STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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F 000	INITIAL COMMENTS Survey Date: 5-19-22 Census: 76 Sample: 21 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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	F 583		5/20/22

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

Electronically Signed | 06/03/2022

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F 583	Continued From page 1 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to provide full visual privacy for 2 of 18 residents reviewed, Resident #72 and Resident #2. The deficient practice was evidenced by the following: On 5/10/22 at 9:46 AM, the surveyor observed the Phlebotomist enter Resident # 72's room and he left the door opened. From the hallway, the surveyor observed the Phlebotomist set up his supplies and attempted to draw the resident's blood. There was no privacy afforded to the resident during this procedure. At 9:54 AM, the surveyor interviewed the Phlebotomist who stated that he should have provided privacy to the resident while performing blood draws for a resident. At 10:01 AM, the surveyor interviewed the Licensed Practical Nurse # 1 (LPN #1) who stated that the Phlebotomist should have provided privacy while doing blood draws.	F 583	Specific Corrective Action 1.The laboratory provider was contacted to request for a change of phlebotomist to service the facility with somebody that has appropriate and current training with resident□s privacy to be observed during all procedures perform. 2.Dry erase board with the toileting schedule for resident #2 was removed. Toileting schedule was placed in the inside door of the resident□s closet. 3.All staff were re-educated regarding the Privacy and Confidentiality Policy. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes a.Policy was created to ensure that residents care information will be placed on the inside of the resident□s closet door	

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F 583	Continued From page 2 The surveyor received and reviewed the policy titled "Residents Privacy" dated 12-28-21, which revealed that during treatments and procedures including blood drawing, each resident has a right to privacy. At 12:54 PM, the surveyor discussed the above concerns with the Administrator, who stated that privacy should always be afforded to the resident. 2. On 5/4/22, 5/5/22, 5/9/22, 5/10/22, and 5/11/22 the surveyor observed the entrance to room 219. An 8 ½ x 11-inch dry erase board was propped in a plastic wall file attached to the wall in the hallway next to the room number. Resident #2's toileting schedule was posted on the dry erase board. The surveyor interviewed the unit LPN #2 on 5/11/22 at 9:35 AM. LPN #2 confirmed posting the toileting schedule in the hallway was a dignity and privacy concern. She stated inside the door of the closet would have been a more appropriate place to list care directions for staff. The surveyor spoke with the Administrator on 5/11/22 at 1:15 PM. The Administrator confirmed resident care instructions should not be visible in the hallway NJAC 8:39-4.1(a)16; 8:39-4.1(a)12	F 583	for staff access b. Unit Managers/Charge Nurses will include in their daily rounds to ensure that there is no posting that violates resident□s privacy c.SW will in-service the staff for privacy and confidentiality monthly X 3 months and quarterly thereafter d.All outside providers will be in-service regarding the Privacy and Confidentiality policy of the facility Monitoring Monthly QAPI will be done by DON/designee to ensure that: a) all care information of all residents care information was place inside the resident□s closet and b) that all outside provider are in-service regarding the facility□s Privacy and confidentiality policy. Reports will be submitted to the administrator and will be discussed during the quarterly meeting	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		5/20/22

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

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must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

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F 623	Continued From page 5 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to notify resident families or resident representatives (RR), and the Ombudsman's office in writing for a facility-initiated transfer to the hospital for 2 of 2 residents (Resident #74 and #39) reviewed for hospitalization. The deficient practice was evidenced by the following: The surveyors reviewed the hybrid medical records (paper and electronic) that revealed facility-initiated hospital transfers had occurred without written notification to the families and Ombudsman's office for the following residents: 1. According to the Discharge Minimum Data Set (MDS) an assessment tool dated 3/7/22, Resident #74 was transferred to the hospital with return not anticipated to the facility. There was no documentation that the facility had notified the resident's family or RR in writing regarding the reason for transfer and bed hold policy. On 5/9/22 at 11:22 AM, the surveyor interviewed	F 623	Specific Corrective Action Nurses, Social worker, Receptionist and Medical Records were in service regarding Emergency Transfer Notification Policy which covers all to all acute care facilities transfer. Identification All residents have the potential to be affected by the deficient practice. System Changes All discharge residents will be discussed during the clinical meeting and copy of the emergency transfer notification will be submitted to the DON/designee and AOD during the weekend transfer Monitoring A monthly QAPI will be done by the DON/designee on Emergency Transfer Notification for all acute discharges	

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F 623	Continued From page 6 the Social Worker (SW) who stated that she was new in the position. She stated the secretary at the front desk sends the letter to the family and the Admissions Department sends the letter to the Ombudsman's office. On 5/9/22 at 11:29 AM, the surveyor interviewed the Licensed Practical Nurse Charge Nurse (LPN/CN #1) who stated that they only call the resident's family when they are transferred to the emergency room, they don't send the letters because they "do not hold beds on the subacute unit." On 5/9/22 at 11:39 AM, the surveyor interviewed the receptionist who stated the nurse on the unit would fill out the Notification for Emergency Transfer form in triplicate. The receptionist explained that the white copy goes with the resident, the yellow copy was sent to the resident's family or RR, which she would mail, and the pink copy goes into the resident's chart. On 5/9/22 at 11:42 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the receptionist was correct and that was the facility's procedure. However, she was not aware that the Notification for Emergency Transfer letters were not going out to families when residents from the subacute unit were being discharged. 2. According to the Discharge MDS dated 01/23/22, Resident #39 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family or Resident Representative in writing regarding the reason for transfer and bed hold policy.	F 623	monthly X 3 months and quarterly thereafter. Reports will be submitted to the administrator and will be discussed during the quarterly meeting.	

