STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING ______ B. WING ______	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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F 000	INITIAL COMMENTS Survey Date: 11/22/21 Census: 101 Sample: 23 Complaint # NJ00148690 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 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) an assessment tool for 1 of 23 residents reviewed for MDS accuracy (Resident #28). This deficient practice was evidenced by the following:	F 637	The Resident who failed to have a SCSA MDS completed at the time of discontinuing NJ Exec. Order 26:4.b Services had one completed immediately. All residents that discontinued NJ Exec. Order 26:4.b services would be Effected.	1/14/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/08/2021

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

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F 637	Continued From page 1 The surveyor observed Resident #28 in bed with eyes open on 11/10/21 at 11:15 AM. On 11/12/21 at 11:19 AM, the surveyor completed a review of the electronic medical record. The Admission Record revealed that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Exec. Order 26:4.b.1 The 9/5/2021 Annual MDS indicated that the resident had NJ Exec. Order 26:4.b.1 . According to the September 2021 Clinical Physician Orders, Resident #28 had physician orders to NJ Exec. Order 26:4.b.1 9/19/21. The surveyor reviewed the MDS assessments for Resident #28. There was no evidence that a SCSA was completed. A SCSA is required when a resident receiving NJ Exec. Order 26:4.b.1 discontinues those services. On 11/17/21 at 12:35 PM, the surveyor interviewed the MDS coordinator. The surveyor asked what type of assessment she would expect to see for a resident who was discharged from NJ Exec. Order 26:4 . The MDS coordinator stated that she would expect to see a SCSA MDS. On 11/17/21 at 1:41 PM, the surveyor discussed the above findings with the Administrator and the Director of Nursing (DON). The DON stated that she would have expected that a SCSA MDS would be completed.	F 637	All resident that discontinued NJ Exec. Order 26:4 services WILL have an audit conducted by the MDS Coordinator to ensure that the SCSA MDS was completed. The Policy and Procedure for Resident Assessments was reviewed by the QAPI team. The Census Distribution list was re-reviewed. The new MDS staff were added on the distribution list. The MDS staff were inserviced by the Administrator on monitoring census for payer changes and Electronic Medical Record for clinical changes. A weekly audit of NJ Exec. Order 26:4.b residents will be conducted during the Utilization Review meeting when the Interdisciplinary Team is present to validate no changes have been made. MDS Coordinator will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks then monthly for 2 more months. MDS/designee will provide a report of her findings to the QA committee for action as appropriate.	

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F 637	Continued From page 2 A review of the facility's policy titled, "Resident Assessments" with a revision date of April 2021 indicated that a SCSA is required within 14 days when a resident discontinues NJ Exec. Order 26:4.b.1. N.J.A.C 8:39-11.2(i)	F 637		
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)-	F 656		1/14/22

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F 656	Continued From page 3 (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 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 implement a comprehensive care plan for Resident #28, 1 of 23 residents reviewed. This deficient practice was evidenced by the following: On 11/10/21 at 11:15 AM, the surveyor observed Resident #28 in bed with eyes open. A NJ Exec. Order was observed in the resident's NJ Exec. Order The NJ Exec. Order 26:4.b.1 was set to NJ Exec. Order 26:4.b. of NJ Exec. Order 26:4.b.1. On 11/12/21 at 11:19 AM, the surveyor reviewed the medical record for Resident #28: The Admission Record revealed that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Exec. Order 26:4.b The 9/5/2021Annual MDS indicated that the resident had NJ Exec. Order 26:4.b.1 and was currently using NJ Exec. Order 26:4.b.1. According to the November 2021 Clinical	F 656	Residents #28 had a care plan implemented for the use of NJ Exec. Order 26: Any resident who uses NJ Exec. Order 26: has the potential to be affected by this practice. All residents with NJ Exec. Order 26:4.b.1 will have a comprehensive care plan audit to ensure the NJ Exec. Order 26:4.b.1 plan for NJ Exec. Order 26:4.b.1 is addressed. All nurses have been re-educated on the process of implementing a Comprehensive Care Plan that includes areas of concerns for the resident. As per the policy, care plans will be updated according to the identified Care Assessment Areas with input from the Interdisciplinary Care Team, Resident, and/or Resident Representative. Director of Nursing/designee will conduct random audits of NJ Exec. Order 26:4.b.1 plans each month . Results of monthly audits will be reported to the QA committee by the Director of Nursing/Designee for 3 months	

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F 656	Continued From page 4 Physician Orders, Resident #28 had physician orders for NJ Exec. Order 26:4.b. of NJ Exec. Order 26:4.b.1. On 11/12/2021 at 12:07 PM, the Director of Nursing (DON) provided the surveyor with Resident #28's care plan. A review of the care plan failed to reveal a comprehensive care plan for the resident's NJ Exec. Order 26:4.b.1 status. On 11/12/21 at 12:25 PM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN stated that he would expect to see a NJ Exec. Order 26:4.b.1 care plan for a resident who is receiving NJ Exec. Order 26:4.b.1. On 11/12/21 at 12:27 PM, the surveyor interviewed the LPN Unit Manager (LPN/UM). The LPN/UM stated that "I think you're right, I don't even see it" regarding the NJ Exec. Order 26:4.b.1 plan. The LPN/UM stated that Resident #28 should have a NJ Exec. Order 26:4.b.1 plan. On 11/17/21 at 1:41 PM, the surveyor presented the above information to the Administrator and DON. The DON stated that she would expect to see a NJ Exec. Order 26:4.b.1 plan for a resident receiving NJ Exec. Order 26:4.b.1. A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered" with a revision date of April 2021 indicated that the care plan will "describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." N.J.A.C. 8:39-11.2(e)	F 656	to the QA committee for action as appropriate.	

