TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>		· · · ·	(X3) DATE SURVEY COMPLETED	
		315104	B. WING			09/21/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 234 CHESTNUT STREET UNION, NJ 07083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
E 000	Initial Comments		EO	00		
K 000	Appendix Z-Emerger Provider and Supplie Guidance 483.73, Re Care (LTC) Facilities.	equirements for Long Term	κo			
K 000	LIFE SAFETY CODE		K U			
K 923	COMPLIANCE WITH SAFETY CODE REC SURVEYED UNDER Gas Equipment - Cyl		К 9	23		10/30/20
SS=D	Gas Equipment - Cyl Greater than or equa Storage locations are ventilated in accordar 5.1.3.3.3. >300 but <3,000 cubi Storage locations are within an enclosed in limited- combustible of gates outdoors) that gases are not stored separated from comb sprinklered) or enclos noncombustible cons 1/2 hr. fire protection Less than or equal to In a single smoke con cylinders available for care areas with an ag	e designed, constructed, and nce with 5.1.3.3.2 and ic feet e outdoors in an enclosure or terior space of non- or construction, with door (or can be secured. Oxidizing with flammables, and are pustibles by 20 feet (5 feet if sed in a cabinet of struction having a minimum rating.				
ORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE
	ically Signed	= = = = = = = = = = = = = = = = =				10/02/202

## Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

## PRINTED: 11/19/2020 FORM APPROVED OMB NO. 0938-0391

DEPART CENTER		PRINTED: 11/19/2020 FORM APPROVED OMB NO. 0938-0391				
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         ND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         315104		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE A. BUILDING <b>0</b>	(X3) DATE SURVEY COMPLETED 09/21/2020		
		B. WING				
NAME OF P	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNELL HALL CARE & REHABILITATION CENTER			234 CHESTNUT STREET UNION, NJ 07083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ON SHOULD BE COMPLETIC TE APPROPRIATE DATE	
K 923	stored in an enclosure handled with precauti A precautionary sign each door or gate of a where the sign includ minimum "CAUTION: STORED WITHIN NC Storage is planned so of which they are reco Empty cylinders are s cylinders. When facil integral pressure gau considered empty is a cylinders are marked Cylinders are marked Cyl	e. Cylinders must be ions as specified in 11.6.2. readable from 5 feet is on a cylinder storage room, es the wording as a OXIDIZING GAS(ES) O SMOKING." o cylinders are used in order eived from the supplier. segregated from full lity employs cylinders with ge, a threshold pressure established. Empty to avoid confusion. e open are protected from , 11.3.4, 11.6.5 (NFPA 99) is not met as evidenced	К 923	<ol> <li>All e-tanks that exceeded the maximum allowed for storage were removed immediately on 09/17/20. A Carboard boxes were moved and stor over 5 feet away from e-tanks with sig posted on 09/17/20.</li> <li>All residents have the potential to b affected by the same alleged deficien practice.</li> <li>Maintenance Director/designee will daily rounds of the storage area as of 09/21/20 and record finds. Maintenar Director/designee rein-service staff or unit about proper storage requiremen for e-tanks and storage of combustibli items stored 5 feet with automatic sprinkler system.</li> </ol>	red jn e t do nce n ts	

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of oxygen stored in this room was 600 cubic feet

Facility ID: NJ62004

If continuation sheet Page 2 of 3

		MEDICAID SERVICES			OMB NO. 0938-03
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 315104		(X2) MULTIPLE A. BUILDING <b>0</b> 1	(X3) DATE SURVEY COMPLETED		
		B. WING	09/21/2020		
NAME OF PROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ORNELL	HALL CARE & REHAE	BILITATION CENTER		34 CHESTNUT STREET NION, NJ 07083	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIC
K 923	Continued From page	-	K 923		
	in volume, exceeding the maximum allowed by 300 cubic feet in volume (12 e-tanks). This finding was verbally acknowledged by the RPM in an interview during the surveyor's observation. The facility's Administrator was informed of this finding during the Life Safety Code exit conference at 1:30 PM.			4. Maintenance Director or desi conduct daily audits of the storage with e-tanks and combustible ite times daily for 6 weeks and on g Results of the audits will be subplaced.	ge unit ms 3 joing.
				the Administrator for review and QAPI committee meetings for recommendations/review.	
	NJAC 8:39-31.2(e)				

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