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F 623	Continued From page 7	F 623		

On 5/10/22 at 10:41 AM, the surveyor interviewed the LPN/CN #2 who stated she was aware of the Notice of Resident transfer or Discharge form and showed a blank carbon copy from the desk drawer. LPN/CN #2 stated that the "SW does it."

LPN/CN #2 further stated they only call the resident's family when they are transferred to the emergency room, they don't send the letters, but they do notify SW and/or document it in the progress note that they notified the family. LPN/CN#2 went through the chart and there was no sheet of the carbon copied document within the chart.

On 5/10/22 at 12:54 PM, the surveyors discussed the above concern with the Administrator. No additional information was provided.

A review of the policy titled Emergency Transfer Notification Policy and Procedure dated 1/5/22 revealed under Procedure #1-2, "When a resident is temporarily transferred to an acute care facility, CMS affirms that this temporary transfer is a facility-initiate transfer. CMS requires that the NOTICE of the temporary transfer MUST be provided to the resident and the resident representative as soon as practicable. In the event of a transfer to the hospital/ED. Nursing will complete the Notice of Emergency Transfer form triplicate, providing the white copy to the resident prior to transfer, if possible and yellow will be sent to the resident representative by receptionist/unit clerk. The pink copy will be given to thee Social Worker/designee for submission to the LTCO and a copy will be placed in the resident's medical record."

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F 623	Continued From page 8 NJAC 8:39-4.1 (a) 31 (i)	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		5/20/22

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F 656	Continued From page 9 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive care plan for a resident receiving oxygen therapy, Resident # 7, who was 1 of 21 residents reviewed for comprehensive care plans. The deficient practice was evidenced by the following: On 5/4/22 at 10:39 AM, the surveyor observed Resident #7 receiving EX Order 26 § 4b1 [redacted] The surveyor reviewed the electronic medical record (EMR) of Resident #7 which revealed the following: The Resident Face Sheet, which listed diagnoses that included EX Order 26 § 4b1 [redacted] The Quarterly Minimum Data Set (MDS) assessment, dated 5/5/22, which indicated the facility assessed the resident's EX Order 26 § 4b1 status using a Brief Interview for Mental Status. The resident scored a EX O[redacted] out of 15 which indicated	F 656	Specific Corrective Action 1.Resident#7- Care Plan was reviewed to reflect that care plan is comprehensive, person-centered care and meet the resident□s physical, psychosocial, and functional needs. The use of oxygen inhalation was also reflected in the care plan 2.All nurses were in-service to update all care plan to ensure that new physician order is reflected in the resident□s care plan when necessary Identification All residents have the potential to be affected by the deficient practice. Systemic Changes 1.Nurses on 11-7 shift will do a 24-hour new physician order check daily and will update care plan when necessary 2.Unit Manager /Designee will do a monthly audit for all new physician□s orders to ensure that resident□s care plan is appropriately updated	

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F 656	Continued From page 10 that the resident had NJ Exec. Order 26:4.b.1 [redacted] The MDS assessment also indicated the resident was receiving NJ Exec. Order 26:4.b.1. A physician's order for Resident #7, dated 4/20/22, which read: EX Order 26 § 4b1 [redacted] Care plans, that included a cardiac care plan dated 12/22/20, with interventions, " EX Order 26 § 4b [redacted] and EX Order 26 § 4b1 [redacted] There was no care plan related to Resident #7 receiving EX Order 26 § 4b1. On 5/9/22 at 1:31 PM, the surveyor asked Licensed Practical Nurse (LPN) #1 who was responsible for updating the care plans. LPN #1 stated there was no permanent nurse on the unit and whichever nurse was working on the floor would update the care plans. LPN #1 further stated that the MDS coordinators would also review the care plans. The LPN acknowledged the resident should have had a care plan for oxygen therapy and stated "EX Order 26 § 4b1 [redacted]. On 5/10/22 at 10:32 AM, a review of care plans in the EMR revealed a EX Order 26 § 4b1 care plan for resident # 7 was created on 5/9/22. On 5/11/22 at 11:04 AM, the surveyor interviewed LPN #2 about the process of updating care plans for residents. LPN #2 stated there were no regular nurses on the unit and the nurses tried their best to update care plans. LPN #2 further stated nurses working temporarily on the unit may not be aware they needed to update care plans	F 656	Monitoring A monthly QAPI on resident□s care plan will be done by DON/Designee monthly X3 months and quarterly thereafter to ensure that the new physician orders were update and reflected in the care plan when appropriate. Reports will be submitted to the administrator and will be discussed during the quarterly meeting.	

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and may have been focused on giving medication and care to the residents. LPN #2 acknowledged Resident #7 should have had a care plan for NJ Exec. Order 26:4.b.1.

On 5/11/22 at 12:20 PM, the surveyor interviewed an MDS coordinator about the respiratory care plan that was added on 5/9/22. The MDS coordinator stated the nurses on the unit were responsible for updating care plans. The MDS coordinator stated she would review residents' charts and add care plans for residents based on the audits of completed MDS assessments. The MDS coordinator stated she completed the audit of the previous MDS assessment for Resident #7, then reviewed the resident's chart and added the care plan on 5/9/22. The MDS coordinator stated Resident #7 did not have a previous care plan for oxygen therapy, as continuous EX Order 26 § 4b1 for the resident wasn't started until mid-April and the resident was previously on EX Order 26 § 4b1 as needed. The MDS coordinator reviewed her audit list that indicated all the residents' MDS assessments she audited. The MDS coordinator stated Resident #7 was not on the list. The MDS coordinator acknowledged the resident should have had a care plan for EX Order 26 § 4b1.

On 5/11/22 at 1:00 PM, the surveyor informed the Administrator of the above concerns. The Administrator stated the supervisors or Assistant Director of Nursing should have been following up that care plans were updated based on residents' status and new physician orders.