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to update and/or revise care plans for 3 of 23 residents reviewed, Resident # 9, Resident # 61, and Resident # 96. The deficient practice was evidenced by the following: 1. The surveyor reviewed an investigation for a	F 657	Residents #9 Fall Care plan was updated immediately with the following interventions to prevent future NJ Exec. O; a longer phone charger cord and a side rail pouch for the resident to keep their cell phone Resident #61 Actual NJ Exec. Order 26:4.b.1 Care Plan was updated immediately with	1/14/22

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F 657

Continued From page 6

NJ Exec. Resident #9 had. The NJ Exec. Order 26:4.b on 2/10/21. The resident NJ Exec. Order 26 sustain any NJ Exec. Order 26. The investigation determined that the resident NJ Exec. Order 26 of bed while reaching for their cell phone that had fallen on the floor. The investigation of the NJ Exec. O indicated that the Interdisciplinary Team agreed to add the following interventions to the care plan to prevent future NJ Exec. O; a longer phone charger cord and a side rail pouch for the resident to keep their cell phone.

The surveyor asked the Director of Nursing (DON) for all of the active care plans for the resident. The DON confirmed that all of the care plans she provided were all of the resident's active care plans. There was no information, update, or revision related to the 2/10/21 NJ Exec. O on the care plan with the focus "I have had NJ Exec. Order 26:4.b. There was a secondary care plan to address NJ Exec. O. There was no information, update, or revision related to the NJ Exec on that secondary care plan with the focus "I am NJ Exec. Order 26:4.b.1

On 11/17/21 at 12:59 PM, the surveyor spoke to the Licensed Practical Nurse/ Unit Manager (LPN/UM) and asked about the care plan for NJ Exec. O not being updated after the 2/10/21 NJ Exec. O the resident had. The LPN/UM said the care plan should have been updated after that NJ Exec. and she didn't know why it had not been updated/revised after the 2/10/21 NJ Exec. O. The LPN/UM confirmed that she would have been responsible for updating the care plan.

2. On 11/10/21 at 11:19 AM, the surveyor

F 657

the actual NJ Exec. Order 26:4.b.1.
Resident #96 NJ Exec. O Care plan was updated immediately with the NJ Exec interventions from NJ Exec. O

Any resident who had a NJ Exec have the potential to be affected by this practice. Any resident with an actual NJ Exec. O have the potential to be affected by this practice.

All residents who have had an actual NJ Exec. will have a comprehensive care plan audit by Director of Nursing to ensure the interventions are in place on the care plan. All residents with an actua NJ Exec. Ord will have a comprehensive care plan audit by the Director of Nursing to ensure the actua NJ Exec. Order 26:4.b.1 is noted.

All nurses have been re-educated on Careplans, Comprehensive Person-Centered by the ADON/designee on the process of implementing a Comprehensive Care Plan that includes areas of concerns for the resident. As per the policy, care plans will be updated according to the identified Care Assessment Areas with input from the Interdisciplinary Care Team, Resident, and/or Resident Representative. Director of Nursing/designee will conduct random audits of NJ Exec. Order 26 4.b.1 Care plans each month. Results of monthly audits will be reported to the QA committee by the Director of Nursing/Designee for 3 months to the QA

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F 657	Continued From page 7 observed Resident #61 in bed, NJ Exec. Order 26 4.b.1 the resident was lying on a NJ Exec. Order 26:4.b. and bed noted to be in a low position. The surveyor reviewed the medical records for Resident #61 that revealed the following: According to the Admission Record, Resident #61 was admitted to the facility with NJ Exec. Order 26:4.b.1 The November 2021 Clinical Physician Orders sheet revealed that Resident #61 had active physician orders to provide NJ Exec. Order 26:4.b.1 The November 2021 ETAR indicated that the treatments to areas mentioned above were scheduled for the evening shift. In addition, the Quarterly Minimum Data Set an assessment tool dated 10/13/21, indicated that the resident had NJ Exec. Order 26:4.b.1 . The most recent Weekly Wound Assessment dated 11/8/21 indicated that the NJ Exec. Order 26:4.b.1 as started. The care plans were reviewed and the care plan titled NJ Exec. Order 26:4.b.1 indicated that the NJ Exec. Order 26:4.b.1 were discontinued. However, there were no other actual NJ Exec. Order 26:4.b.1 listed including the NJ Exec. Order 26:4.b.1 that was indicated on the 10/13/21 Quarterly MDS. NJ Exec. Orde The last update on the care plan was dated 7/16/21.	F 657	committee for action as appropriate.	

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F 657	Continued From page 8 3. On 11/10/21 at 11:27 AM, the surveyor observed Resident #96 in bed, with eyes closed. The resident was lying on a NJ Exec. Order 26:4.b.1 The surveyor reviewed the medical records for Resident #96 that revealed the following: According to the Admission Record, Resident #96 was readmitted to the facility with the diagnosis of NJ Exec. Order 26:4.b.1 The NJ Exec. O Incident Description dated 10/9/21 revealed the resident was found on the floor in the resident's room next to the resident's bed. The resident was crying and stated "I was trying to walk to the bathroom. The resident stated that he/she NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 The resident was sent to the NJ Exec. Order 26:4.b.1 for evaluation. The resident was NJ Exec. Order 26:4.b.1 . The November 2021 Electronic Medication Administration Record showed the resident had NJ Exec. Order 26:4.b.1 nine times from November 2nd through November 15th. The resident had a care plan related to NJ Exec. Order 26:4.b. secondary to NJ Exec. Order 26:4.b.1 However, it was observed that the care plan had not been reviewed and updated to include the resident NJ Exec on 10/9/21. On 11/17/21 at 12:40 PM, the surveyor interviewed MDS Coordinator who stated that the care plans are reviewed and revised at care plan	F 657		

