

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center	STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202
---	--

(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
--------------------	--	---------------	---	----------------------

F0000	<p>INITIAL COMMENTS</p> <p>Standard Survey: 5/29/2025 to 6/5/2025</p> <p>Census: 88</p> <p>Sample Size: 19 + 3 closed records</p> <p>The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.</p>	F0000		
F0880 SS = F	<p>Infection Prevention & Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>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.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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 §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p>	F0880	<p>F880</p> <p>483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>Element #1.</p> <p>The Policy on Linen Management was updated on 6/4/2025.</p> <p>The laundry room personnel and the US FOIA (b)(6) were immediately in-serviced by the Infection Preventionist/Director of Nursing on the updated Linen Management Policy especially regarding PPE and apron/gown use while handling soiled linens.</p> <p>Laundry personnel also received instructions on PPE supplies, gowns and aprons, these items are readily available in the washing machine area for use by laundry personnel by the Infection Preventionist and the housekeeping director.</p> <p>Element #2</p> <p>All residents have the potential to be affected by these deficient infection control practices.</p> <p>Element #3.</p> <p>All housekeeping and laundry personnel and the US FOIA (b)(6) were in-serviced on 6/19/2025 and educated by the Infection Preventionist on laundry and</p>	06/27/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
F0880 SS = F	<p>Continued from page 1</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and a review of facility documentation, it was determined that the facility failed to ensure laundry staff had the proper</p>	F0880	<p>Continued from page 1</p> <p>linen handling, and use of PPE/gowns/aprons. A PPE sign off log will be present for the laundry staff to sign off daily that they are using proper PPE for infection control purposes.</p> <p>Element #4.</p> <p>For three (3) months (from 6/6/25 till 9/6/25), the Housekeeping Director and Infection Preventionist will monitor linen handling (3) times weekly for (4) weeks, then weekly for (2) months, then monthly thereafter for laundry personnels compliance with infection prevention over the next two quarters.</p> <p>The Infection Preventionist and Nursing Director or designee will review the results of these audits, including any actions taken for correction.</p> <p>All findings to be reported and discussed by the next two QAPI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
F0880 SS = F	<p>Continued from page 2 personal protection equipment (PPE) necessary to handle linens to prevent the spread of infection.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 6/4/25 at 11:10 AM, the surveyor toured the laundry room along with the US FOIA (b)(6). Upon entry to the clean laundry area, two laundry aides were emptying a dryer. The laundry room consisted of an area with two front loading washers, both which were running. There was another area with three dryers and room for folding laundry. The surveyor asked the laundry aides, what they needed to do when loading the dirty laundry into the washers. The aide explained that sometimes she finds NJ Exec Order 26.4b1 in the wash when emptying the washer into the dryer. She further stated that if a NJ Exec Order 26.4b1 was found, she removed them and disposed of them in the garbage. The surveyor asked if she needed to wear anything to protect her when handling the dirty linens. She repeated her comments about the NJ Exec Order 26.4b1. The surveyor did not observe any gowns or aprons in the laundry area.</p> <p>On 6/4/25 at 11:20 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding if any PPE was needed when handling soiled linen. She stated, "Not that I know of." The US was present and stated the staff should wear PPE when handling the soiled linens into the washers.</p> <p>On 6/4/25 at 11:29 AM, the US showed the surveyor a laundry bag that disintegrates when it hits water. She stated that "we use these bags, so they (the laundry staff) aren't touching soiled linens."</p> <p>On 6/4/25 at 11:40 AM, the surveyor interviewed two US FOIA (b)(6) on the 10th floor. The surveyor observed CNA#1 with a clear plastic bag (not biodegradable) and asked what that bag was for. CNA#1 she stated it was for the dirty laundry. The surveyor asked if those laundry bags were also used for isolation. CNA#2 stated they used different bags for isolation, "the kind that go right into the washer."</p> <p>On 6/4/25 at 11:50 am, the surveyor requested a policy from the US FOIA (b)(6) regarding infection control in the laundry room. She stated she was looking for a policy but couldn't find one. She further stated that she</p>	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
F0880 SS = F	<p>Continued from page 3 googled it, and it does say staff was supposed to wear PPE when handling soiled linen. The surveyor asked what site she googled. She showed the surveyor her phone's screen which was on an AI (artificial intelligence) overview. She also stated that this was her first time doing laundry and housekeeping.</p> <p>On 6/4/25 at 11:55 AM, the surveyor observed two laundry aides in the folding area, folding clean linens with the clean sheets touching their clothing during the folding process. The [redacted] entered the laundry area while the surveyor was there. She stated she was looking for a PPE apron. No apron was observed in the laundry area.</p> <p>On 6/4/25 at 01:08 PM, the [redacted] U.S. FOIA (b)(6) were notified of the concerns in the laundry room.</p> <p>A review of the facility provided policy "Standard Precaution and Transmission-Based Precaution: Droplet, Universal and Contact Precautions", reviewed January 2025 included:</p> <p>Policy: Standard Precautions are the minimum prevention practices that applies to all resident/patient care, regardless of suspected or confirmed infection status of the resident/patient.</p> <p>Standard Precautions include:</p> <p>Hand Hygiene</p> <p>Use of Personal protected equipment i.e. gloves, mask, eyewear</p> <p>Standard Precautions:</p> <p>Gloves: Staff must use gloves when they anticipate contact with potentially infectious materials, non-intact skin, or potentially contaminated intact skin (i.e. resident incontinent of stool or urine).</p> <p>Gowns: Staff must use gowns to protect skin and prevent</p>	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
F0880 SS = F	<p>Continued from page 4 soiling or contamination of clothing during care or treatment administration when they anticipate contact with body fluids or excretions.</p> <p>A review of facility provided policy "Linen Management", dated June 2025, included:</p> <p>Policy: All linen is handled, stored, transported, and processed in a manner that will prevent contamination and maintain a clean environment for residents, health care workers, and visitors.</p> <p>Standard precautions will be followed when handling soiled linen.</p> <p>Guidelines for Linen Management are as follows:</p> <p>Laundry Staff:</p> <p>11. Residents on Transmission-based precautions:</p> <p>a. While wearing gloves; remove the bag from soiled linen container, then, place the water dissolvable bag will be opened directly into the washer.</p> <p>b. Generally, soiled linen bag will be opened directly into the washer with gloved hands and apron/gown will place the soiled linen in the washer.</p> <p>NJAC 8:36-19.4 (a) (b) (c)</p>	F0880		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 602030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
S0000	Initial Comments No Information	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documents, 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 for 1 out of 14 shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and	S0560	Element #1 The staffing coordinator was in-serviced on 6/20/2025 by the Administrator and Nursing Director; education provided included the importance of meeting the minimum staffing requirements and utilizing all possible avenues to proactively increase staffing in the facility. Element #2. All residents have the potential to be affected by this deficient practice when staffing regulations are not met. Element #3. The staffing coordinator continues to utilize all possible means to increase facility staff, including offering bonuses to staff that refer to CNAs. The staffing coordinator will review the scheduled monthly staffing, any shift not adequately staffed the staffing coordinator will reach out to our contracted staffing agencies, who assure us they will make all efforts to supply the necessary staff. In addition the staffing coordinator can offer part-time/per-diem employment to our sister facilities CNA that may be seeking additional working hours. Staffing Coordinator, Nursing Director and Administrator have listed job opportunities/openings on indeed and Apploi for hiring nursing staff. Element #4. The Administrator or designee will monitor daily staffing levels with the staffing coordinator for the next 4 months, (6/20/2025-10/20/2025). Weekly for the first 4 weeks and after 4 weeks, bi-weekly for 12	06/27/2025

Office of Primary Care and Health Systems Management

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 602030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
S0560	<p>Continued from page 1 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 CNA and perform CNA duties.</p> <p>A review of the "Nursing Staffing Report" completed by the facility for the staffing for the weeks of 5/11/25 to 5/24/25, revealed the facility was deficient in CNA staffing to residents ratios for 1 of 14 day shifts as follows:</p> <p>-05/19/25 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.</p> <p>On 6/03/25 at 2:43 PM, the surveyor interviewed the Staffing Coordinator, who stated she was familiar with the CNA staffing ratios. She stated the facility was able to meet the ratios.</p> <p>A review of the facility's policy titled, "Staffing" review dated 1-2025, revealed Policy: Our facility has developed and assigned hours for the Nursing Services department in accordance with the needs of our residents and Center of Medicare and Medicaid staffing levels (CMS). Resources: New Jersey Long Term Care Statues.</p>	S0560	<p>Continued from page 1 weeks.</p> <p>All findings to be reported and discussed by the next two QAPI meeting.</p>	
S1405	<p>Mandatory Infection Control and Sanitation</p> <p>CFR(s): 8:39-19.5(a)</p> <p>The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure newly hired employees had received an examination by a Physician, an Advanced Practice Nurse,</p>	S1405	<p>Element #1.</p> <p>On 6/5/2025 The facility Human Resource Manager (HR), Administrator and Director of Nursing began an audit on all new hire within the last (1) year to schedule date for each new hire to complete a Register Nurse (RN) assessment or physical examination.</p> <p>The Facility Administrator in-serviced on 6/6/2025 the director of nursing to follow the facilities policy on completing an Registered Nurse assessment upon prior to hire date and schedule health physician exam with the facilities medical director for all new employees in the required time frame.</p> <p>Element #2.</p> <p>All residents have the potential to be affected by this deficient practice by not completing registered nursing assessment or physician assessment within the required time frame.</p>	06/27/2025

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 602030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
S1405	<p>Continued from page 2 or a Licensed Physician Assistant within two weeks prior to employment or upon employment, or within thirty days if a Registered Nurse (RN) completed an assessment upon employment, for 6 out of 10 newly hired employee files reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 6/3/25 at 12:57 PM, the surveyor reviewed the employee health files for 10 random newly hired employees since the last recertification survey date of [redacted] which revealed the following:</p> <p>-Registered Nurse (RN) #1 had a date of hire (DOH) of [redacted] and a completed "Pre-Employment Health Screen" which was signed by the physician and dated [redacted].</p> <p>-RN #2 had a DOH of [redacted] and a completed "Pre-Employment Health Screen" which was signed by the physician and dated [redacted].</p> <p>-Licensed Practical Nurse (LPN) #1 had a DOH of [redacted] and a completed "Pre-Employment Health Screen" which was signed by the physician and dated [redacted].</p> <p>-LPN #2 had a DOH of [redacted] and no "Pre-Employment Health Screen" or other documentation that a physical was completed.</p> <p>-Certified Nursing Aide (CNA) #1 had a DOH of [redacted] and a health report dated [redacted].</p> <p>-CNA #2 had a DOH of [redacted] and a "Physical examination Record for CNA Student" dated [redacted].</p> <p>On 6/3/25 at 2:20 PM, the surveyor interviewed the Director of Nursing (DON), who stated new hires had to have a physical 1 to 2 weeks prior to starting work and they were usually done by the facility's medical director. She reviewed the above mentioned employee files in the presence of the surveyor and confirmed the above mentioned information was correct. At that time, she stated she needed to review the information with human resources and the staffing coordinator.</p>	S1405	<p>Continued from page 2 Element #3.</p> <p>The Administrator on 6/20/2025 met with the Facility Medical Director and Human Resources Manager and Director of Nursing, in-service education the facilities policy on the timely completion of all new hire health history and physicals within the required time frame.</p> <p>Element #4.</p> <p>The Administrator and the Director of Nursing will monitor and review on a weekly basis for 3 months (from 6/5/25 till 9/5/25), the monthly log for all new hire health history and physical to ensure compliance.</p> <p>The Nursing Director, Human Resources and the Administrator will review the results of these audits, including any actions taken for correction.</p> <p>All findings will be reported at the next two quarterly QAPI meeting.</p>	

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 602030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
S1405	<p>Continued from page 3</p> <p>On 6/4/25 at 10:24 AM, during a follow up interview, the DON stated new employees should receive a physical from a physician or advanced practice nurse within 2 weeks of employment or a registered nurse assessment upon hire and a physician assessment within 30 days. The DON confirmed no additional information could be provided for the above mentioned employees.</p> <p>On 6/5/25 at 9:51 AM, during a meeting with the survey team, the Licensed Nursing Home Administrator, the facility's owner, the DON and the Infection Preventionist were made aware of the above mentioned concerns.</p> <p>No additional information was provided.</p> <p>A review of the facility's policy "Employee Health Protocol", revision date of January 2025, revealed Policy: This policy is to promote a safe and healthy environment for our residents and our staff. Therefore, this Center will assure that all employees upon hire will have a Health Review followed with a physical by the Center's Medical Director. Section I; 8:39-19.5 Mandatory staff qualifications; health history and examinations. All new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two (2) weeks prior to the first day of employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment.</p>	S1405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
F0000	<p>INITIAL COMMENTS</p> <p>An offsite/desktop review of the facility's Plan of Correction was conducted on 7/24/2025 in relation to the 6/5/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
---	---	--	---

NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center	STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202
---	--

(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
--------------------	--	---------------	---	----------------------

E0000	Initial Comments An Emergency Preparedness Survey was conducted on June 4-5, 2025 at Plaza Healthcare and Rehabilitation Center. The facility was found to be not in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		
E0041 SS = F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)	E0041	E041 Element #1 On 6/6/2025 the Administrator and the Maintenance Director went to do an audit on the facility contract and reports with our vendor powerhouse which services our generator. In the binder of contracts, we found the contract dated 1/1/2025 stating clearly that Powerhouse will service our facility with fuel throughout the time the generator is on during an emergency and will replace it with a rental if the current generator malfunctions (see policy attached) Element #2 All residents have the potential to be affected by this deficient practice when life safety reports and contracts are not handy and not in the right binder. Element #3 The administrator in- serviced the US FOIA (b)(6) the same day 6/6/25 about the importance of having all reports and contracts related to lift safety, to be stored in the emergency preparedness binder and to check monthly contract and report from the Vendor Powerhouse who services the generator, that they are up to date with life safety compliance. In addition, the administrator in-serviced the maintenance director on the responsibility of having a contracted vendor service the generator throughout the emergency and having a backup generator in case it malfunctions. Element #4 The Administrator will monitor the Maintenance Director for three (3) months starting 6/9/2025- 9/9/2025 weekly	06/27/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
E0041 SS = F	<p>Continued from page 1</p> <p>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2)</p> <p>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):]</p> <p>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.</p> <p>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p>	E0041	Continued from page 1 on having all life safety reports and contracts handy and placed in the Emergency preparedness binder for all life safety compliance. All findings will be reviewed and discussed in the next Quarterly QAPI committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
E0041 SS = F	<p>Continued from page 2</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview on 06/05/25, the facility failed to ensure its emergency preparedness policy plan included how the facility would maintain generator power/fuel during an emergency. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>A review of the facility's Emergency Preparedness Policy, provided by the U.S. FOIA (b)(6), revealed that the Policy lacked a reference to a plan to maintain its fuel/operational power systems during an emergency.</p> <p>At 12:30 PM the surveyor interviewed the U.S. FOIA (b)(6) who verified that the facility lacked a plan to maintain fuel sources for emergency power during an emergency or plan to supply power to the building when the generator failed to operate power during an emergency.</p> <p>The facility's U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM.</p> <p>NJAC 8:39-31.2(e)</p> <p>NFPA 99,110</p>	E0041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 456 RAHWAY AVENUE , ELIZABETH, New Jersey, 07202	
(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
E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 8/22/2025 in relation to the 6/5/2025 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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 reverse for further 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.

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