On 5/12/22 at 9:20 AM, the surveyor reviewed the facility policy titled, "Care Plans, Comprehensive Person-Center", which was dated 10/20/2021. Under Policy, it read: "A comprehensive,

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F 656	Continued From page 12 person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.". Under Procedure, number 8 (b) read: "The comprehensive, person-centered care plan will: Describe the service that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being". Under Procedure, number 13 read: "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change". NJAC 8:39-11.2, 2	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide care and services consistent with professional standards of practice during a wound	F 686	Specific Corrective Action 1.LPN that was observed performing the treatment for Resident #7 was	5/20/22

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	315378	A. BUILDING _____ B. WING _____	05/19/2022

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F 686	Continued From page 13 treatment. This was found with Resident #7, who was 1 of 3 residents reviewed for pressure ulcer care and prevention. The deficient practice was evidenced by the following: On 5/9/22 at 10:30 AM, the surveyor spoke with Resident #7 who stated, "I have a NJ Exec. Order 26 by the NJ Exec. Orde" and that the nurses provided treatment to the wound. Resident #7 said, "I think it's some type of cream they [nurses] put and they [nurses] say it's getting better". On 5/9/22 at 11:23 AM, the surveyor observed a Licensed Practical Nurse (LPN) perform a NJ Exec. Order 26 to the NJ Exec. Order 26:4 of Resident #7. The LPN applied NJ Exec. Orde paste (a NJ Exec. Order 26:4.b.1 paste) to the resident's wound. The LPN did not cleanse the wound site prior to applying the topical treatment. On 5/9/22 at 1:22 PM, the surveyor interviewed the LPN about the wound care procedure and the observation of the wound site not being cleansed prior to applying the topical paste during the wound treatment. The LPN stated the treatment order didn't specify to cleanse the wound, and also, the area was cleansed during hygiene care provided by the Certified Nursing Assistant prior to the wound treatment. The LPN further stated cleansing the wound depended on what was written on the physician's order and that she ensured a wound area was clean prior to applying a treatment for residents. The LPN stated if the wound area for Resident #7 was soiled at the time of the treatment she would have cleansed it prior to applying the NJ Exec. Orde paste.	F 686	re-educated on facility□s Clean Technique Dressing Change Policy and was observed for skill competency test for wound treatment administration 2.LPN that was observed performing the treatment for resident #7 was in-service to check the physician□s order prior to treatment administration. The staff must call the physician for order clarification or order change if the staff□s assessment indicates that treatment order is not appropriate. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes 1.Unit Manager/Charge Nurses will do a monthly audit on all treatment orders to ensure that orders are written appropriately which includes the cleansing direction, location of the wound, medication/ointment, type of dressing and frequency. Reports will be submitted to the DON/Designee 2.Wound care nurse/ designee will do a monthly wound care treatment observation on all nurses X 3 months and quarterly thereafter. Reports will be submitted to the DON/designee for QAPI Monitoring 1.A monthly QAPI will be done by	

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F 686	Continued From page 14 The surveyor reviewed the electronic medical record of Resident #7 which revealed the following: The Quarterly Minimum Data Set (MDS) an assessment, dated 5/5/22, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status. The resident scored a [redacted] out of 15 which indicated that the resident had NJ Exec. Order 26:4.b.1 The MDS assessment also indicated the resident had an NJ Exec. Order 26:4.b.1 . A medical progress note by the Infectious Disease Advanced Practice Nurse, which was dated 4/27/22, revealed the resident was evaluated for a sacral wound. The note indicated the resident had an unstageable pressure injury to the sacrum. A physician's order for Resident #7, which was dated 4/27/22, read: "apply by topical route to NJ Exec. Order 26:4.b.1 TID [three times a day] and PRN [as needed] for soilage". On 5/12/22 at 1:26 PM, the surveyor informed the Administrator about the observation of the LPN not cleansing the wound prior to applying the topical paste. The Administrator acknowledged the nurses should cleanse a wound site prior to applying a topical treatment. On 5/13/22 at 10:05 AM, the surveyor reviewed the facility's policy titled, "Clean Technique, Dressing Change", which was dated 2/23/22. Under Policy, it read: "Clean Dressing Change Technique is used to eliminate skin irritation and to promote wound healing". Under Procedure, number 5 read: "Cleanse wound as prescribed.".	F 686	DON/Designee on wound care treatment orders to ensure that physician wound orders are written appropriately X 3months and quarterly thereafter. Reports will be submitted to the administrator and will be discussed during the quarterly meeting. 2.A monthly QAPI for wound treatment observation will be done by DON/Designee monthly x3 and quarterly thereafter. Reports will be submitted to the administration and will be discussed during the quarterly meeting	

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F 686	Continued From page 15 NJAC 8:39-27.1 (a)	F 686		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 755		5/20/22