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F 657	Continued From page 9 meetings. She stated the Unit Managers are on top of it. At 12:59 PM, the surveyor interviewed the LPN/UM who stated that the residents care plans are updated by the UM or if she is not in the facility the supervisor would do it. The LPN/UM was not aware that the care plans that were not updated. On 11/17/21 at 1:41 PM, the surveyors discussed the above care plan concerns with the Administrator and DON. They both agreed that the care plans should have been updated. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised in April 2021 revealed the following under Policy Interpretation and Implementation #13, #14-(a,b,c,d); #13" Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. " #14(a,b,c,d) "The interdisciplinary team must review the care plan: a. when there has been a significant change in condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. NJAC 8:39-11.2 ,2, (i)	F 657		
F 658 SS=E	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.	F 658		1/14/22

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F 658	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice for not following physician orders for 1 of 23 residents (Resident #70) which occurred over a three month period and failed to document in the Electronic Treatment Administration Record (ETAR) for 2 of 23 residents (Resident #88 and #61) reviewed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens 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 casefinding; 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."	F 658	Resident #70, #88 and #61 had no ill effects. All residents with withhold NJ Exec. Order 26:4.b.1 have the potential to be affected. All Nurses identified with the deficient practice were re-educated on our facility policy and were counseled. All Nurses will be re-educated by Pharmacy Consultant and/or designee on administering medications with parameters, documenting on Treatment Orders, and facility policy. Director of Nursing/designee will conduct weekly audits of Medication and Treatment Administration Record. Results of weekly audits will be aggregated by the Director of Nursing/designee and reported to the QA committee by the Director of Nursing/Designee for 3 months for action as appropriate.	

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F 658	Continued From page 11	F 658		

1. The surveyor reviewed the medical records for Resident #70 that revealed the following:

According to the November 2021 Clinical Physicians Order sheet Resident #70 had an order dated 2/25/2020 for NJ Exec. Order 26:4.b.1

The August 2021, September 2021, and October 2021 ETAR revealed there were several dates that the nurse gave the NJ Exec. Order 26:4.b.1

NJ Exec. Order 26:4.b.1 was NJ Exec. Order 26:4.b.1 by the 11-7 nurse on 8/7/21, 8/28/21, 9/4/21, 9/12/21, 9/21/21, 10/9/21, 10/24/21, 10/26/21, 10/27/21, and 10/28/21 and was given when the NJ Exec. Order 26:4.b.1 by the 3-11 nurse on 8/6/21, 8/7/21, 8/11/21, 8/22/21, 9/9/21, 9/10/21, 9/20/21, 9/25/21, 10/4/21, 10/21/21, 10/28/21.

The surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) on 11/17/21 at 1:25 PM. The LPN/UM stated that it is a medication error to give medications outside of ordered parameters.

A review of the facility's policy Administering Medication with a revision date of April 2021 indicated under Policy Interpretation and Implementation #3, "Medications must be administered in accordance with the orders".

2. The surveyor reviewed the medical records for

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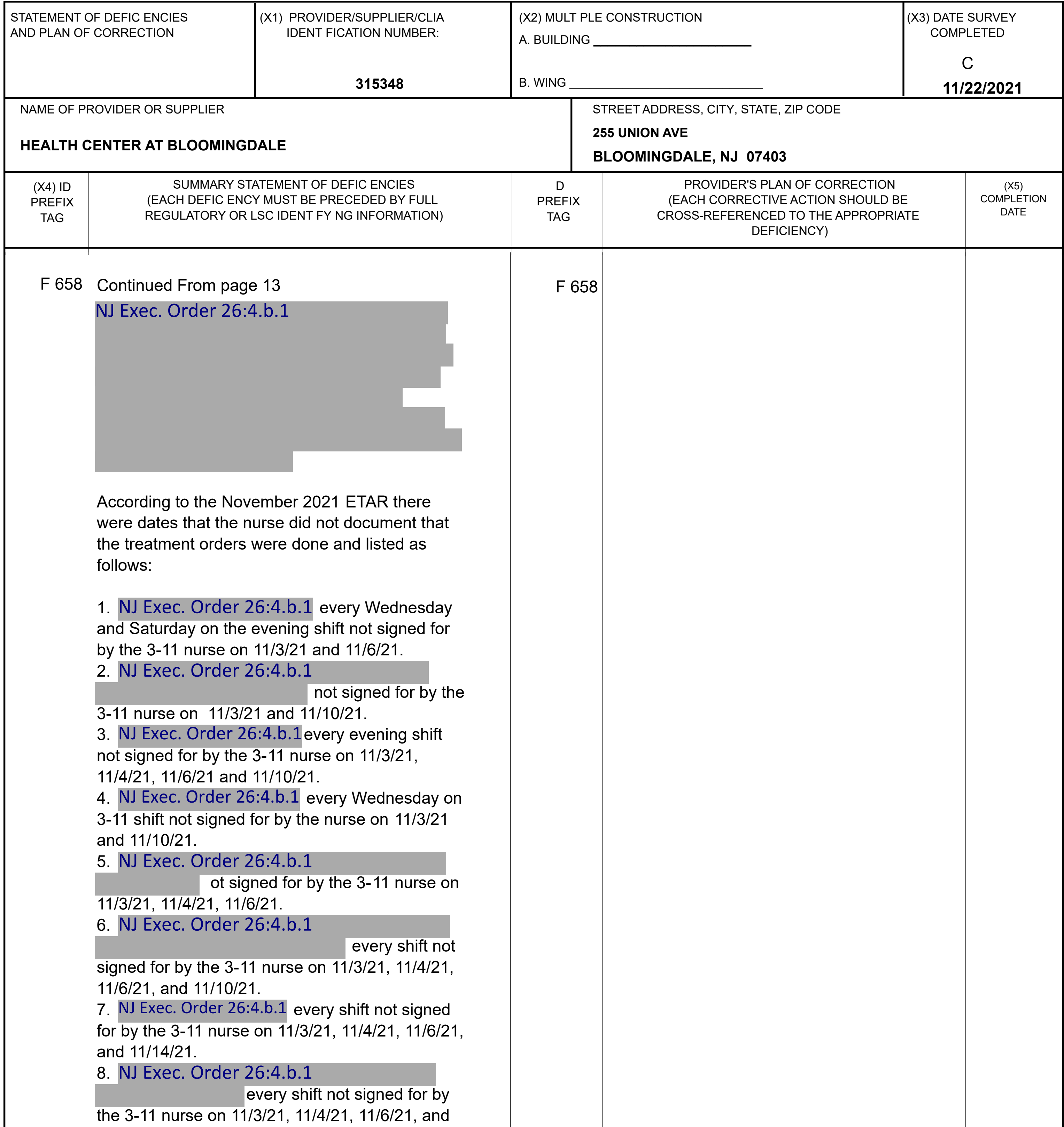
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 Resident #88 that revealed the following: According to the Clinical Physician Orders sheet, Resident #88 had physician orders for the NJ Exec. Order 26:4.b.1 The November 2021 Electronic Treatment Administration Record (ETAR) revealed the nurse did not document that the treatment was done, that NJ Exec. Order 26:4.b.1 were applied and did not document NJ Exec. Order 26:4.b.1 on the following dates: 1. NJ Exec. Order 26:4.b.1 twice a day was not signed by the 3-11 nurse on 11/5/21, 11/13/21, and 11/15/21. 2. NJ Exec. Order 26:4.b.1 wice a day was not signed by the 3-11 nurse on 11/5/21 and 11/15/21. 3. NJ Exec. Order 26:4.b.1 as not signed by the 3-11 nurse on 11/5/21, and not signed for by the 11-7 nurse on 11/4/21-11/6/21, and not signed for by the 7-3 nurse on 11/15/21. 4. NJ Exec. Order 26:4.b.1 every shift was not signed for by the 3-11 nurse on 11/4/21-11/6/21 and 11/15/21, and not signed for by the 11-7 nurse on 11/4/21-11/6/21 and on 11/15/21. 3. The surveyor reviewed the medical records for Resident #61 that revealed the following: According to the Clinical Physician Orders sheet, Resident #61 had physician orders for NJ Exec. Order 26:4.b.	F 658		



