsequent to any power outages or by Resident/Resident Representative request. On August 10,2022, Resident Bathroom Exhaust Fan, was added to the Maintenance Checklist to ensure documentation and to aide in tracking/trending, and root cause analysis.

4. To ensure that the problem does not reoccur, the Maintenance Director or his designee will review the checklist monthly for thoroughness. Results will be brought to the Quality Assurance Committee for quarterly review or revision. The Quality Assurance Performance Improvement process may be conducted more frequently in the event of noncompliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315354	A. BUILDING 02 B. WING ______	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE MANOR	2500 RIDGEWOOD ROAD WALL, NJ 07719

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K 521	Continued From page 2 bathroom, when tested the exhaust system did not function properly. 7. At 11:32 AM, inside Resident Room #168 bathroom, when tested the exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. These finding was verified by the facility's DOM at the time of inspection. The Licensed Nursing Home Administrator was notified of the findings at the Life Safety Code exit conference on 8/10/22 at 2:05 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 918 SS=F	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	K 918		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315354	A. BUILDING **02** B. WING ___	**08/10/2022**

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K 918	Continued From page 3 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 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 8/10/22 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice could affect all residents and was evidenced by the following: During the survey entrance conference on 8/10/22 at 09:05 AM, the surveyor asked the facility's Director of Maintenance (DOM) if the facility had an emergency generator, and the DOM replied, yes. During the building tour with the facility's DOM at 11:45 AM, an inspection outside where the	K 918	1. The facility's Emergency Generator was not equipped with a Remote Stop Switch. 2. All Residents have the potential to be affected by the absence of a Generator Remote Stop Switch. 3. A Remote Stop Switch was installed by our generator vendor on September 2nd, 2022. The facility Maintenance department will assess function during its monthly generator tests or more frequently as a result of generator activation. 4. The Maintenance Director or his designee will review the functional	

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K 918	Continued From page 4 emergency generator was located was conducted. At this time, the surveyor asked the DOM where was the emergency shut off for the generator located? The DOM opened a generator housing door and stated, inside. The surveyor observed that the generator's emergency stop button was located inside the generator's metal housing. At this time, the surveyor asked the DOM if there was a remote stop button located somewhere else for the generator. The DOM responded, no that was the emergency stop button. This finding was verified by the facility's DOM Director at the time of inspection. The Licensed Nursing Home Administrator was notified of the finding at the Life Safety Code exit conference on 8/10/22 at 2:05 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	reliability of the Generator Remote Stop Switch quarterly with the Quality Assurance Committee for review or revision. The Quality Assurance Performance Improvement process may be conducted more frequently in the event of malfunction.	

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
315354 Y1	A. Building 02 - SUNNYSIDE MANOR II B. Wing Y2	10/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE MANOR	2500 RIDGEWOOD ROAD WALL, NJ 07719

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