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F 755	Continued From page 16 Based on interview, and record review, it was determined that the facility failed to ensure that all DEA [Drug Enforcement Administration] 222 forms were completed with sufficient detail to enable accurate accountability and reconciliation for controlled medications for 3 of 3 DEA FORM-222 provided. This deficient practice was evidenced by the following: On 5/10/22 at 11:15 AM, the surveyor reviewed the DEA 222 forms provided by the Administrator. The surveyor noted the following: 1. A DEA FORM-222 dated 3/9/22, which included an order for EX Order 26 § 4b1 [redacted] The number received for the order and the supplier DEA number was not documented on the form. 2. An undated DEA FORM-222, which included an order for EX Order 26 § 4b1 [redacted] The number received and date received for the order and the supplier DEA number was not documented on the form. 3. A DEA FORM-222, dated 8/16/21, which included an order for EX Order 26 § 4b1 [redacted] The supplier DEA number was not documented on the form.	F 755	Specific Corrective Action 1.Back -Up Narcotics Policy was updated to include a system of record of receipt and disposition on controlled drugs in a sufficient detail to enable an accurate reconciliation and to ensure proper completion of the DEA 222 form 2.DON/Designee were in-service regarding the complete instructions for filling out the DEA 222 form 3.All nurses were in serviced on the updated Back Up Narcotic□s Accountability Policy Identification All residents have the potential to be affected by this deficient practice System Changes 1.Unit Manager/Designee will do a weekly audit on all Narcotic Reconciliation form x 3 months and monthly thereafter. Report will be submitted to the DON 2.Pharmacy consultant will review all Narcotics Reconciliation form including the DEA 222 form during the monthly visit Monitoring 1.DON/Designee will do a monthly QAPI on Narcotic Reconciliation audits x3 months and quarterly thereafter. Report will be submitted to the administrator and	

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F 755	Continued From page 17 On 5/10/22 at 12:22 PM, the surveyor interviewed the Administrator about the DEA forms reviewed. The Administrator stated she was familiar with the DEA FORM-222. The surveyor reviewed the DEA 222 forms with the Administrator and identified concerns. The Administrator stated the packing slip and controlled drug record forms were attached to the DEA 222 forms to account for the number received in the order. The Administrator acknowledged the missing information should have been documented on the DEA 222 forms and further stated the former Director of Nursing was responsible for the DEA 222 forms. The Administrator showed the surveyor a copy of instructions for filling out the DEA 222 forms that was located in the binder containing the DEA 222 forms for the facility. The "Instructions for DEA FORM 222" document was reviewed, which indicated under Part 1: Purchaser Information, "The order form must be signed and dated by the purchaser on the day it is submitted for filling"; Under Part 2: Supplier Identification, it indicated "Enter the DEA number, name, and address of supplier; Under Part 5: Controlled Substance Receipt it read, "1. The purchaser fills out this section on its copy of the original order form" and "2. Enter the number of packages received and date received for each line item." On 5/11/22 at 9:25 AM, the Administrator provided a copy of the facility's policies titled "Narcotic Accountability" and "Back up Narcotics Accountability", dated 10/23/21. The surveyor reviewed the provided policies, and it did not address DEA 222 forms or outline a system to account for controlled medications ordered and received.	F 755	will be discussed during the quarterly meeting. 2.DON/Designee will do a QAPI on the DEA form completion monthly and quarterly thereafter. Report will be submitted to the DON and will be discussed during the quarterly meeting	

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F 755	Continued From page 18 NJAC 8:39-29.7 (c)	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		7/6/22

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F 880	Continued From page 19 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate measures to prevent and control the spread of infection for 1 of 1 Phlebotomist observed. This deficient practice was as evidenced by the following: On 5/10/22 at 9:46 AM, the surveyor observed	F 880	Specific Corrective Action a. The laboratory provider was contacted to request for a change of phlebotomist to service the facility with somebody that has appropriate and current training with infection control in preventing the spread of infection that needs to be observed	

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F 880	Continued From page 20 the Phlebotomist enter Resident # 72's room and he left the door opened. From the hallway, the surveyor observed the Phlebotomist perform hand hygiene and put on gloves. With his gloved hands, the Phlebotomist grabbed the bedside table and pushed it away from the resident's bed. Then, with his gloved hands, the Phlebotomist picked up and moved the paperwork from the bedside table, pushed a button on the side of the resident's handrail to raise the bed up and grabbed his laboratory supplies from his rolling bag and placed them on the bed next to the resident. The surveyor observed the Phlebotomist, with his gloved hands place a tourniquet on the resident's arm and wiped the resident's skin with an alcohol preparation pad. The Phlebotomist inserted a needle into the resident's skin to draw blood from the resident's arm and after a failed attempt to draw blood, the Phlebotomist discarded that needle into a biohazard container. The Phlebotomist grabbed new laboratory supplies and placed them on the bed next the resident. With his gloved hands, the Phlebotomist touched the resident's skin in multiple areas and then inserted a new needle into another spot on the resident's arm without cleaning the skin. After another failed attempt to draw blood, the Phlebotomist discarded those supplies into a biohazard container. The Phlebotomist removed his gloves and grabbed the handle of his rolling bag and brought it near the bathroom door inside the resident's room. The Phlebotomist walked into the bathroom, placed soap on his hands and placed his hands under the running water while rubbing	F 880	during all procedures perform b. Laboratory provider had assigned another phlebotomist with appropriate training for infection control in preventing the spread of infection that needs to be observed during all procedures perform. c. A competency skills done for handwashing, donning and doffing by Infection Control Preventionist to the new assigned phlebotomist d. Infection Control Preventionist/Designee educate the new assigned phlebotomist on Infection Control policy of the facility in preventing the spread of infections 5. The DPOC was completed which includes ,the RCA that was conducted and facility found out that the contracted vendor was new, inexperienced and not properly trained and Directed Inservice Training-certificate of completion was submitted. Directed Inservice training on the following was completed by the Phlebotomist: - CDC Keep Covid-19 Out! - CDC Sparkling Surfaces - CDC Clean Hands - CDC Closely Monitor Residents - CDC Use PPE Correctly for COVID-19 Directed Inservice training on the following was completed by Front Line staff: - CDC Keep Covid-19 Out! - CDC Sparkling Surfaces	