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F 658	Continued From page 13 NJ Exec. Order 26:4.b.1 According to the November 2021 ETAR there were dates that the nurse did not document that the treatment orders were done and listed as follows: 1. NJ Exec. Order 26:4.b.1 every Wednesday and Saturday on the evening shift not signed for by the 3-11 nurse on 11/3/21 and 11/6/21. 2. NJ Exec. Order 26:4.b.1 not signed for by the 3-11 nurse on 11/3/21 and 11/10/21. 3. NJ Exec. Order 26:4.b.1 every evening shift not signed for by the 3-11 nurse on 11/3/21, 11/4/21, 11/6/21 and 11/10/21. 4. NJ Exec. Order 26:4.b.1 every Wednesday on 3-11 shift not signed for by the nurse on 11/3/21 and 11/10/21. 5. NJ Exec. Order 26:4.b.1 ot signed for by the 3-11 nurse on 11/3/21, 11/4/21, 11/6/21. 6. NJ Exec. Order 26:4.b.1 every shift not signed for by the 3-11 nurse on 11/3/21, 11/4/21, 11/6/21, and 11/10/21. 7. NJ Exec. Order 26:4.b.1 every shift not signed for by the 3-11 nurse on 11/3/21, 11/4/21, 11/6/21, and 11/14/21. 8. NJ Exec. Order 26:4.b.1 every shift not signed for by the 3-11 nurse on 11/3/21, 11/4/21, 11/6/21, and	F 658		

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F 658	Continued From page 14 11/14/21. 9. NJ Exec. Order 26:4.b.1 not signed for by the 3-11 nurse on 11/1/21, 11/3/21, 11/4/21, 11/6/21, and 11/14/21. On 11/16/21 at 1:12 PM, the surveyors discussed the above concerns with the Administrator and DON. A review of the facility's policy Administering Medication with a revision date of April 2021 indicated under Policy Interpretation and Implementation #12, "Topical medications used in treatments must be recorded on the resident's treatment record (TAR)." NJAC 8:39-27.1(a)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure a resident received the necessary supervision for NJ Exec. Order 26:4.b and storage of NJ Exec. Order 26:4.b materials. The deficient practice was identified for 1 resident (Resident #42) of 2 reviewed for NJ Exec. Order 26:4.b and is evidenced by the following:	F 689	Resident #42 NJ Exec. Order 26:4.b assessment dated November 10, 2021. Resident was independent. All resident NJ Exec. Order 26:4.b. have the potential to be affected. An audit of resident NJ Exec. Order 26:4.b	1/14/22

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F 689	Continued From page 15 The surveyor interviewed Resident #42 on 11/10/21 at 10:27 AM. The resident stated they independently NJ Exec. Order 26:4. and held their own NJ Exec. Order 26:4.b.1. The resident further stated they were able to go outside at any time unsupervised to NJ Exec. Order 26: The resident stated their NJ Exec. Order 26:4.b materials were kept in their pocket when not in use. The surveyor observed the resident NJ Exec. Order 26:4.b unsupervised on 11/10/21 at 11:04 AM and on 11/15/21 at 11:07 AM. A review of the medical record revealed the following information: The 9/25/21 quarterly Minimum Data Set (MDS) assessment tool indicated the resident had no cognitive deficits as evidenced by a Brief Interview for Mental Status score of 15 of a possible 15. The resident's needs with Activities of Daily Living (ADLs) varied from supervision to limited assistance of one caregiver. The resident had NJ Exec. Order 26:4.b.1 The Registered Nurse Unit Manager (RNUM) provided the surveyor with the two most recent quarterly NJ Exec. Order 26:4.b. Assessments completed on 6/22/21 and 9/25/21. The assessments indicated the resident required supervision when NJ Exec. Order 26:4.b. and required the facility to store the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26 The resident's care plan addressing NJ Exec. Order 26:4.b, initiated 6/25/21, indicated the resident was an independent NJ Exec. Order 26: and NJ Exec. Order 26:4.b materials were to be kept in the medication cart.	F 689	assessments were done immediately by Director of Social Services. Education to social work/nursing staff on completion and accuracy of NJ Exec. Order 26:4.b assessments was conducted by the Staff Educator. All staff will be educated on the Facility NJ Exec. Order 26:4.b. Policy by the Staff Educator. The Resident NJ Exec. Order 26:4.b.1 Policy and Agreement was revised. The Residents were re-educated by the Director of Social Services on the revised NJ Exec. Order 26:4.b. Agreement and signed a new agreement. Weekly Random audits of NJ Exec. Order 26:4.b assessments and storage of NJ Exec. Order 26:4.b materials will be completed Administrator/Designee to assure accuracy. The results will be reported to the QA committee monthly for 2 months by Administrator/Designee. The QA committee will then recommend follow up based upon the results.	

