STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01A002	A. BUILDING: _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERS PLACE	199 STEELMANVILLE ROAD EGG HARBOR TOWNSHIP, NJ 08234

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard CENSUS: 36 SAMPLE SIZE: 5 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 901	8:36-10.5(c)(4) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes, shall be kept on file in the facility for at least 30 days;	A 901		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 901	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide the lunch meal in accordance with the preplanned menu for 1 of 2 days of the survey. The written menus did not identify specific portion sizes nor was the menu posted in the kitchen preparation/serving area. The facility failed to retain a record of menu changes and substitutions as required by regulation and facility policy. This deficient practice was evidenced by the following: On 6/28/21 at 10:20 a.m., the surveyor interviewed the Executive Director (ED) and requested the facility's planned menus. The ED stated that the facility followed a five-week cycle menu. The ED provided the following menus: 1. "Weekly Menu June 28 -July 4" with "5" hand written in the upper right corner 2. "Weekly Menu July 5-July 11 hand written "we are currently on week 5" This menu had "wk 1" hand written in the upper right corner 3. "Weekly Menu July12 - July 18" hand written in the upper right corner "[Wk] 2" 4. "Weekly Menu July 19 - July 25" hand written in the upper right corner"[Wk] 3" 5. "Weekly Menu July 26 - August 1" hand written in the upper right corner[Wk] 4" Review of the weekly menus provided by the ED, revealed that the menus did not identify specific portion sizes of each food item for each meal.	A 901		

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A 901	Continued From page 2 On 6/28/21, during the lunch meal preparation at the facility's kitchen, the surveyor observed the following dietary concerns: At 11:30 a.m. on 6/28/21, the surveyor observed Week #5 menu "Weekly Menu August 2 - August 8" posted on the board in the dining room which included Herbed Pork Chop, Quaker Barley Risotto, and Roasted Carrots for lunch. At 11:45 a.m., in the facility kitchen, the surveyor observed the cook by the steam table who prepared a plate of Chicken Dumpling using a shallow ladle and broccoli, using a tong. The surveyor observed that there was no menu posted in the serving area as the cook plated the food. The surveyor interviewed the cook and asked him what the specified portion size was for the Chicken Dumpling and broccoli to be served. He stated that he used the two -ladle full for the Chicken Dumpling and one to two scoops of broccoli using the tong. The cook stated that it depends on the resident; some were given one scoop, some two. The surveyor asked to see if there was a measuring size indicated on the ladle. The ladle was inspected by the cook in the presence of the surveyor and found no measurement/size identified on the ladle. The surveyor continued the interview and asked if the cook was aware of the requirement to post a menu with portion sizes specified for each food item. He stated that he was not aware of this requirement. At 11:55 a.m., the surveyor observed the ED serve fish and broccoli on a plate. The surveyor interviewed the ED and asked why fish was served that day. The ED stated that they	A 901		

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A 901	Continued From page 3 substituted and changed the menu: instead of the Pork Chop, they cooked the fish due to some ingredients that were not available at that time. The surveyor also observed that the food groups served during the lunch meal that day 6/28/21 did not include a starch or carbohydrate group and with only two food groups (protein and vegetables) with the fish and broccoli plated. Review of facility "Standardized Menus and Meal Planning" policy dated 07/01/2014, page 1 of 1, revealed the following statements: "...vii Permanent changes to the menu should follow the pattern of the meal identifying appropriate choices for the item(s) changed (i.e. entree for an entree, vegetable for a vegetable, etc.) Changes that will be made to the menu should be documented ... and on the menu substitution list." At 12:10 p.m., the surveyor asked the ED if menu changes were documented and kept on file for 30 days. The ED responded and said, "No." The ED was unable to provide documentation of menu changes during the survey on 6/28/21 and 6/29/21. Review of facility "Standardized Menus and Meal Planning" policy dated 07/01/2014, page 1 of 1, revealed the following statements: "VI. Records of substitutions and meals as served will be maintained as required by state regulations." N.J.A.C 8:36-10.5(c)4 requires "Menus with changes or substitutes shall be kept on file in the facility for at least 30 days."	A 901		
A 925	8:36-11.2 Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance	A 925		