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F 880	Continued From page 21 his hands for four seconds. The Phlebotomist grabbed the handle of his rolling bag and exited the resident's room. At 9:54 AM, the surveyor interviewed the Phlebotomist who stated that he should not have touched all the stuff in the resident's room with gloved hands. The Phlebotomist stated that his gloved hands are considered a clean surface once they are on after proper hand washing. He stated that he should have washed his hands for at least 20 seconds and that he should have cleaned the resident's skin prior to inserting a needle to draw blood. At 10:01 AM, the surveyor interviewed the unit Licensed Practical Nurse who stated that the Phlebotomist should have followed proper infection control technique while providing care to the resident. At 12:54 PM, the surveyor discussed the above concerns with the Administrator, who stated that all staff should follow proper infection control technique during treatments at all times. The surveyor reviewed the Infection Control for Outside Services Provider policy and procedure, dated 12-28-21, which revealed that all outside providers are expected to follow the policy of infection control by observing universal precaution when in contact with a resident. NJAC 8:39-19.4(a)	F 880	- CDC Clean Hands - CDC Closely Monitor Residents - CDC Use PPE Correctly for COVID-19 Directed Inservice training on the following was completed by Top Line Staff and Infection Preventionist: - Module 1 - Infection Prevention & Control Program - Module 5 - Outbreaks - Module 11B - Environmental Cleaning and Disinfection - Module 4 - Infection Surveillance Directed inservice training on the following was completed by All Staff including Top Line and Infection Preventionist: - Module 7 - Hand Hygiene - Module 6A - Prinicples of Standard Precautions - Module 6B - Priniciples of Transmisison Based Precautions Identification All residents have the potential to be affected by this deficient practice Systemic Changes a. Infection Control Preventionist/Designee will educate all individuals providing care under contractual arrangement on facility's Infection Control policy in preventing the spread of infections b. All individuals providing care under contractual arrangement will provide a	

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F 880	Continued From page 22	F 880	competency report for hand hygiene and donning and doffing prior to providing care. Monitoring A QAPI will be done by Infection Control Preventionist/Designee to ensure that all individuals providing with contractual arrangement have a basic and proper training on infection control with competency and are educated on the facility's infection control policy in preventing the spread of infection monthly x 3 months and quarterly thereafter. Report will be submitted will be submitted to the QAPI Committee monthly and will be discussed during Quality Assurance meeting quarterly. A QAPI will be done by the Infection Control Preventionist/Designee to ensure that individuals with contractual arrangements will be observed for competency on hand hygiene ; donning and doffing monthly x 3 months and quarterly thereafter. Report will be submitted to QAPI Committee monthly and will be discussed during the Quality Assurance meeting quarterly	

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE 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 maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	Specific Corrective Action 1. The facility to utilizes several staffing agencies for the required staffing needed to meet the resident's needs 2. The facility has instituted incentive programs for current staff for any extra shifts by giving bonuses to meet the required staffing necessary for the resident's care. 3. The facility is actively recruiting license staff and certified nursing assistant by	5/20/22

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

Electronically Signed | 06/03/22

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(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) COMPLETE DATE
S 560	Continued From page 1 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 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.	S 560	placing an ad and working directly with recruitment agency to cover the staffing requirements 4. The facility has instituted a sign-on bonus, and employee referral program to attract new staff. 5. Hired new Nursing assistant that are currently in a CNA class program from 5-20-2022 to 7-30-2022 6. The facility had secure new contract with a staffing agency to to provide relief staffing to provide the required staffing to mee the needs of the residents. the needs of the facility 7. Facility has been involved in a different job fair Identification All residents have the potential to be affected by this deficient practice Systemic Changes 1. The Director of Nursing/Designee will review Nursing/CNA Monthly Schedule to ensure appropriate staffing is in place to meet the needs of the residents 2. Staff Development/Designee will conduct a monthly education to all nursing staff and new hire about call outs and how the impact of the call outs affects the resident care. 3. facility will conduct a job fai at the facility quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061905	A. BUILDING: _____ B. WING _____	05/19/2022

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S 560	Continued From page 2 (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 "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 4/17/22 and 4/24/22 revealed the following: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -04/17/22 had 8 CNAs for 76 residents on the day shift, required 10 CNAs. -04/18/22 had 6 CNAs for 76 residents on the day shift, required 10 CNAs. -04/19/22 had 6.5 CNAs for 75 residents on the day shift, required 10 CNAs. -04/20/22 had 6.75 CNAs for 75 residents on the day shift, required 10 CNAs -04/21/22 had 8 CNAs for 73 residents on the day shift. Required 10 CNAs. -04/22/22 had 8 CNAs for 73 residents on the day shift, required 10 CNAs. -04/23/22 had 8 CNAs for 73 residents on the day shift, required 10 CNAs. -04/24/22 had 5 CNAs for 73 residents on the day shift, required 10 CNAs. -04/25/22 had 5.75 CNAs for 73 residents on the day shift, required 10 CNAs. -04/26/22 had 6 CNAs for 76 residents on the day shift, required 10 CNAs.	S 560	Monitoring 1. Director of Nursing/Designee will do a monthly QAPI Nursing/Monthly Schedule x 12 months then quarterly thereafter to ensure that staffing coverage meets the resident's needs. Reports will be submitted to Administrator and discussed during quarterly meeting. 2. Human Resources will conduct a monthly QAPI on hiring and retention specific to nursing staff monthly for 12 months then quarterly thereafter to ensure that Nursing department had the required staff to cover required staffing to meet the resident's needs by continouosly pushing Reports will be submitted to Administrator and discussed during quarterly meeting.	