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F 689	Continued From page 16	F 689		

The facility's Resident NJ Exec. Order 26:4.b. Policy, revised 2018, indicated an independent NJ Exec. Order 26:4 may NJ Exec. Order 26: safely without supervision, however, NJ Exec. Order 26: equipment such as safety NJ Exec. Order 26: and NJ Exec. Order 26:4.b must be kept at the front desk of the facility.

The surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #42 on 11/15/21 at 9:48 AM. He stated Resident #42 was assessed to be independent with NJ Exec. Order 26:4.b and was able to hold NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26: or NJ Exec. Order 26:4.b in their room.

The surveyor interviewed the RNUM on 11/15/21 at 9:59 AM. She stated presently all NJ Exec. Order 26:4.b on the unit were independent and holding their own NJ Exec. Order 26:4.b materials.

The surveyor interviewed the Receptionist on 11/15/21 at 12:04 PM. The Receptionist stated she gives NJ Exec. Order 26:4.b. a walkie talkie and a NJ Exec. Order 2 before they leave through the front entrance. She signs them out in a book kept behind the desk.

The surveyor discussed the concerns regarding storage of NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4 supplies with the Administrator, Director of Nursing, and the Infection Preventionist on 11/16/21 at 1:15 PM.

The surveyor discussed the concerns regarding storage of NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4 supplies with the Administrator, Director of Nursing, and the Infection Preventionist on 11/16/21 at 1:15 PM.
The Administrator provided the surveyor with further information on 11/17/21 at 9:03 AM as follows: A revised Resident NJ Exec. Order 26:4.b.1 Policy dated 11/16/21 requiring independent NJ Exec. Order 26:4.b to keep all NJ Exec. Order 26:4.b materials in a locked drawer in the

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F 689	Continued From page 17 residents room. NJAC 8:39-27.1(a)	F 689		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756		1/14/22

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F 756	Continued From page 18 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to respond to the consultant pharmacist recommendations for 1 of 21 residents (Resident #70) reviewed. This deficient practice continued over four months and was evidenced by the following: According to the November 2021 Clinical Physicians Order sheet Resident #70 had an order dated 2/25/2020 for NJ Exec. Order 26:4.b.1 The surveyor reviewed the August 2021, September 2021, and October 2021 Electronic Medication Administration Record that revealed the nurses administered the NJ Exec. Order 26:4.b.1 The surveyor reviewed the Consultant Pharmacist Medication Regimen Review report for June 2021, July 2021, August 2021, and September 2021. The Consultant Pharmacist had submitted to the facility the report that identified for Resident #70 the medication NJ Exec. Order 26:4.b.1 had not been held as per hold parameters in June, July, August, and September. On 11/17/21 at 1:25 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager	F 756	Resident #70 had no ill effects. The physician was notified of the medications given outside for the parameters. All residents have the potential to be affected. All residents with pharmacy recommendations will be reviewed by the Director of Nursing/Designee to ensure recommendations were addressed. All Nurses were educated by ADON/Designee on responding to Consultant Pharmacy Recommendations by the Consultant Pharmacist and/or designee. Nurses identified with the deficient practice were re-educated on our facility policy and were counseled. A monthly audit of consultant pharmacy recommendations will be conducted by the DON/Designee. The DON will present the findings to the QA committee monthly for 2 more months. The QAPI committee will then recommend follow up based upon the results.	

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F 756	Continued From page 19 (LPN/UM). The LPN/UM stated that she did not see the Consultant Pharmacist recommendations but that it is her and administration's responsibility to review them. On 11/17/21 at 1:41 PM, the surveyor discussed the above information with the Administrator and Director of Nursing. On 11/18/21 at 10:56 AM, the surveyor interviewed the Consultant Pharmacist. The Consultant Pharmacist stated that he believes that there is an issue with education for the nurses on the floor. On 11/18/21 at 11:03 AM, the surveyor discussed the above information with the Administrator and Director of Nursing (DON). N.J.A.C. 8:39-29.3(a)	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/14/22

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F 761	Continued From page 20 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 1 of 5 medication carts and 1 of 2 emergency boxes that were inspected. The expired medication in the emergency boxes continued for four months and was evidenced by the following: On 11/12/21 at 11:11 AM, the surveyor inspected the 2nd floor South-side medication cart in the presence of a Licensed Practical Nurse (LPN #1). The surveyor observed an opened bottle of Blood Glucose control solution with an opened date of 8/1/21 that was expired (90-day expiration date). The surveyor interviewed LPN #1 who stated that the opened bottle of Blood Glucose control solution was expired and should have been removed from the medication cart. On 11/12/21 at 11:30 AM, the surveyor inspected the 3rd floor emergency box in the presence of the Unit Manager (UM). The surveyor observed on the emergency kit contents page had an expiration date of 8/31/21. A review of the contents inside the emergency kit revealed the following:	F 761	The identified expired glucose solution was removed and replaced immediately. The identified expired emergency kit was removed and replaced immediately. All medication carts and emergency kits were audited immediately by Director of Nursing to ensure medications and kits are not expired. The policy for Storage of Medication was reviewed and updated. All Nurses will be educated on the updated policy by the Staff Educator/Designee. All Medication Cart and All Emergency Kits will be audited monthly by the Pharmacy and Pharmacy Consultant. The results of these audits will be presented to the QA Pharmacy Committee on a monthly basis for 3 months. The QA committee will request action as appropriate.	

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F 761	Continued From page 21 1. Two (2) vials of Atropine 0.4mg/ml injection had an expiration date of 10/31/21 2. One (1) vial of Dexamethasone 10mg/ml injection had an expiration date of 10/31/21 3. Two (2) vials of Epinephrine 1:1000 injection had an expiration date of 9/30/21 4. Two (2) pens of EpiPen 0.3mg injection had an expiration date of 8/31/21 5. Two (2) vials of Heparin 5000 units/ml injection had an expiration date of 11/1/21 6. One (1) vial of Phenytoin 100mg/2ml injection have an expiration date of 9/30/21 At that time, the surveyor interviewed the UM who stated that the Emergency Kit was expired and should have been returned to the pharmacy. On 11/12/21 at 1:00 PM, the surveyor met with the Administrator and the Director of Nursing (DON) and no further information was provided by the facility. A review of the facility's policy for Storage of Medication which was undated and was provided by the DON indicated the following: "Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		1/14/22

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F 812	Continued From page 22 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to restrain employee hair in the kitchen. This deficient practice was evidenced by the following: On 11/10/21 at 9:37 AM, in the presence of the Director of Nutritional Services (DNS), the surveyor observed the following: In the food preparation area, the surveyor observed the DNS without a hair net over his hair. The surveyor also observed a Food Service Worker in the food preparation area with a hair net on her head yet, her bangs were not fully restrained inside the hair net. The DNS agreed that the hair nets should have been worn appropriately according to facility's policy.	F 812	All staff members identified with the deficient practice were immediately corrected . All staff members identified with the deficient practice were provided with re-education and corrective action by the Infection Control Practitioner (ICP) for failing to wear and/or wear the hair net properly. All residents might be affected by improper hair net use. The facility re-installed the hairnet box outside of the kitchen. The Policy and Procedure for Food Preparation and Service was reviewed by the QA team. All dietary staff were in-serviced by the facility educator on the proper way to wear a hair net and to put on the hair net prior to entering the kitchen.	

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HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 23 The surveyor reviewed the facility's policy titled, "Food Preparation and Service" dated April 2021. The policy indicated that food and nutrition services staff wear hair restraints so that hair does not contact the food. On 11/10/21 at 12:48 PM, the surveyor brought the above concerns to the attention of the Administrator and Director of Nursing. NJAC 8:39-17.2(g)	F 812	ICP and/or designee will conduct random audits each month in the Dietary Department for proper Hair Net Use. The results of these audits will be presented to the QA Committee on a monthly basis for 3 months. The QA committee will request action as appropriate.	
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	F 880		1/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING ______ B. WING ______	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE BLOOMINGDALE, NJ 07403**

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F 880	Continued From page 24 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 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING ______ B. WING ______	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE BLOOMINGDALE, NJ 07403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 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: a.) hand hygiene during food and dish handling and b.) failure to properly don (put on) surgical and respirator masks. The deficient practices were evidenced by the following: 1. On 11/10/21 at 9:37 AM, the surveyor observed the Director of Nutritional Services (DNS) in the food preparation area of the kitchen with his respirator mask covering his mouth and not covering his nose. The DNS stated that he had just arrived for work and should have worn his mask appropriately. 2. In the food preparation area, the surveyor observed Food Service Worker (FSW) #1 with gloved hands adjust her hair net on her head, remove her gloves and immediately don a new pair of gloves with no hand hygiene performed. 3. At 9:47 AM, in the dish washing area of the kitchen, the surveyor observed FSW # 2 on the clean side of the dish machine with a surgical mask covering his mouth and not covering his nose. The DNS instructed the FSW #2 to fix his mask. The surveyor observed the FSW #2, with gloved hands, adjust his mask and without any glove changing or hand hygiene, the FSW #2 proceeded to handle the clean dishes. The DNS instructed the FSW #2 to remove his gloves and to perform hand hygiene prior to donning a new pair of gloves.	F 880	All staff members identified with the deficient practice were immediately corrected. All staff members identified with the deficient practice were provided with re-education and corrective action by the Infection Control Practitioner (ICP) for failing to perform hand hygiene, touching the power switch with dirty gloves and not properly wearing the respirator masks. All residents might be affected by failing to perform hand hygiene and for failing to properly don surgical and respirator masks. The Policy and Procedure for Handwashing /Hand Hygiene and the policy for Personal Protective Equipment-Using Face Masks was reviewed by the QAPI team. All staff members were re-educated by the facility educator on hand hygiene during food and dish handling. All staff members were re-educated and a competency was conducted by the facility educator/designee on properly doning surgical and respirator masks. The IP Nurse and DON and Department Directors took training on Infection Prevention & Control Program Module 1 All staff were trained on the following 9 topics: A. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING ______ B. WING ______	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 880 Continued From page 26

4. In the dish washing area of the kitchen, the surveyor observed a FSW # handling soiled dishware with gloved hands. With his soiled gloved hands, the FSW # 3 touched the dish machine power switch to turn it off. The surveyor observed the FSW # 2, who was on the clean side of the dish machine with gloved hands, touch the same power switch to turn it back on and then the FSW # 2 proceeded to handle clean dishes.

5. At 11:00 AM, on the third floor in the dayroom, the surveyor observed an Activities Aid (AA) # 1 and an AA #2 both wearing respirator masks. The surveyor observed that both of the AA #1 and AA #2 respirator masks' elastic bands were cut and tied in knots, with the elastic bands secured behind the ears of AA #1 and AA #2.

6. The surveyor also observed an AA #3 wearing a surgical mask which was covering a respirator mask. The surveyor observed the respirator masks' elastic bands were tucked under the surgical mask and not secured on the AA #3's head and neck.

At 11:17 AM, the surveyor interviewed the Licensed Practical Nurse, Unit Manager (LPN, UM) who stated that the masks should be worn correctly as instructed during fit testing. The LPN, UM stated that she is responsible for surveillance of proper donning and doffing of personal protective equipment that is used by the staff on her floor.

At 11:30 AM the surveyor interviewed the Activities Director (AD) who stated that the masks should be worn properly as instructed during fit testing. The AD stated that elastic band straps of

F 880

out COVID-19 Out!
B. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff Sparkling Surfaces
C. Environmental Cleaning and Disinfection
D. CDC COVID-19 Prevention Messages for Front Line Long-Term Care: Use PPE Correctly for COVID
E. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff Clean Hands
F. Hand Hygiene
G. Infection Surveillance
H. Principles of Standard Precautions
I. Principles of Transmission-Based Precautions

A RCA was conducted. These staff members did not recognize the severity of not wearing a mask appropriately to prevent the spread of COVID-19 even for a short period.
These staff members did not recognize failure to perform hand hygiene and procedure of glove changes which may contribute to cross contamination

The IP Nurse/designee will audit 5 staff members on a weekly basis for 4 weeks; then monthly x 3 and quarterly x 2 until compliance attained and maintained. Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and action as appropriate. The QAPI committee meets quarterly. The

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING ______ B. WING ______	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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F 880	Continued From page 27 the respirator should be worn on the crown of the head and the neck. The surveyor reviewed the facility's policy titled, "Handwashing/Hand Hygiene" dated 3/31/21. The policy indicated that hand hygiene is to be performed before applying new gloves and hand hygiene is to be performed after removing gloves. The surveyor reviewed the facility's policy titled, "Personal Protective Equipment-Using Face Masks" dated 10/31/21. The policy indicated that face masks are to be placed over the nose and mouth and depending on the mask, secure elastic bands at middle of the head and neck. The surveyor reviewed the facility's policy titled, "Outbreak Plan" dated 10/11/21. The policy indicated that the outbreak recommendations are to implement universal transmission-based precautions and wear recommended personal protective equipment including NIOSH approved N95 or higher level respirator masks for the care of all residents. At 11/10/21, the surveyor discussed the above concerns with the Administrator and Director of Nursing. No additional information was provided On 11/16/21 at 12:38 PM, the surveyor interviewed the Infection Preventionist (IP) who stated that all the facility staff are fit tested for respirator use and since the facility is in outbreak mode, the respirators should be worn properly in the resident areas. The IP also stated that the kitchen staff are allowed to wear surgical masks and that the surgical masks should also be worn properly covering the nose and mouth. The IP also stated that the kitchen staff hands should be	F 880	Committee will determine the need for further audits and or action plans.	

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F 880	Continued From page 28 washed properly between doffing and donning a new pair of gloves. N.J.A.C. 8:39-19.4(a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061631	A. BUILDING: ______ B. WING ______	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE BLOOMINGDALE, NJ 07403**

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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 interview and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18	S 560	All residents are potentially affected by this practice. Rates increased Ads updated to reflect increases Offer agency staff bonuses Offer staff member bonuses Job Fair Utilize temporary nursing assistants The DON to have weekly meetings with Staffing Coordinator to determine upcoming schedules to anticipate needs.	1/14/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/08/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061631	A. BUILDING: ___ B. WING ___	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE BLOOMINGDALE, NJ 07403**

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S 560	Continued From page 1 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. (3) All computations shall be based on the	S 560	The DON/designee will report findings to the Administrator. The DON/designee will aggregate findings from these rounds monthly and review the findings with the Administrator. Quarterly on an ongoing basis the DON/designee will provide a report of his findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061631	A. BUILDING: ____ B. WING ____	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE BLOOMINGDALE, NJ 07403**

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S 560	Continued From page 2	S 560		

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 period beginning October 24, 2021 and ending November 6, 2021 revealed the following:

The facility was deficient in CNA staffing for residents on 9 of 14 day shifts and were deficient in total staff for residents on 2 of 14 overnight shifts as follows:

- 10/24/21 had 9 CNAs for 100 residents on the day shift, required 13 CNAs.
- 10/25/21 had 12 CNAs for 100 residents on the day shift, required 13 CNAs.
- 10/26/21 had 12 CNAs for 100 residents on the day shift, required 13 CNAs.
- 10/27/21 had 12 CNAs for 100 residents on the day shift, required 13 CNAs.
- 10/28/21 had 12 CNAs for 100 residents on the day shift, required 13 CNAs.
- 10/30/21 had 11 CNAs for 100 residents on the day shift, required 13 CNAs.
- 10/30/21 had 7 total staff for 100 residents on the overnight shift, required 8 total staff.
- 10/31/21 had 9 CNAs for 100 residents on the day shift, required 13 CNAs.
- 10/31/21 had 7 total staff for 100 residents on the overnight shift, required 8 total staff.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061631	A. BUILDING: ______ B. WING ______	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE BLOOMINGDALE, NJ 07403**

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S 560	Continued From page 3 - 11/02/21 had 11 CNAs for 100 residents on the day shift, required 13 CNAs. - 11/06/21 had 12 CNAs for 99 residents on the day shift, required 13 CNAs. On 11/17/21 at 12:00 PM, the surveyor discussed the staffing ratio concerns with the Administrator and Director of Nursing, who stated they were aware of the staffing ratio criteria and that they are attempting to hire new CNAs and offer incentives.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315348	A. Building B. Wing	3/10/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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 F0637 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 01/14/2022	ID Prefix F0656 Reg. # 483.21(b)(1) LSC	Correction Completed 01/14/2022	ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 01/14/2022
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 01/14/2022	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 01/14/2022	ID Prefix F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 01/14/2022
ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 01/14/2022	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/14/2022	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/14/2022
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