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A 925	Continued From page 4 with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility nursing staff failed to ensure the medication found in the medication (med) cart contained the correct medication in accordance with the prescriber's orders and that the label on the vial contained the correct resident's full name, prescription number, date of issue and directions for use for 1 out of 5 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 6/28/21 at 10:15 a.m., the surveyor inspected medication cart #1 in the presence of the Registered Nurse (RN). In the locked narcotic box, the surveyor observed a prescription bottle of Executive Order 26, 4.b. (Executive Order 26, 4.b.) Executive Order 26, 4.b. and observed that the label had been altered. The Resident had a prescriber's order for Executive Order 26, 4.b. Executive Order 26, 4.b.) Executive Order 26, 4.b. Executive Order 26, 4.b. . The medication in the erroneously labeled vial contained Executive Order 26, 4.b. and did not reflect the physician's order for Executive Order 26, 4.b. . Further observation of the prescription bottle revealed that the first name on the bottle was crossed off and Resident #2's first name was handwritten on the bottle. The surveyor also observed that the frequency of administration had been altered. The original label revealed Executive Order 26, 4.b.	A 925		

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A 925	Continued From page 5	A 925		

Executive Order 26, 4.b." and was altered to Executive Order 26, 4.b.

The surveyor interviewed the RN who reported that a family member had dropped off Resident #2's medication and that the label was altered when she received it. In the presence of the surveyor, the RN locked the bottle of Executive Order 26, 4.b. away from the active inventory section of the narcotic box.

The surveyor reviewed the medical record (MR) of Resident #2, who Executive Order 26, 4.b. with diagnoses which included Executive Order 26, 4.b. Executive Order 26, 4.b..

In addition, the surveyor observed in the MR a document dated Executive Order 26, titled, "PHYSICIAN PLAN OF CARE" which revealed, "Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. The vial however was labeled for another Executive Order 26, 4.b. Executive r, Executive Order 26, 4.b. a generic for Executive Order 26, 4.b..

On 6/28/21 at 12:30 p.m., the surveyor interviewed the RN who stated that Resident #2 never received the Executive Order 26, 4.b. The surveyor reviewed the Medication Administration Record (MAR) and confirmed that Resident #2 had not received Executive Order 26, 4.b.

On 6/29/21 at 1:50 p.m., the surveyor interviewed Resident #2 who Executive Order 26, 4.b. and stated that he/she had Executive Order 26, 4.b. and Executive Order 26, 4.b.

The surveyor reviewed the facility's policy titled, "MEDICATION PACKAGING" which revealed, "IV. Medications will be packaged, labeled, and

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A 925	Continued From page 6 stored in accordance with federal and state laws and assisted living regulations." The facility failed to ensure that Resident #2 had his/her own medication and that the medication provided was properly labeled and in accordance with the prescriber's order.	A 925		
A 939	8:36-11.5(b)(1)(i-ii) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 1. A unit-of-use/unit dose drug distribution system shall be developed and implemented whenever the administration of medication is delegated by the registered professional nurse to a certified medication aide; i. Over-the-counter (OTC) solid and liquid dosage forms may be dispensed in a non unit-of-use or non unit-dose medication distribution system. ii. Prescription liquid medications (that is, conventional bottles, concentrates) may be dispensed in a non unit-of-use, non unit-dose, or conventional medication distribution system. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	A 939		