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S 560	Continued From page 3 -04/27/22 had 8 CNAs for 76 residents on the day shift, required 10 CNAs. -04/28/22 had 7 CNAs for 74 residents on the day shift, required 10 CNAs. -04/29/22 had 7 CNAs for 74 residents on the day shift, required 10 CNAs. -04/30/22 had 6 CNAs for 74 residents on the day shift, required 10 CNAs. The facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs during the 7:00 AM - 3:00 PM shift during the period from 4/17/22 through 4/30/22. On 5/12/22 at 12:00 p.m., the surveyor discussed the staffing ratio concerns with the Administrator, who stated they were aware of the staffing ratio criteria.	S 560		

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
315378 Y1	A. Building B. Wing Y2	8/15/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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 F0583	Correction	ID Prefix F0623	Correction	ID Prefix F0656	Correction
Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.21(b)(1)	Completed
LSC	05/20/2022	LSC	05/20/2022	LSC	05/20/2022
ID Prefix F0686	Correction	ID Prefix F0755	Correction	ID Prefix F0880	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	05/20/2022	LSC	05/20/2022	LSC	07/06/2022
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	
5/19/2022	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061905 Y1	A. Building B. Wing Y2	8/15/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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 05/20/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 5/19/2022	☐ 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
	315378	A. BUILDING **01** B. WING _____	**05/19/2022**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
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 5/18/22 and 5/19/22, 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 Occupancy The facility is a 4-story building that was built in 90's, It is composed of Type III unprotected construction. The facility is divided into 8- smoke zones. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 128 certified beds. At the time of the survey the census was 78.	K 000		

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

Electronically Signed | 06/03/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on documentation review on 5/18/22, in the presence of the Maintenance staff member, Regional Plant Operations Director and Maintenance in training, it was determined that the facility failed to inspect fire doors Annually in accordance with S&C 17-38-LSC. This deficient practice was evidenced for 8 of 8 fire doors observed by the following: At 10:00 AM, the surveyor reviewed all provided documentation from the Maintenance staff member. The annual fire door inspection documentation was not provided for the facility's fire door assemblies. An interview was conducted with the Maintenance staff member, during the document review, where they stated that currently no further documentation could be provided on fire door inspections (Annual) for the last 12-months. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/19/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 211	Specific Corrective Action 1. All Fire Doors on 1st, 2nd, 3rd and 4th floors have been inspected by the maintenance staff. 2. Door Inspection Checklist was created to be utilized for inspection to ensure hinges are checked for proper swing, seal between the doors top and bottom, door latches and panic bar to ensure proper closure. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes Fire Door inspection will be conducted Annual and documented in the new Door Inspection Checklist. Monitoring: QAPI will be conducted on all Fire Doors on all floors by the Maintenance	5/23/22

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K 211	Continued From page 2 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8	K 211	Director/designee to ensure that the Fire Doors are inspected as required by the regulation monthly X3 months and annually thereafter. The report will be submitted to Administrator and discussed at quarterly meeting.	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/19/22, the facility failed to provide stair tread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing, and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3. The deficient practice was observed in 2 of 2 stairwells identified by the Regional Plant Operations Director as stairwell A and B. While touring the facility on 5/19/22, from approximately 9:40 AM to 3:00 PM, the Surveyor, Maintenance staff member and Regional Plant Operations Director observed that the exit/egress stairwells revealed that marking stripes were not present on each step, floor landing, and handrails	K 225	Specific Corrective Action Stairwell A & B striping line on all steps, handrails and each floor landing has been done by maintenance staff. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes Maintenance staff will conduct monthly inspections to ensure that the striping on all steps, handrails and each floor landing are maintained. Monitoring	5/26/22

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K 225	Continued From page 3 for the 2- stairwells observed. The Administrator was informed of this finding during the Life Safety Code survey exit conference on 5/19/22. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	A QAPI will be conducted by the Maintenance Director/designee to ensure that the striping on all steps, handrails and each floor landing are maintained monthly X3 months and quarterly thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/19/22, it was determined that the facility failed to provide an operational battery backup emergency light above A. The outside fire pump house where the transfer switch was located, B. The emergency generator's transfer switch room, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed for 2 of 2 transfer switches and was evidenced by the following: A. At 1:10 PM, the Surveyor Maintenance staff member, Plant Operations Director and Maintenance in training, observed in the fire pump transfer switch exterior house, that no emergency lighting was provided. B. At 11:08 AM, the Surveyor Maintenance staff	K 291	Specific Corrective Action 1. A 1 1/2 hour battery backup emergency light has been installed facing the emergency generator transfer switch. 2. A 1 1/2 hour battery backup emergency light has been installed in the Pump room facing the Emergency Fire pump. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes 1. A monthly emergency light audit will be conducted by the Maintenance Director/designee with a pass or fail notation test all battery backup emergency lighting by pushing the test button then	6/1/22

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K 291	Continued From page 4 member, Plant Operations Director and Maintenance in training, observed in the facility electrical room, where the emergency generator transfer switch was located, that no emergency lighting was provided where the transfer switch was located. This finding was verified by the Maintenance staff member, Plant Operations Director and Maintenance in training, at the time of the observation's. The Administrator was notified of the above findings at the Life Safety Code exit conference on 5/19/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	record his findings. 2. An annual run test of the emergency light will be conducted by Maintenance Director/designee to test the backup lighting that illuminates the generator transfer switch and the emergency fire pump removing the continuous power from the light and allowing the backup battery to operate the unit. Monitoring Maintenance Director/designee will conduct a monthly QAPI to ensure that the emergency battery backup lighting is operational X3 months and quarterly thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 5/19/22, in the presence of the Maintenance staff member, Regional Plant Operations Director and Maintenance in training, it was determined that the facility failed to ensure that exit directional	K 293	Specific Corrective Action The temporary exit signs have been placed on both sides of the plastic barrier used in the COVID-19 wing.	5/20/22

