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

PRINTED: 08/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
					С			
	315427		B. WING _	B. WING		04/27/2021		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRES	S, CITY, STATE, ZIP CODE			
UNITED N	IETHODIST COMMUNIT	IES AT PITMAN		535 N OAK AVE				
				PITMAN, NJ 0	8071			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTIO			ON	
F 000	INITIAL COMMENT	S	F 0	00				
	COMPLIANT#: NJ	143549, NJ144750						
	Census: 65							
	Sample: 8							
F 908 SS=D	F 908 Essential Equipment, Safe Operating SS=D CFR(s): 483.90(d)(2)		F 9	08		5/25/21		
	and patient care equicondition. This REQUIREMEN by:	ain all mechanical, electrical, ipment in safe operating  T is not met as evidenced						
	COMPLIANT: NJ 1	43549		F 908 SS		thie		
	facility provided doc was determined that its hot water Basebo and optimal working (Room	deficient practice was		cited pract unit stem room on May 18 rooms ider survey visi adverse at practice. F change in	was no resident affected by tice. The baseboard heating apperature control knobs for and will be replaced and will be replaced. At 21. Residents residing in the state of the	ed ne		
	Environmental Servi inspected rooms a	second and floor on sence of the Director of ces (DES), the surveyor and identified the Baseboard not functioning as follows:		healthcare to affected heat is on.	sidents residing in the e community have the potent I by this cited practice when facility'□s current HVAC			
	#202 Baseboard He the high, medium, a	surveyor observed Room ating Unit (BHU) was missing nd low fan speed control ad a toggle switch installed in		company of assess the identified i	came to facility on May 4, 21 e temperature control proble n this cited practice and a pl devised to replace the	m		
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE		TITLE	(X6) DATE		

Electronically Signed 05/14/2021

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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			7 50.25.			(	2
		315427	B. WING			04/27/2021	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNITED METHODIST COMMUNITIES AT PITMAN					35 N OAK AVE		
				P	ITMAN, NJ 08071		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)				(X5) COMPLETION DATE
F 908	Continued From page 1 place of a temperature control knob. There was		F 9	908	temperature controls in all the other		
	this BHU had no mea	sting control turn knob, and ans to control the fan speed.			rooms within the next 90 days (8/30/21 The building service director and the N will be responsible for ensuring	•	
	During Room tour, the DES stated that the high, medium, and low buttons control the fan speed. The DES also stated that the toggle switch was installed to replace a temperature adjusting knob. The DES explained when the				compliance and will monitor. Upon installation of the temperature controls, The building service director will provid		
					in-service education to the maintenanc staff on the proper function and		
	toggle switch is in the on position, it is full heat,				maintenance of the controls to ensure		
	and when the switch is turned off, there is no		safe and optimal operation. Nursing wil				
	heat.				continue to observe residents in the citorooms for comfort until new temperatur		
, the BHU was miss		surveyor observed Room nissing the high, medium,			controls are installed in their rooms in t event heat has to be turned back on.		
		ontrol buttons. This unit had sting control turn knob. This			4. All rooms will be monitored weekly	bv	
		to control the heat or fan			the building service director until completion of the work order for replacement of temperature controls. A		
	3. At 12:58 p.m., the surveyor observed Room the BHU was missing the high, medium,				problems identified related to resident comfort will be immediately addressed	u.y	
	and low fan speed control buttons. This unit had no temperature adjusting control turn knob. The				and work order prioritized until all has been resolved. Completion dates for		
	unit had a toggle switch to provide either heat or no heat. This BHU had no means to control the				repairs will be tracked by the building service director and reviewed weekly b	-	
	fan speed.				the Administrator for the next 2 months ensure that all work orders related to ci	ted	
	There were no means to control the temperatures and the amount of air movement in the rooms.  The facility failed to maintain its heating				practice are completed timely. Findings and progress of work order will be		
	equipment in proper				reviewed by the NHA in the monthly QA and safety committee meetings until completion of the job on 8/30/21. Once job completed, the building service		
	N.J.A.C. 8:39 -31.2 (e).				director will complete a random audit of the function of the heat temperature controls monthly from October 1, 2021 April 30,2022 to ensure they are proper and safely operating during heat	to	

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		315427	B. WING			C <b>04/27/2021</b>		
NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODI			2112021	
				535 N OAK AVE	022			
UNITED N	ETHODIST COMMUNIT	IES AT PITMAN		PITMAN, NJ 08071				
(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 ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 908	Continued From pag	e 2	FS	controlled months. Findings be reviewed in the monthly corrective action as warran Date of completion May 25	QAPI with ted.	ill		