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A 939	Continued From page 7 review it was determined that the Registered Nurse (RN) failed to ensure that every medication delegated for administration to the Certified Medication Aides (CMA's) was in a unit of use/unit dose distribution system for 1 of 5 residents reviewed, Resident #1. This deficient practice was evidenced by the following: On 6/28/21 at 10:15 a.m., the surveyor inspected medication cart #1 and observed that Resident #1 had a Executive Order 26, 4.b. was not packaged in a unit of use drug distribution form in order for the CMA to administer medications. Resident #1 had a prescriber's order dated Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. . The surveyor along with the RN reviewed Resident #1's Medication Administration Record (MAR) and confirmed that the CMA's administered Executive Order 26, 4.b. Executive Order 26, 4.b. . The RN stated that she was aware that CMA's were not allowed to administer prescription medications from a multiple dose bottle. On 6/28/21 at 11:00 a.m., the surveyor interviewed a CMA who stated that she was aware that she should not have administered prescribed medications from a bottle. The surveyor reviewed the facility's policy titled, Medication Administration-Delegation Medication administration / CMA policy" which revealed, "Medication Packaging...A unit-of-use/unit dose drug distribution system shall be developed and implemented whenever the administration of medication is delegated by the registered professional nurse to a certified medication aide;"	A 939		

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A 939	Continued From page 8 The facility and the RN failed to provide a unit of use/unit dose drug distribution system for medication administration by CMA's.	A 939		
A 975	8:36-11.7(a)(1) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart. 1. The storage area shall be kept locked when not in use. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure all medications that were not self-administered by residents were stored in a safe storage area and kept locked when not in use and unattended for 1 of 2 medication (med) carts. This evidence was based on the following: On 6/29/21 at 8:25 a.m., the surveyor observed that medication cart #2 which was stored near the dining room was left unlocked. Upon further inspection of the cart, the surveyor was able to open the drawers of the med cart without staff present.	A 975		

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	01A002	A. BUILDING: _____ B. WING _____	06/30/2021

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A 975	Continued From page 9 At this time the surveyor observed the Executive Director (ED) in the dining room serving breakfast. The ED was called over to the cart where she observed that the med cart had been left unlocked and unattended. The ED was able to open the top drawer. The ED further stated that the med cart should have been locked and that the Registered Nurse (RN) was responsible since she was administering medications. On 6/29/21 at 9:15 a.m., the surveyor interviewed the RN who stated that the med cart should have been locked and was unaware that the medication cart had been left unlocked and unattended. The surveyor reviewed the facility's policy titled, "STORAGE OF MEDICATIONS" which revealed, "1. All medications stored by the community must be...locked. The medication cart...kept locked when not in use."	A 975		
A1097	8:36-16.6 Physical Plant All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.	A1097		

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A1097	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/30/2021 in the presence of facility management, it was determined that the facility failed to provide proper fire sprinkler installation after repair work had been preformed. The evidence includes the following, During the survey entrance at 8:29 AM with the facility Administrator and Maintenance Manager (MM), a request was made to provide a copy of the facility layout which identified the various rooms in the facility. Starting at 9:06 AM with the facility MM, a tour of the building was performed. During this tour of the building, the surveyor observed fire sprinkler heads that had penetrations around the heads. These penetrations would allow fire, smoke and poisonous gasses to by-pass the frangible glass of the sprinkler head. This would not allow the fire sprinkler to function properly in the event of a fire in the following locations, 1) At 9:16 AM one sprinkler head with a white extension cap by the kitchen door was hanging down 1" leaving an approximately 1" opening around the sprinkler pipe through the wall board ceiling to the attic above. 2) At 9:55 AM, one sprinkler head in the corridor near Resident apartment [redacted] had a 3/8" penetration through the wall board ceiling to the attic above. 3) At 9:56 AM one sprinkler head in the corridor near the telephone equipment room had an approximately 1/4" penetration around the echelon cap leaving an opening through to the	A1097		

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A1097	Continued From page 11 attic above. 4) At 10:03 AM one sprinkler head near the electrical room next to Resident apartment [redacted] had a 3/4" penetration through the wall board ceiling to the attic above. 5) At 10:05 AM one sprinkler head near Resident apartment [redacted] white extension cap was hanging down 1", this left a 3/8" penetration through the wall board ceiling to the attic above. 6) At 10:17 AM inside a closet next to Resident apartment [redacted] had a sprinkler drain pipe that was missing the fire caulking around the pipe. This left a 3/8" penetration around the pipe to the attic above. 7) At 10:18 AM one sprinkler head in the corridor by Resident apartment [redacted] had a 3/8" gap around the echelon cap leaving an opening to the attic. 8) At 10:23 AM one sprinkler head in the corridor by Resident apartment [redacted] had a 1/4" gap in the wall board ceiling leaving an opening to the attic above. 9) At 10:30 AM one sprinkler head in the corridor next to Resident apartment [redacted] had a 1/4" gap in the wall board ceiling to the attic above. Along the tour, the MM told the surveyor that the facility had some sprinkler repair work done and that the vendor had to re-hang some of the pipes. During the survey exit, the Administrator was informed of the findings. NFPA -13	A1097		

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A1169	8:36-16.15(a) Physical Plant (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101. This REQUIREMENT is not met as evidenced by: Based on observation on 6/30/2021 in the presence of facility management, it was determined that the facility failed to install portable fire extinguishers within the required height in accordance with the requirements of National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. The evidence includes the following: Reference #1 NFPA 10 - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. During the building tour starting at 9:06 AM in the presence of the facility Maintenance Manager (MM), the surveyor observed 1 of 9 portable fire extinguishers that were installed at excessive height high in the following locations,	A1169		

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A1169	Continued From page 13 1) One ABC type fire extinguisher inside the Activities room appeared to be mounted to the wall too high. At this time the surveyor recorded measurements from the floor to the pressure indicating needle was 5'-8" The findings were verified by the MM at the times of the observation. The Administrator was notified of the findings at the life safety code exit conference on 6/30/2021. NFPA 10	A1169		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility failed to provide a safe and fire hazard free environment for the residents. This placed all residents at risk for harm. The evidence of this includes the following:	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01A002	A. BUILDING: _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERS PLACE	199 STEELMANVILLE ROAD EGG HARBOR TOWNSHIP, NJ 08234

(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) COMPLETE DATE
A1249	Continued From page 14 During the building tour on 6/30/2021 in the presence of the facility Maintenance Manager (MM) at 9:14 AM, an inspection of the facility Kitchen was performed. The surveyor observed the one hour fire rated door leading into the Main Electrical room (Adjacent to the kitchen) was ajar and not fully closed into its frame. At this time the surveyor performed a closure test of the door. When the surveyor opened the door to a 90 degree opening to the door frame and released the door, the door did not fully close and positive latch into its frame. This test was repeated two (2) additional times with the same results. The door would need to self-close and positive latch into its frame to maintain the Electrical room's one hour fire rated construction as required by code. Fire Hazard.	A1249		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
01A002 Y1	A. Building B. Wing Y2	7/29/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERS PLACE	199 STEELMANVILLE ROAD EGG HARBOR TOWNSHIP, NJ 08234

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 A0901	Correction	ID Prefix A0925	Correction	ID Prefix A0939	Correction
Reg. # 8:36-10.5(c)(4)	Completed	Reg. # 8:36-11.2	Completed	Reg. # 8:36-11.5(b)(1)(i-ii)	Completed
LSC	08/10/2021	LSC	08/10/2021	LSC	08/10/2021
ID Prefix A0975	Correction	ID Prefix A1097	Correction	ID Prefix A1169	Correction
Reg. # 8:36-11.7(a)(1)	Completed	Reg. # 8:36-16.6	Completed	Reg. # 8:36-16.15(a)	Completed
LSC	08/10/2021	LSC	08/10/2021	LSC	08/10/2021
ID Prefix A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/10/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/30/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Somers Place
Senior Living

A000

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

A 901

8:36-10.5(c)(4) Dining Services

All residents have the potential to be affected by deficient practice.

On 7/20/2021, the Regional Director of Care Services (RDCS) in-serviced the Executive Director (ED) on the requirements set within Regulation 8:36-10.5(c)4 Dining Services and Enlivant Policy, "Standardized Menus and Meal Planning" (Exhibit A1 - In service)

On 7/21/2021, the ED in-serviced the Chef and Cook on the requirements set within regulation 8:36-10.5(c) 4 Dining Services and Enlivant Policy, "Standardized Menus and Meal Planning". (Exhibit A2 - In-service)

On 7/19/2021, the ED audited the succeeding 5 weeks of menus validating the presence of food portion sizes and physical means to establish portion size at time of serving. Exhibit A3 - Audit Tool)

On7/19/2021, the ED posted the written menu, which included specific portion sizes in the kitchen preparation/serving area. The ED and/or designee will audit the written menu 3 times per week for 4 weeks, then 2 times per week x 4 weeks, then 1 time per Week x 4 weeks to ensure the menu is posted on the food preparation area, is conspicuously within the home, and that the menus corresponds with the days prepared and served foods, portion sizes are documented and followed, and menu substitutes are provided and documented per regulation and policy. (Exhibit A4 – Audit Tool)

Results of the audit will be discussed during Monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of Compliance.

A925

Pharmaceutical Services

Resident #2 did not suffer a negative effect related to this finding.

All residents have the potential to be affected by deficient practice.

On 06/28/2021 The Care Service Manager removed Resident #2's erroneously labeled medication from the medication cart and it was stored in a secure manner until retrieved by Resident #2 responsible party on 7/2/2021.

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609-926-5893 f

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Continued from page 1

On 7/9/2021, a physician's order to [redacted] Resident #2s Executive Order 26, 4.b. was received by the RN.

On 7/20/2021, the Regional Director of Care Services in-serviced the Care Services Manager (CSM) on the Pharmaceutical Services and facility policy "Medication Packaging".

On 7/20/2021, The Care Service Manager (CSM) in-serviced Certified medication Aides (CMA) on Pharmaceutical Services and facility Policy "Medication Packaging".

On 7/21/2021, The Care Service Manager (CSM) conducted a medication cart audit to validate that current resident medications are on-hand and comply in accordance with prescriber orders, and that the prescription labels contain the correct resident's full name, prescription number, date of issue, and directions for use.

The Care Service Manager and/or designee will audit the medication cart monthly x 3 months to ensure each residents prescribed medications are on-hand and prescription labels contain the correct resident's full name, prescription number, date of issue, and directions for use. Results of the audit will be discussed during monthly QI meetings.

Completion Date 8/10/2021

A939

Pharmaceutical Services

Resident #1 did not suffer a negative effect related to this finding.

All residents have the potential to be affected by deficient practice.

On 06/28/2021, resident #1's multidose bottle of Executive Order 26, 4.b. were secured by the Registered Nurse (RN) and an order for [redacted] by Resident #1's physician, medication was subsequently Executive Order 26, 4.b. by the Care Service Manager.

On 7/20/21, Regional Director of Care Services in-served the Care Service Manager and Executive Director on Pharmaceutical Services, as well as facility policy "Medication Administration-Delegation Medication Administration / CMA policy".

On 7/20/21, Care Service Manager in-serviced Certified Medication Aides on Pharmaceutical services, as well as facility policy "Medication Administration-Delegation Medication Administration / CMA policy"

On 7/21/2021, The Care Service Manager conducted a medication cart audit to validate that current resident medications are dispensed in unit-dose/use packaging. Medications identified in multidose bottles were ordered in unit-dose form by the Care Service Manager. Certified Medication Aides were subsequently instructed by the Care Service Manager to summon a licensed nurse to administer these medications pending the receipt of the unit-dose packaging without delay of administration. The Care Service Manager will audit residents prescribed medications monthly x 3 months, to ensure each resident prescribed medication is dispensed in unit dose packaging. Results of the audit will be discussed during monthly QI meetings.

Completion Date 8/10/2021

A 975

Pharmaceutical Services

On 6/29/2021 at 8:26 a.m. medication cart #2 was appropriately locked by the CMA.

All residents have the potential to be affected by deficient practice.

On 7/20/2021 the Regional Director of Care Services in-serviced the Care Service Manager on Pharmaceutical Services and facility policy "Storage of Medications".

On 7/20/2021, the Care Service Manager in-serviced nursing staff on Pharmaceutical Services and facility policy "Storage of Medications".

The Care Service Manager and/or designee will audit the medication cart weekly x 12 weeks to ensure that the cart is kept locked when not in use. Results of the audit will be discussed during monthly QI meetings.

Completion Date 8/10/2021

A 1097

Physical Plant

All residents have the potential to be affected by deficient practice.

On 7/20/2021, Regional Director of Facilities Management (RDFM) In-serviced the Maintenance Manager (MM) on the requirements set within regulation 8:36-16.6 Physical Plant. (Exhibit E1 – In service)

On 7/5/2021, the sprinkler head with a white extension cap by the kitchen door was repaired by the MM. (Exhibit E2 – Completed work order)

On 7/5/2021, the sprinkler head in the corridor near resident apartment #[redacted] was repaired by the MM. (Exhibit E3 – Completed work order)

On 7/5/2021, the sprinkler head in the corridor near the telephone equipment room was repaired by the MM. (Exhibit E4 – Completed work order)

On 7/5/2021, the sprinkler head near the electrical room next to resident apartment #[redacted] was repaired by the MM. (Exhibit E5 – Completed work order)

On 7/5/2021, the sprinkler head near resident apartment #[redacted] was repaired by the MM. (Exhibit E6 – Completed work order)

On 7/6/2021, the sprinkler drainpipe, inside a closet, next to Resident apartment #[redacted] was repaired by the MM. (Exhibit E7 – Completed work order)

On 7/6/2021, the sprinkler head in the corridor by Resident apartment #[redacted] was repaired by the MM. (Exhibit E8 – Completed work order)

On 7/6/2021, the sprinkler head in the corridor next to Resident apartment [redacted] was repaired by the MM. (Exhibit E9 – Completed work order)

On 7/19/2021, the MM audited the communities fire suppression system validating absence of penetrations around sprinkler heads and drainpipes. (Exhibit E10 – Audit tool)

Continued from page 3

The MM and/or designee will audit the community's fire suppression system sprinkler heads and drainpipes weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x1, to ensure absence of penetrations around sprinkler heads and drainpipes. (Exhibit E11 – Audit Tool) results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.

Completion Date 8/10/2021

A 1169

Physical Plant

All residents have the potential to be affected by deficient practice.

On 7/20/2021, the Regional Director of Facilities Management in-serviced the Maintenance Manager (MM) on the requirements set within regulation 8:36-16.15(a) Physical Plant. (Exhibit F1 – In-service)

On 7/2/2021, the MM remounted the fire extinguisher inside of the Activities room within the parameters set within regulation 8:36-16.15(a) Physical Plant, set by the National fire Protection Association (NFPA) 10, 2010 edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. (Exhibit F2 – completed work order)

On 7/21/21, the MM audited the facilities portable wall mounted fire extinguisher heights to validate that in no case is top of a fire extinguisher more than 5 feet above the floor and in no case is the clearance between the bottom of the hand portable fire extinguisher and the floor less than 4 inches. No additional mounted fire extinguishers identified outside of compliance. (Exhibit F3- Audit tool)

The MM and/or designee will audit the communities portable fire extinguishers weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x1, to ensure that in no case is top of a fire extinguisher more than 5 feet above the floor and in no case is the clearance between the bottom of the hand portable fire extinguisher and the floor less than 4 inches. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.

Completion Date 8/10/2021

A 1249

Housekeeping-Sanitation-Safety- Maintenance

All residents have the potential to be affected by deficient practice.

On 7/20/21, the Regional Director of Facilities Management in-serviced the Maintenance Manager (MM) on the requirements set within regulation 8:36-17.7 8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance. (Exhibit G1- In service)

On 7/6/2021, the MM repaired the fire door leading into the Main Electrical room Adjacent to the Kitchen) resulting in door properly self-closing a positively latching into its frame. (Exhibit G2 –work order)

On 7/21/21, the MM audited the facilities fire doors to validate proper function. No additional fire doors affected. (Exhibit G3 – Audit tool) The MM and/or designee will audit the communities fire doors weekly x 4 weeks, then Bi-weekly x 4 weeks, then monthly x1, to ensure their proper function. (Exhibit G4- Audit tool) results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.

Completion Date 8/10/2021