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K 293	Continued From page 5 signs were installed and illuminated at all times. This deficient practice was evidenced for 1 of 1 wings of the facility by the following: At 11:59 AM, the surveyor observed on floor 2 that a temporary (obscured) plastic barrier was used as a covid-19 wing for person's under investigation (PUI). The plastic barrier is required to have temporary exit signs on both sides of the obscured plastic in the exit/egress corridor in the event of an emergency evacuation and/or fire. An interviewed was conducted with the Maintenance staff member, Regional Plant Operations Director and Maintenance in training and they stated that they were unaware of this requirement. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 5/19/22. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use unless otherwise provided in 7.8.1.2.2. NJAC 8:39-31.2(e) NFPA 101 2012 existing Life Safety Code 7.10 19.2.10.1	K 293	Identification All residents have the potential to be affected by the deficient practice. Systemic Changes 1. The Maintenance staff will check daily to ensure that all signage is present and using a daily round audit for documentation. All findings will be reported to the Maintenance Director/designee. Monitoring A QAPI will be conducted by the Maintenance Director/designee to ensure that exit directional signs were installed and illuminated at all times monthly X3 months then quarterly thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	
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	K 353		6/3/22

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K 353	Continued From page 6 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. 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, interview and review of facility vendor documentation, the facility failed to maintain the sprinkler system by not ensuring that all components of the facility diesel fire pump were in working order. This deficient practice was evidenced for 1 of 1 fire pumps as evidenced by the following: On 5/19/22 at approximately 10:00 AM, the surveyor requested from the Maintenance staff member, Plant Operations Director and Maintenance in training, the annual diesel fire pump inspection report. The 6/18/21 report indicated that the water temperature and oil pressure gauges were not operating correctly and there was a leak at the threaded connection. The Plant Operations Director was asked to provide a work order as to when the repairs were completed. No further documentation was provided as of the Life Safety Code exit	K 353	Specific Corrective Action Sprinkler company was contracted to make all repairs to replace: " one water temperature Gauge " one oil Pressure Gauge " stop leaking around the thread of the connections. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes Maintenance Director/designee will ensure that sprinkler company recommendations are followed. A monthly compliance schedule will be maintained help identify any issues that	

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	315378	A. BUILDING **01** B. WING _____	**05/19/2022**

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K 353	Continued From page 7 conference. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/19/22. NJAC 8:39-312(e) NFPA 25	K 353	may arise. A monthly review of all documentation shall be done by the Maintenance Director and any issue found will be reported to the Administrator for a resolution. Monitoring A QAPI will be conducted by the Maintenance Director/designee monthly to ensure all inspections and recommendations by inspection company are being done and are in compliance monthly X3 months and quarterly thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 5/19/22 in the presence of facility Maintenance staff member, Plant Operations Director and	K 511	Specific Corrective Action 1. An outlet cover was replaced in the	5/27/22

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K 511	Continued From page 8 Maintenance in training, it was determined that the facility failed to maintain electrical wiring in accordance with NFPA 70 (National Electrical Code) Section 400-8. This deficient practice was evidenced for 3 of 50 areas observed by the following: 1. At 11:09 AM, the surveyor observed in the floor 2 day/dining room that the rear duplex wall electrical outlet, was missing the outlet plate cover. The wall mounted TV was plugged into the duplex wall outlet. 2. At 11:26 AM, the surveyor observed in resident room 230 windowside, that the black wire to the resident bed, was frayed and needed replacement. 3. At 1:50 AM, the surveyor observed in the floor-1, TV/conference room, that the wall mounted TV electrical cord, was installed above the drop ceiling tiles. An interview was conducted and the Maintenance staff member, Regional Plant Operations Director and Maintenance in training, where they confirmed the above observation's. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/19/22. NJAC 8:39-31.2(e) NFPA 70, 99	K 511	second-floor dining room. 2. In room 230 the bed was removed and replace with another bed that has no frayed wires. 3. The tv in the conference room was unplugged from the ceiling and an outlet has been installed for its use. 4. Audit tool for electrical equipment, wiring, outlets has been created for monthly inspection. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes The Maintenance staff will inspect all electrical equipment in operation in the facility using an audit tool created by the Maintenance Director monthly to check and remove any defective equipment out of use and check all outlet covers to ensure they are not broken as well as check all electric equipment wiring in use in the building to ensure they meet the regulation standards. Monitoring A QAPI on all electrical wiring will be conducted to ensure wiring is in compliance with the standards set by NFPA by the Maintenance Director/designee monthly X3 months and quarterly thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	

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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 observation and interview on 5/18/22, in the presence of the Maintenance staff member, Plant Operations Director and Maintenance in training, it was determined that the facility failed to ensure resident bathroom ventilation systems for 70 of 82 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: The Surveyor, Maintenance and Operations Director observed that the ventilation in the following resident room bathrooms did not function: 1. Floor 4 resident rooms G-1 to G-26 2. Floor 3 resident rooms 301 to 334 3. Floor 2 A-wing only The surveyor requested that the Maintenance Director confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a	K 521	Specific Corrective Action The bathroom ventilations on Floor 4 resident rooms G-1 to G-26, Floor 3 resident rooms 301 to 334, Floor 2 A-wing have been fixed by maintenance staff. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes Maintenance staff will audit all bathroom ventilation monthly. Reports will be submitted to Maintenance Director/designee. Monitoring A QAPI will be conducted by Maintenance Director/designee to ensure that the bathroom ventilation is functioning monthly X3 months and quarterly	5/27/22

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K 521	Continued From page 10 window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Maintenance staff member and Regional Plant Operations Director, who confirmed that the exhaust vents in the above resident room bathrooms were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 5/19/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	
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	K 531		6/3/22

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K 531	Continued From page 11 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: Observation, interview and record review, on 5/19/22, it was determined no evidence that Fire Fighters' Emergency Operations Inspection and Test was performed and written record of Phase I recall by use of the key switch, and a minimum of one floor operation, including findings documented monthly testing for 2 of 2 elevators, in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. This deficient practice was evidenced by the following: During a tour with the Surveyor, Maintenance staff member, Regional Plant Operations Director and Maintenance in training observed that 2 of 2 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). The facility provided a general elevator phase I and phase II fire test log from their elevator vendor that indicated car #1 and car #2 testing, that was just checked off and not descriptive as to what floor. The log indicated that on February 2022, the test was not in the correct sign-off row. The findings were verified by the Maintenance staff member and Regional Plant Operations	K 531	Specific Corrective Action The elevator company inspection form is updated to reflect all functions of phase 1 and 2 with specific recall testing. The facility requested the elevator company to have the inspection documentation for the inspection to indicate the specific floor during the recall test Identification All residents have the potential to be affected by the deficient practice. Systemic Changes Maintenance staff will conduct monthly elevator Phase 1 & 2 recall testing. Monitoring A QAPI will be conducted by Maintenance Director/designee monthly on Phase 1 & 2 elevator recall testing. The report will be submitted to Administrator to be discussed at quarterly meeting.	

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K 531	Continued From page 12 Director at the time of the observations. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/19/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review on 5/18/22, in the presence of Maintenance staff, Regional Plant Operations Director and Maintenance in training, it was determined that the facility failed to conduct fire drills at unexpected times under varying conditions for 3 of 3 shifts. This deficient practice was evidenced by the following: 1. A review of the facility's fire drill documentation for 12-months revealed that the facility conducted 1st shift (7 p.m. to 3 p.m.) drills within the same	K 712	Specific Corrective Action The fire drill company were requested to conduct fire drills for all 3 shifts at various times and should be distributed at beginning, middle and end of each shift. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes	5/26/22

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K 712	Continued From page 13 60-minute time frame each Quarter as follows: - 4/21/22 at 10:46 AM - 1/27/22 at 10:40 AM - 10/20/21 at 9:35 AM - 7/23/21 at 10:20 AM 2. A review of the facility's fire drill documentation for 12-months revealed that the facility conducted 2nd shift (3 p.m. to 11 a.m.) drills within the same 90-minute time frame each Quarter as follows: - 2/29/22 at 4:41 PM -11/18/22 at 4:45 PM - 8/22/21 at 6:00 PM - 5/26/22 at 4:40 PM 3. A review of the facility's fire drill documentation for 12-months revealed that the facility conducted 3rd shift (11 p.m. to 7 a.m.) drills within the same 30-minute time frame each Quarter as follows: - 3/23/22 at 12:40 AM - 12/8/21 at 12:35 AM - 9/26/21 at 12:15 AM - 6/30/21 at 12:40 AM The Maintenance staff member confirmed the findings while reviewing the documentation and he agreed the times were to close on each shift. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/19/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712	The Maintenance director/designee will request schedule from the Fire Drill Company ensuring that the schedule provides for all 3 shifts at various times and should be distributed at beginning, middle and end of each shift. Monitoring A QAPI will be conducted by the Maintenance director/designee to ensure that the fire drills are conducted at various times for all 3 shifts monthly X3 months and quarterly thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	
K 908 SS=F	Gas and Vacuum Piped Systems - Inspection and	K 908		6/30/22

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K 908	Continued From page 14 CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 5/19/22, in the presence of the Maintenance staff member, Regional Plant Operations Director and Maintenance in training, it was determined that the facility failed to inspect and test the piped-in Oxygen system as part of a maintenance program in accordance with NFPA 99. This deficient practice was evidenced for 14 of 14 Oxygen outlets, by the following: A review of the facility's piped-in Oxygen system inspections revealed that the last inspection of the system by a licensed vendor was conducted on 10/12/20, more than 19-months ago. In an interview, at 11:45 AM, the facility's Maintenance staff member stated and confirmed that the system was not inspected due to a communication issue with the previous Maintenance Director and was not scheduled. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 5/19/22.	K 908	Specific Corrective Action The inspection of all rooms with piped in oxygen will be conducted by licensed Vendor. The annual Inspection of Medical gas Outlets and Systems were completed 6/30/2022. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes Maintenance Director/designee will schedule annual inspection of all rooms with piped in oxygen with the licensed vendor. Monitoring A QAPI will be conducted by the Maintenance director/designee to review	

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K 908	Continued From page 15 NJAC 8:39-31.2(e) NFPA 99	K 908	all required inspections monthly X3 months and quarterly thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	
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 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	K 918		6/2/22

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K 918	Continued From page 16 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 5/19/22, it was determined that the facility did not ensure a remote manual stop station for 1 of 1 generators, was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: On 5/19/22, the Surveyor, Maintenance staff member, Plant Operations Director and Maintenance in training, observed the exterior diesel generator. There was no remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed. An interview was conducted during the observation with the Maintenance staff member, Plant Operations Director and Maintenance in training, where they stated that at the time of observation, the exterior generator was observed to not have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/19/22. 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	Specific Corrective Action A remote manual stop station will be installed by the Generator Company. A work order was obtained. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes A monthly test will be conducted to ensure the remote manual stop station is operational by Maintenance staff. Monitoring A QAPI will be conducted by Maintenance director/designee to ensure the remote manual stop station will prevent inadvertent or unintentional operation for the emergency generator monthly X3 months and quarterly thereafter. The report will be submitted to Administrator to be discussed at quarterly meeting.	

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
315378 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/15/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

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 K0211	05/23/2022	LSC K0225	05/26/2022	LSC K0291	06/01/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	05/20/2022	LSC K0353	06/03/2022	LSC K0511	05/27/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	05/27/2022	LSC K0531	06/03/2022	LSC K0712	05/26/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0908	06/30/2022	LSC K0918	06/02/2022	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	
5/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO