		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 12/06/2021 APPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
		315331	B. WING		06/17/2019		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	E CARE AT FAIR LAWN	EDGE		77 EAST 43RD STREET			
		LUGL		PATERSON, NJ 07514			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000	0			
	E000 Emergency	Preparedness					
	Appendix Z-Emergen Provider and Supplie	quirements for Long Term					
K 000	INITIAL COMMENTS		K 000	ס			
	KOOO LIFE SAFET	TY CODE 101:2012					
		ubstantial compliance with ety Code requirements as -2786R.					
K 923 SS=D	Gas Equipment - Cyli CFR(s): NFPA 101	nder and Container Storag	K 923	3		7/19/19	
	Greater than or equa Storage locations are ventilated in accordan 5.1.3.3.3. >300 but <3,000 cubi Storage locations are	designed, constructed, and nce with 5.1.3.3.2 and					
	gates outdoors) that o gases are not stored separated from comb sprinklered) or enclose	truction having a minimum					
	Less than or equal to In a single smoke cor cylinders available fo care areas with an ag	300 cubic feet					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE	

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.

07/03/2019

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315331			(X2) MULTIPI	LE CONSTRUCTION		<u>O. 0938-039</u> E SURVEY		
			A. BUILDING 01			COMPLETED		
		315331	B. WING		06	06/17/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
001101 53			77 EAST 43RD STREET					
COMPLET	E CARE AT FAIR LAW	NEDGE	PATERSON, NJ 07514					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION					
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE		
K 923	Continued From pag	ne 1	K 92	3				
			K 92					
		re. Cylinders must be tions as specified in 11.6.2.						
		readable from 5 feet is on						
		a cylinder storage room,						
		des the wording as a						
	minimum "CAUTION	: OXIDIZING GAS(ES)						
	STORED WITHIN N							
		so cylinders are used in order						
	-	ceived from the supplier.						
		segregated from full						
		ility employs cylinders with uge, a threshold pressure						
		established. Empty cylinders						
		confusion. Cylinders stored						
	in the open are prote	•						
	11.3.1, 11.3.2, 11.3.3	3, 11.3.4, 11.6.5 (NFPA 99)						
	This REQUIREMEN	T is not met as evidenced						
	by:							
		on and interview on 06/11/19,		I.CORRECTIVE ACTIONS FC	R THOSE			
		at the facility failed to comply		AFFECTED:				
	NFPA 99 as evidenc	storage requirements of		Ovugan tanka avagading 200 c	ubic fact in			
	INFER 33 as evidenc	ed by the following.		Oxygen tanks exceeding 300 c volume have been removed im				
	Oxvgen tanks excee	ding 300 cubic feet in volume		Nursing and maintenance staff	•			
	(12 e-tanks) were st	•		inserviced on not storing more				
		At 12:00 PM, the surveyor		e-tanks in the clean utility room				
		sence of the facility's						
		or, 24 oxygen cylinders		II.ID OTHERS WITH THE POT	ENTIAL			
		in 4-feet of combustible		TO BE AFFECTED:				
		y room located on the 2nd						
		le items were assorted		The whole facility has the pote	ntial to be			
		s in multiple cardboard boxes hard plastic storage unit. The		affected.				
		en stored in this room was		III.SYSTEMIC CHANGES:				
	600 cubic feet in vol							
		y 300 cubic feet in volume		Moving forward the maximum	number of			
	(12 e-tanks).	,		tanks that will be stored in the				
				will not exceed 12 e-tanks to m	-			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ61630

If continuation sheet Page 2 of 3

PRINTED: 12/06/2021

		ID HUMAN SERVICES				FORM	APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ICARE & MEDICAID SERVICES s (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		315331	B. WING _	B. WING		06/17/2019		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 77 EAST 43RD STREET				
COMPLET	TE CARE AT FAIR LAWN	EDGE		PATERSON, NJ 07514				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG				(X5) COMPLETION DATE	
K 923	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		K	TAG CROSS-REFERENCED TO THE APPROPR		on S		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ61630

If continuation sheet Page 3 of 3

PRINTED: 12/06/2021