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	
11/22/2021	☐ 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
061631 Y1	A. Building B. Wing Y2	3/10/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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 01/14/2022	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	
11/22/2021	☐ 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
	315348	A. BUILDING 01 B. WING ___	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 11/22/2021 and Health Center at Bloomingdale 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. Health Center at Bloomingdale is a three (3), Type II Protected building that was built in January 1995. The facility is divided into 9 smoke zones.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation on 11/22/2021, it was	K 293	Two emergency exit lights were out. Both	12/22/21

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/08/2021

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
	315348	A. BUILDING 01 B. WING ___	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

(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 293	Continued From page 1 determined that the facility failed to ensure that two (2) exit signs were illuminated at all times to clearly identify the exit access path to reach an exit. This deficient practice was evidenced by the following: During the survey entrance at 9:21 AM, a request was made to the facility's Administrator and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms in the facility. Starting at 9:42 AM during a facility tour, in the presence of the facility's DOM, the surveyor observed the following: 1) At 10:14 AM, on the third (3) floor, the surveyor observed near Resident room #315, that the illuminated exit sign above the stairwell exit access door was not lit. 2) At 11:31 AM, inside the first floor stairwell near the boiler room, the illuminated exit sign above the exit discharge door was no lit. The surveyor informed the Administrator of the above finding during the Life Safety Code exit conference at 2:03 PM. NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3,	K 293	emergency exit lights had the light bulbs replaced immediately by the Director of Maintenance. All residents may be affected by the lack of emergency exit lights. All emergency exit lights were audited by The Director of Maintenance to ensure illumination. The Maintenance Department was educated to inspect all emergency exit lights during rounds. The Director of Maintenance/designee will audit all emergency exit lights signs weekly. Results of the weekly audits will be reported to the QA committee by the Director of Maintenance for 3 months QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING **01** B. WING ______	**11/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE** **BLOOMINGDALE, NJ 07403**

(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 293	Continued From page 2 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
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 interview conducted on 11/22/2021, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 6 of 10 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During a tour of the building starting at 9:42 AM, in the presence of the facility's Director of Maintenance (DOM), an inspection inside of ten (10) resident bathrooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single	K 521	The exhaust fan system had a belt replaced by the Director of Maintenance and is now back in operational order. All residents may be affected by the lack of facility ventilation. All rooftop exhaust fans were inspected by The Director of Maintenance and found to be in operational order. The Maintenance employees were educated to inspect the rooftop exhaust fans weekly. The Director of Maintenance/designee will conduct inspection of rooftop exhaust fans weekly. Results of the weekly audits	12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING **01** B. WING ______	**11/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE** **BLOOMINGDALE, NJ 07403**

(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 521	Continued From page 3 ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 6 of 10 resident bathrooms in the following locations: 1. At 9:54 AM, inside Resident room #303 bathroom, the exhaust system did not function properly when tested. 2. At 9:56 AM, inside the Activity/ Sensory room (#304) bathroom, the exhaust system did not function properly when tested. 3. At 10:08 AM, inside Resident room #314 bathroom, the exhaust system did not function properly when tested. 4. At 10:17 AM, inside Resident room #323 bathroom, the exhaust system did not function properly when tested. 5. At 10:26 AM, inside the 2nd. floor Resident/ Visitor unisex bathroom, the exhaust system did not function properly when tested. 6. At 10:54 AM, inside Resident room #213 bathroom, the exhaust system did not function properly when tested. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The surveyor informed the Administrator of the above finding during the Life Safety Code exit conference at 2:03 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	will be reported to the QA committee by the Director of Maintenance for 3 months QA committee for action as appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING 01 B. WING ___	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

(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 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 11/22/2021, it was determined that the facility failed to ensure that 2 of 10 electrical outlets located next to a water source were equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: During the building tour in the presence of the facility Director of Maintenance (DOM), the surveyor conducted an inspection inside eight (8) resident bathrooms, four (4) Resident shower rooms and common areas on three (3) floors. Along the tour, when the surveyor used a GFCI tester to de-energize the GFCI outlets, two (2) GFCI electrical outlets had not de-energize, as required by code in the following locations: 1) At 10:26 AM, inside the 2nd. floor Visitor's Unisex bathroom one GFCI electrical outlet twelve (12) inches to the left of the sink when tested did not de-energize.	K 912	GFCI outlets in two bathrooms, were replaced immediately by the Director of Maintenance. All residents may be affected by an outlet that does not de-energize. All bathrooms and shower rooms GFCI will be audited by the Maintenance Department to ensure that the outlets de-energize when tested. The Maintenance employees were educated to test the outlets during their audits. During monthly visual inspection the Director of Maintenance/designee will conduct audit of GFCI□s in resident bathrooms and shower rooms with a GFCI ground tester, results of audit will be reported to the QA Committee for two months and follow up action as needed.	12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING **01** B. WING ______	**11/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE** **BLOOMINGDALE, NJ 07403**

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K 912	Continued From page 5 At this time the DOM told the surveyor that the GFCI electrical outlet was just put in. 2) At 11:02 AM, inside the 2nd. floor Resident shower bathroom one GFCI electrical outlet twenty three (23) inches to the left of the sink when tested did not de-energize. The surveyor informed the Administrator of the above finding during the Life Safety Code exit conference at 2:03 PM. NJAC 8:39 -31.2 (e) NFPA 99	K 912		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315348	A. Building 01 - MAIN BUILDING 01 B. Wing	3/10/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 12/22/2021	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 12/22/2021	ID Prefix Reg. # NFPA 101 LSC K0912	Correction Completed 12/22/2021
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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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	
11/22/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO