	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		015100	B. WING		с		
		315128			03/02/2023		
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE			
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER		62 RICHMOND AVENUE LUMBERTON, NJ 08048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC		
F 000	INITIAL COMMENTS		F 000				
(COMPLAINT # NJ157751, NJ155889						
	CENSUS: 130						
	SAMPLE SIZE: 7						
	42 CFR PART 483, S	IT IN SUBSTANTIAL THE REQUIREMENTS OF UBPART B, FOR LONG TIES BASED ON THIS					
F 580 SS=D	Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.))(i)-(iv)(15)	F 580		4/12/23		
	consult with the resid consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue treatment due to adve commence a new form (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the					
SURATORY I	JIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	(E	TITLE	(X6) DATE		

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.

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10 FORM APP OMB NO. 09	ROVE	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	TIPLE CONSTRUCTION	(X3) DATE SURV COMPLETEI C		
		315128	B. WING		03/02/2023		
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, 62 RICHMOND AVENUE			
				LUMBERTON, NJ 08048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE COM D TO THE APPROPRIATE CIENCY)	(X5) IPLETION DATE	
F 580	is available and provi physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483. (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must n update the address (n phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configurat locations that comprise part, and must specifi room changes betwee under §483.15(c)(9). This REQUIREMENT by: Complaint#: NJ1558 Based on interviews, review of other pertin	on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ins as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced asso medical records review, and ent facility documentation on 6, and 3/2/2023, it was	F	-Resident #7 no longe facility. -All residents receiving potential for this deficie comprehensive audit of to validate the dischar needs will be complete	g therapy have the ent practice. A of current residents ge plans of therapy		
	that the Resident's Pl discontinued on	This deficient practice 7 residents (Resident #7)		Rehab along with the l Nursing/designee to va notification of discontir services. Any identified addressed and correct	alidate patient nuation of therapy d issues are		

Facility ID: NJ60310

If continuation sheet Page 2 of 31

CENTER STATEMENT (-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	FORM OMB NC (X3) DATE	D: 10/20/2023 M APPROVED D: 0938-0391 SURVEY PLETED
		315128	B. WING			C 102/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
MOUNT H		& HEALTHCARE CENTER		2 RICHMOND AVENUE UMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	was as follows: According to the Adm Resident #7 was adm with diagno were not limited t According to the Minin assessment tool date had a Brief Interview of score of the Interview of a surface-to-surface transformed on the Interview of the Interview of surface-to-surface transformed and Plan of Treatment on the Interview of showed a was completed on the Evaluation and Plan of Resident #7 had a "C Interview of the Treatment on through the Interview	onic Medical Record (MR) ission Record (AR), hitted to the facility on oses which included but isses which included but included but included but included but included but included the Resident #7 of Mental Status (BIMS) indicated the Resident was indicated the Re	F 580	-Director of Nursing and Director of R will re-educate therapists and nurses the Focus on F-tag 580 and the "Cha in Condition" procedure for the need for notify resident/responsible party that the resident's therapy will be discontinued the documentation that is required on before the date of compliance. -Utilizing the "Admission, Transfer an Discharge Review" The Director of Physical Therapy/designee will audit residents with therapy discharge order daily x5 and weekly x4 and monthly x validate that the care plans accurately reflect the resident therapy discharge status. The Director of Rehab will rep the results to the Quality Initiative committee. The Quality Initiative committee consists of the Administrat Director of Nursing and the Medical Director.	on nge o he I and or d rs 3 to 7	
	A review of the Treatm	nent Encounter Notes for eveals that Resident #7 erapy 4-5 times a week				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED			
		315128	B. WING				/02/2023			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER			RICHMOND AVENUE MBERTON, NJ 08048					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 580	starting on However, there was r However, there was r Physical Therapy End #7's representative w had been discontinue A review of the Physic Summary electronica Therapy Assistant (P' co-signed by the Physic that Resident #7 was for "Highest Nevertheless, they we discharge summary the representative was no During an interview on Director of Social Ser the family when a res When asked by the set documented in the Res she stated, "Yes, I do interview at 4:10 p.m. Resident #7's represent notified of discharge for the former Social Wor provide any evidence former SW. At the time of the sum- provide evidence that representative was no discharge from PT. Review of the undate Change in a Resident Policy Statement indiano notifies the resident, H	and ending on Constant to documentation in the counter Notes that Resident as notified that PT services d. cal Therapy Discharge Ily signed by the Physical TA) and electronically sical Therapist (PT) reveals discharged from PT on Practical Level Achieved." ere no documentation in the nat the Resident or their otified of the discharge. n 3/2/2023 at 4:00 p.m., the vices (DSS) stated: "I notify ident is discharged from PT. urveyor if this is esident's medical record, cument." During a second , the DSS stated that entative should have been from Physical Therapy by rker (SW, but, she could not of the notification from the vey, the facility could not : Resident #7' or his/her otified of the Resident's d facility policy titled: t's Condition or Status under cates: "Our facility promptly	F	580						

Facility ID: NJ60310

If continuation sheet Page 4 of 31

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DA	10. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COI	MPLETED
		315128	B. WING		0	C 3/02/2023
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER	-	RICHMOND AVENUE MBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	9 4	F 580			
F 656 SS=D	care, billing/payments Under Policy Interpre the policy reveals: "5. emergencies, notifica twenty-four (24) hours the Resident's medica [] 11. A representation notify the Resident, h representative (spons change in the Reside Develop/Implement C	is (e.g., changes in level of s, resident rights, etc.)." tation and Implementation, Except in medical tions will be made within s of a change occurring in al/mental condition or status. tive of the business office will is/her family, or sor), when: [] b. there is a nt's level of care status."	F 656			4/12/23
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that y under §483.24, §483. provided due to the re under §483.10, include treatment under §483. (iii) Any specialized s	cility must develop and densive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial died in the comprehensive hprehensive care plan must d - the to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 0.10(c)(6). ervices or specialized the nursing facility will				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315128	B. WING				C / 02/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER			RICHMOND AVENUE JMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	findings of the PASAH rationale in the reside (iv)In consultation wit resident's representa (A) The resident's go desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident' community was asse local contact agencie entities, for this purper (C) Discharge plans i plan, as appropriate, requirements set forth section. §483.21(b)(3) The se- by the facility, as outh care plan, must- (iii) Be culturally-com This REQUIREMENT by: Complaint#: NJ1558 Based on interviews,	a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and eference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. n the comprehensive care in accordance with the h in paragraph (c) of this rvices provided or arranged ined by the comprehensive petent and trauma-informed. T is not met as evidenced 389 medical records review, and	F	356	-Resident #7 no longer resides in the facility. -All residents with the facility is and or the point of the facility is a facility of the facility is a facility of the facili	tential ice. An	
	review of other pertinent facility documentation on 2/22/2023, 2/23/2023, and 3/2/2023, it was determined that the facility failed to develop and implement a comprehensive care plan (CP) for a resident with a new diagnosis of the second and a second for 1 of 7 residents (Resident #7). The facility also failed to follow its policy titled "Care Plans, Comprehensive Person-Centered." This deficient practice was evidenced by the following:				care plan were identified as needed -Licensed nurses will be educated b Director of Nursing/designee on the on F-tag 656 and how to develop an implement a comprehensive care p a resident with a new diagnosis of	l. Focus nd lan for care. s, The	

Event ID: FH7V11

Facility ID: NJ60310

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		ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES					0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED	
		315128	B. WING _				C 02/2023	
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	OLLY REHABILITATION	& HEALTHCARE CENTER		62	RICHMOND AVENUE			
				LUMBERTON, NJ 08048				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	was as follows: According to the Adm Resident #7 was adm with diagne were not limited to According to the Mini assessment tool date had a Brief Interview score of , which Resident #7 needed one person's physica Daily Living (ADLs). A review of Resident written by the Registe 4:51 a.m. revealed Re with no even and A review of Resident Licensed Practical Nu at 7:52 p.m., revealed was [appointment] 6/15. Co i ; no adverse A review of the Comp initiated showed Re	initial methanism in the initial methanism in	F6	556	with daily x5, weekly x4 and mor x3 to validate care plans accurately ref the residents with the result of the Quality Initiative committee. The Quality Initiative committee consists of Administrator, Director of Nursing, and Medical Director.	ilect ind ts the		
	A review of the Comp	rehensive Care Plans						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		315128	B. WING				02/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER			2 RICHMOND AVENUE UMBERTON, NJ 08048		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page During an interview of the presence of the R (RCN), the Director of there was no care plated and that the care precautions. She furth who wrote the Progress should have initiated stated that the Nurse the facility. During an interview of When the Surveyor at implementing a Reside (UM) stated that the U Preventionist writes the Every She agreed there show Comprehensive Care and Comprehensive Care and Care Care Care Care Care and Care Care Care Care Care Care and Care Care Care Care Care and Care Care Care Care Care Care and Care Care Care Care Care Care Care and Care Care Care Care Care Care Care and Care Care Care Care Care Care Care Care	a 7 In 3/2/2023 at 3:00 p.m., in legional Clinical Nurse f Nursing (DON) stated that in for Resident #7 for the plan would include infection her stated that the Nurse ss Note with the lab results the care plan. She also was no longer working at In 3/2/2023 at 4:05 p.m., sked who is responsible for lent's CP, the Unit Manager JM, a nurse, or the Infection he Care Plans for vone [nurses] is responsible. buld have been a Plan for Resident #7's In 3/2/2023 at 4:43 p.m., in legional Clinical Nurse nal Director of Operations, g (DON) stated that the Unit the unit initiated and wrote care Plan. <i>y</i> policy titled "Care Plans, on-Centered" with a Version ad the following: Under icluded "A comprehensive,		656			
	resident's physical, p	s and timetables to meet the sychosocial and functional nd implemented for each licy Interpretation and					

Facility ID: NJ60310

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM): 10/20/202 1 APPROVE 9. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		- (X3) DATE SURVEY COMPLETED C - 03/02/2023		
		315128	B. WING				
IAME OF PI	ROVIDER OR SUPPLIER	I	STRE	EET ADDRESS, CITY, STATE, ZIP C	· · · · · · · · · · · · · · · · · · ·		
IOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER		ICHMOND AVENUE IBERTON, NJ 08048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Implementation: [] person-centered care objectives and time fr services that are to b maintain the Residen physical, mental, and] reflects currently r practice for problem a Assessments of resid plans are revised as i residents and the res The interdisciplinary to the care plan: a. whe	The comprehensive, plan includes measurable ames, describes the e furnished to attain or t's highest practicable psychosocial well-being, [ecognized standards of areas and conditions. [] lents are ongoing and care nformation about the idents' conditions change. eam reviews and updates	F 656				
F 842 SS=D	§483.20(f)(5) Resider (i) A facility may not r resident-identifiable tr (ii) The facility may re resident-identifiable tr accordance with a co agrees not to use or o except to the extent t to do so. §483.70(i) Medical re §483.70(i)(1) In accor professional standard	dentifiable Information 483.70(i)(1)-(5) nt-identifiable information. elease information that is to the public. elease information that is to an agent only in ntract under which the agent disclose the information he facility itself is permitted	F 842			4/12/23	

Facility ID: NJ60310

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315128	B. WING				C 102/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER	62 RICHMOND AVENUE LUMBERTON, NJ 08048				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 842	 (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The facialli information contair regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitti with 45 CFR 164.506 (iv) For public health an eglect, or domestic wat activities, judicial and law enforcement purp purposes, research predical examiners, furthat serious threat to heat by and in compliance §483.70(i)(3) The facial record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 year legal age under State §483.70(i)(5) The mere (ii) A record of the rest 	e; and ganized lity must keep confidential hed in the resident's records, h or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, tosses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident;	F	842			

		D HUMAN SERVICES MEDICAID SERVICES				FORM	10/20/2023 APPROVED 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315128	B. WING			C 03/0	2/2023
NAME OF PF	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
MOUNT H		& HEALTHCARE CENTER		62 RICHMOND AVENUE LUMBERTON, NJ 08048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 842	and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiole services reports as re This REQUIREMENT by: Complaint #: NJ1558 Based on interviews, review of other pertine 2/22/2023, 2/23/2023, determined that the fa complete the Residen Report v2" for 2 of 7 F #7) reviewed for Activ The facility also failed "Charting and Docum Living (ADLs), Suppor Nursing Assistant" job practice was evidence A review of the Electro was as follows: 1. According to the "A Resident #2 was adm diagnoses which inclu	r preadmission screening valuations and cted by the State; 's, and other licensed ss notes; and ogy and other diagnostic quired under §483.50. is not met as evidenced 389, NJ157751 medical records review, and ent facility documentation on , and 3/2/2023, it was icility failed to consistently t's "Documentation Survey Residents (Resident #2 & ities of Daily Living (ADLs). to follow its policies titled entation," "Activities of Daily rting," and the "Certified o description. This deficient ed by the following: ponic Medical Record (EMR)	F 84	 -Residents #2 and # residents in the facili -All residents have the affected by this defice comprehensive revie was completed by the to validate Activities being documented a - Certified Nursing A on the "Activities of I policy and process to Nursing/designee or compliance. Utilizing the "Staff I The Director of Nurse Leadership team will documentation every weekly x4 and monthe Nursing will report the Quality Initiative com Initiative Committee Administrator, Director 	ity. he potential to be cient practice. A ew from 3.1.23-4.1.2 he Director of Nursir of Daily Living are and completed. ids will be educated Daily Documentatio by the Director of n or before the date Education" QAPI to ing and Nursing I audit the ADL y shift for 5 days, hly x3. The Director he results to the mmittee. The Quality consist of the	ng d of ol, ⁻ of	

Facility ID: NJ60310

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315128	B. WING				C 102/2023
NAME OF PI	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER		-	62 RICHMOND AVENUE LUMBERTON, NJ 08048		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 842	Resident needed limit Resident needed limit Daily Living (ADLs) at The Resident uses a mobility. The Surveyor reviewe Documentation Surve care task provided to documented by the C (CNAs) during their a C(CNAs) during their a Marchine (C) A review of the DSR f documentation of Inter dated 8/1/200 revealed blank space was not documented a.m3:00 p.m. shift, c 8/12/2022, 8/21/2022 8/25/2022-8/28/2022; shift, on 8/3/2022, 8/3 8/22/2022, 8/4/2022	d Constant , Resident #2 had ental Status (BIMS) score of Resident was Constant The MDS also showed the ted assistance with assist with most Activities of nd is at risk for Constant for ed Resident #2's ey Report v2 (DSR), an ADL the Resident and ertified Nursing Assistants ssigned shift. The DSR from the Resident and ertified Nursing Assistants ssigned Status status as follows: on the 7:00 on 8/3/2022, 8/6/2022, and on the 3:00 p.m11:00 p.m. 5/2022, 8/10/2022, and a 11:00 p.m7:00 a.m. shift, 2, 8/9/2022-8/11/2022, and a 11:00 p.m7:00 a.m. shift, 2, 8/23/2022, 8/24/2022,	F	842			
	, dated 8/1/20	form used for ADL ervention/Tasks, ADL - 22 through 8/31/2022 s which indicated the task					

Facility ID: NJ60310

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	FED: 10/20/2023 RM APPROVED NO. 0938-039	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		INSTRUCTION	· · · ·	ATE SURVEY DMPLETED	
		315128	B. WING _				03/02/2023	
	ROVIDER OR SUPPLIER OLLY REHABILITATION	& HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIF 62 RICHMOND AVENUE LUMBERTON, NJ 08048					
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	was not documented a.m3:00 p.m. shift, o 8/12/2022, 8/21/2022 8/25/2022-8/28/2022 shift, on 8/3/2022, 8/4 8/12/2022, 8/13/2022 8/31/2022, 8/4/2022 8/31/2022, 8/4/2022 8/31/2022, 8/4/2022 8/26/2022-8/29/2022 A review of the DSR documentation of Inte 1/2022, 8/21/2022 8/25/2022-8/28/2022 shift, on 8/3/2022, 8/4 8/12/2022, 8/21/2022 8/25/2022-8/28/2022 shift, on 8/3/2022, 8/4/2022 8/26/2022-8/28/2022 8/31/2022, 8/13/2022 8/31/2022, 8/10/2022 8/31/2022, 8/10/2022 8/26/2022-8/29/2022 A review of the DSR documentation of Inte on 8/2/2022, 8/4/2022 8/31/2022, 8/10/2022 8/31/2022 revealed b the task was not docu 7:00 a.m3:00 p.m. s 8/12/2022, 8/29/2022 A review of the DSR documentation of Inte 1/2022, 8/10/2022 8/25/2022-8/29/2022 A review of the DSR documentation of Inte 1/2022, 8/10/2022 8/25/2022-8/28/2022 shift, on 8/3/2022, 8/2 8/12/2022, 8/13/2022 shift, on 8/3/2022, 8/3 8/12/2022, 8/13/2022 shift, on 8/3/2022, 8/3	as follows: on the7:00 on 8/3/2022, 8/6/2022, 2, 8/22/2022, and ; on the 3:00 p.m11:00 p.m. 5/2022, 8/10/2022, 2, 8/15/2022, 8/28/2022, 8/30/2022, and e 11:00 p.m7:00 a.m. shift, 2, 8/9/2022-8/11/2022, 2, 8/23/2022, 8/24/2022, 4, and 8/31/2022. form used for ADL ervention/Tasks, ADL - dated 8/1/2022 through blank spaces which indicated umented as follows: on the shift, on 8/3/2022, 8/6/2022, 2, 8/22/2022, and ; on the 3:00 p.m11:00 p.m. 5/2022, 8/10/2022, 8/8/2022, 8/30/2022, and e 11:00 p.m7:00 a.m. shift, 2, 8/9/2022-8/11/2022, 8/23/2022, 8/24/2022, and 8/31/2022. form used for ADL ervention/Tasks, ADL - ated 8/1/2022 through blank spaces which indicated umented as follows: on the shift, on 8/3/2022, 8/6/2022, 2, 8/23/2022, 8/24/2022, 3, and 8/31/2022.	F	342				

Facility ID: NJ60310

If continuation sheet Page 13 of 31

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/20/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315128	B. WING _				C 102/2023
NAME OF PI	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER					
					UMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 842	Continued From page	e 13	F8	342			
	5 - · · · · · · · · · · · · · · · · · ·	1:00 p.m7:00 a.m. shift, on					
	8/2/2022, 8/4/2022, 8	/9/2022-8/11/2022, , 8/23/2022, 8/24/2022,					
	A review of the DSR	form used for ADL					
		ervention/Tasks, ADL - ated 8/1/2022 through					
		lank spaces which indicated					
		umented as follows: on the					
	7:00 a.m3:00 p.m. s 8/12/2022, 8/21/2022	hift, on 8/3/2022, 8/6/2022, 8/22/2022, and					
		; on the 3:00 p.m11:00 p.m.					
	shift, on 8/3/2022, 8/5						
	8/12/2022, 8/13/2022 8/20/2022-8/22/2022	, 8/15/2022, , 8/28/2022, 8/30/2022, and					
		e 11:00 p.m7:00 a.m. shift,					
		2, 8/9/2022-8/11/2022,					
	8/17/2022, 8/10/2022 8/26/2022-8/29/2022	, 8/23/2022, 8/24/2022, , and 8/31/2022.					
	A review of the DSR						
		ervention/Tasks, ADL - CNA 1/2022 through 8/31/2022					
		s which indicated the task					
		as follows: on the 7:00					
	a.m3:00 p.m. shift, o 8/12/2022, 8/21/2022	on 8/3/2022, 8/6/2022, 8/22/2022, and					
		; on the 3:00 p.m11:00 p.m.					
	shift, on 8/3/2022, 8/5	5/2022, 8/10/2022,					
	8/12/2022, 8/13/2022						
		, 8/28/2022, 8/30/2022, and 1:00 p.m7:00 a.m. shift, on					
	8/2/2022, 8/4/2022, 8	•					
	8/17/2022, 8/10/2022 8/26/2022-8/29/2022	, 8/23/2022, 8/24/2022, , and 8/31/2022.					
	A review of the DSR						
	documentation of Inte	ervention/Tasks, ADL -					

Facility ID: NJ60310

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 10/20/202 RM APPROVE IO. 0938-039	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			TE SURVEY MPLETED C	
		315128	B. WING		o	3/02/2023	
	ROVIDER OR SUPPLIER OLLY REHABILITATION	& HEALTHCARE CENTER	62 R	EET ADDRESS, CITY, STATE, ZIP CO RICHMOND AVENUE ABERTON, NJ 08048			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	revealed blank space was not documented a.m3:00 p.m. shift, 6 8/12/2022, 8/21/2022 8/25/2022-8/28/2022 shift, on 8/3/2022, 8/4 8/12/2022, 8/13/2022 8/20/2022-8/22/2022 8/31/2022, 8/4/2022 8/17/2022, 8/10/2022 8/26/2022-8/29/2022 A review of the DSR i documentation of Inte indicated the task wa follows: on the 7:00 a 8/3/2022, 8/6/2022, 8/ 8/22/2022, and 8/25/2 p.m11:00 p.m. shift, 8/10/2022, 8/12/2022 8/31/2022, 8/4/2022, 8/ 8/22/2022, 8/4/2022, 8/ 8/22/2022, 8/4/2022, 8/ 8/22/2022, 8/4/2022, 8/ 8/17/2022, 8/10/2022 8/31/2022, 8/4/2022, 8/ 8/31/2022, revealed f the task was not docu 7:00 a.m3:00 p.m. s 8/12/2022, 8/21/2022	2022 through 8/31/2022, as which indicated the task as follows: on the 7:00 on 8/3/2022, 8/6/2022, 2, 8/22/2022, and ; on the 3:00 p.m11:00 p.m. 5/2022, 8/10/2022, 2, 8/15/2022, 8/28/2022, 8/30/2022, and e 11:00 p.m7:00 a.m. shift, 2, 8/9/2022-8/11/2022, 2, 8/23/2022, 8/24/2022, , and 8/31/2022. form used for ADL ervention/Tasks, ADL - n Hallway, dated 8/1/2022 vealed blank spaces which s not documented as a.m3:00 p.m. shift, on 3/12/2022, 8/21/2022, 2022-8/28/2022; on the 3:00 on 8/3/2022, 8/5/2022, 2, 8/13/2022, 8/15/2022, 2, 8/13/2022, 8/15/2022, 2, 8/23/2022, 8/30/2022, and 1:00 p.m7:00 a.m. shift, on 3/9/2022-8/11/2022, 2, 8/23/2022, 8/24/2022, 3, and 8/31/2022. form used for ADL ervention/Tasks, ADL - ated 8/1/2022 through blank spaces which indicated umented as follows: on the shift, on 8/3/2022, 8/6/2022, 2, 8/22/2022, and ; on the 3:00 p.m11:00 p.m.	F 842				

Facility ID: NJ60310

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CENTER	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,)	· · ·	PLETED
						С
		315128	B. WING		03	/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER		62 RICHMOND AVENUE LUMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 842			F 84	2		
	8/31/2022; and the 11 8/2/2022, 8/4/2022, 8 8/17/2022, 8/10/2022	8/28/2022, 8/30/2022, and 1:00 p.m7:00 a.m. shift, on /9/2022-8/11/2022, , 8/23/2022, 8/24/2022,				
	8/26/2022-8/29/2022, and 8/31/2022. A review of the DSR form used for ADL documentation of Intervention/Tasks, ADL - dated 8/1/2022 through 8/31/2022 revealed blank spaces which indicated the task was not documented as follows: on the 7:00 a.m3:00 p.m. shift, on 8/3/2022, 8/6/2022, 8/12/2022, 8/21/2022, 8/22/2022, and 8/25/2022-8/28/2022; on the 3:00 p.m11:00 p.m. shift, on 8/3/2022, 8/5/2022, 8/10/2022, 8/12/2022, 8/13/2022, 8/15/2022, 8/20/2022-8/22/2022, 8/28/2022, 8/30/2022, and 8/31/2022; and on the 11:00 p.m7:00 a.m. shift, on 8/2/2022, 8/10/2022, 8/9/2022-8/11/2022, 8/17/2022, 8/10/2022, 8/23/2022, 8/24/2022, 8/26/2022-8/29/2022, and 8/31/2022.					
	dated 8/ revealed blank space was not documented a.m3:00 p.m. shift, of 8/12/2022, 8/21/2022 8/25/2022-8/28/2022; shift, on 8/3/2022, 8/5 8/12/2022, 8/13/2022 8/20/2022-8/22/2022, 8/31/2022; and on the on 8/2/2022, 8/4/2022	ervention/Tasks, ADL - (1/2022 through 8/31/2022, s which indicated the task as follows: on the 7:00 on 8/3/2022, 8/6/2022, , 8/22/2022, and on the 3:00 p.m11:00 p.m. 5/2022, 8/10/2022, , 8/15/2022, 8/28/2022, 8/30/2022, and e 11:00 p.m7:00 a.m. shift, 2, 8/9/2022-8/11/2022, , 8/23/2022, 8/24/2022,				

Facility ID: NJ60310

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	: 10/20/2023 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315128	B. WING		_	03/	C 02/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER		2 RICHMOND AVENUE	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	The Surveyor reviewed documented by the C shift. The DSR from S September 30, 2022, A review of the DSR f documentation of Inte dated 9/1/20 revealed blank space was not documented a.m3:00 p.m. shift, c 9/16/2022-9/18/2022, 9/29/2022; on the 3:0 9/1/2022, 9/2/2022, 9, 9/10/2022, 9/2/2022, 9, 9/10/2022, 9/2/2022, and on the 11:00 p.m. 9/1/2022, 9/2/2022, 9/29/2022. A review of the DSR f documentation of Inte 1000, dated 9/1/20 revealed blank space was not documented a.m3:00 p.m. shift, c 9/16/2022-9/18/2022, 9/29/2022; on the 3:0 9/1/2022, 9/2/2022, 9, 9/10/2022, 9/2/2022, 9, 9/10/2022, 9/2/2022, 9, 9/10/2022, 9/2/2022, 9, 9/10/2022, 9/2/2022, 9, 9/10/2022, 9/18/2022 9/29/2022. A review of the DSR f	Add Resident #2's DSR NAs during their assigned September 1, 2022, through revealed the following: form used for ADL ervention/Tasks, ADL - 22 through 9/30/2022, s which indicated the task as follows: on the 7:00 on 9/2/2022, 9/3/2022, 9/24/2022, 9/25/2022, and 0 p.m11:00 p.m. shift, on /6/2022, 9/8/2022, , 9/16/2022-9/18/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on /11/2022, 9/12/2022, and form used for ADL ervention/Tasks, ADL - 22 through 9/30/2022, s which indicated the task as follows: on the 7:00 on 9/2/2022, 9/3/2022, s which indicated the task as follows: on the 7:00 on 9/2/2022, 9/3/2022, 9/24/2022, 9/25/2022, and 0 p.m11:00 p.m. shift, on /6/2022, 9/8/2022, 9/16/2022-9/18/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on /11/2022, 9/12/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on /11/2022, 9/12/2022, and	F 842				

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 10/20/202 FORM APPROVE IB NO. 0938-039	
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		NSTRUCTION		3) DATE SURVEY COMPLETED	
		315128	B. WING				C 03/02/2023	
	ROVIDER OR SUPPLIER OLLY REHABILITATION	& HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP 62 RICHMOND AVENUE LUMBERTON, NJ 08048			•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 842	9/30/2022 revealed to the task was not doc 7:00 a.m3:00 p.m. se 9/16/2022-9/18/2022 9/29/2022; on the 3:0 9/12/022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/15/2022, 9/18/2022 9/29/2022. A review of the DSR documentation of Intermediate the task was not doc 7:00 a.m3:00 p.m. se 9/16/2022-9/18/2022 9/20/2022; and on the 11:00 p.m sector 9/1/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/2022, 9/21/202, 9/21/202, 9/21/202	dated 9/1/2022 through blank spaces which indicated umented as follows: on the shift, on 9/2/2022, 9/3/2022, 2, 9/24/2022, 9/25/2022, and 00 p.m11:00 p.m. shift, on 0/6/2022, 9/8/2022, 2, 9/16/2022-9/18/2022, 2, 9/16/2022-9/18/2022, 2, and 9/25/2022-9/30/2022; n7:00 a.m. shift, on 0/11/2022, 9/12/2022, 2, 9/20/2022, 9/27/2022, and form used for ADL ervention/Tasks, ADL - ated 9/1/2022 through blank spaces which indicated umented as follows: on the shift, on 9/2/2022, 9/3/2022, 2, 9/24/2022, 9/25/2022, and 00 p.m11:00 p.m. shift, on 0/6/2022, 9/8/2022, 2, 9/16/2022-9/18/2022, 2, 9/16/2022-9/18/2022, 2, 9/20/2022, 9/27/2022, and form used for ADL ervention/Tasks, ADL - 11/2022, 9/12/2022, and 0/11/2022, 9/12/2022, and form used for ADL ervention/Tasks, ADL - lated 9/1/2022 through blank spaces which indicated umented as follows: on the shift, on 9/2/2022, 9/3/2022, and form used for ADL ervention/Tasks, ADL - lated 9/1/2022 through blank spaces which indicated umented as follows: on the shift, on 9/2/2022, 9/3/2022, and 00 p.m11:00 p.m. shift, on	F	342				

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		MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		<u>D. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	IG	· · ·	PLETED
						С
		315128	B. WING			/02/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER		62 RICHMOND AVENUE LUMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PI (EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE
F 842	9/10/2022, 9/11/2022	e 18 , 9/16/2022-9/18/2022, and 9/25/2022-9/30/2022;	F 8	42		
	and on the 11:00 p.m 9/1/2022, 9/2/2022, 9	7:00 a.m. shift, on				
	A review of the DSR form used for ADL documentation of Intervention/Tasks, ADL - CNA documentation, dated 9/1/2022 through 9/30/2022 revealed blank spaces which indicated the task was not documented as follows: on the 7:00 a.m3:00 p.m. shift, on 9/2/2022, 9/3/2022, 9/16/2022-9/18/2022, 9/24/2022, 9/25/2022, and 9/29/2022; on the 3:00 p.m11:00 p.m. shift, on 9/1/2022, 9/2/2022, 9/6/2022, 9/8/2022,					
	9/10/2022, 9/11/2022 9/21/2022-9/23/2022, and on the 11:00 p.m 9/1/2022, 9/2/2022, 9	, 9/16/2022-9/18/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on				
	, dated 9/1/2 revealed blank space was not documented a.m3:00 p.m. shift, o 9/16/2022-9/18/2022, 9/29/2022; on the 3:0 9/1/2022, 9/2/2022, 9 9/10/2022, 9/11/2022	ervention/Tasks, ADL - 2022 through 9/30/2022, s which indicated the task as follows: on the 7:00 on 9/2/2022, 9/3/2022, 9/24/2022, 9/25/2022, and 0 p.m11:00 p.m. shift, on				
	and on the 11:00 p.m 9/1/2022, 9/2/2022, 9	7:00 a.m. shift, on				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	
		315128	B. WING				02/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER			2 RICHMOND AVENUE UMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	A review of the DSR f documentation of Inter 9/1/2022 through 9/30 spaces which indicate documented as follow p.m. shift, on 9/2/2022 9/16/2022-9/18/2022, 9 9/10/2022, 9/18/2022, 9 9/10/2022, 9/2/2022, 9 9/10/2022, 9/2/2022, 9 9/12/2022-9/23/2022, and on the 11:00 p.m 9/1/2022, 9/2/2022, 9 9/15/2022, 9/18/2022 9/29/2022. A review of the DSR f documentation of Inter 100 a.m3:00 p.m. s 9/16/2022-9/18/2022, 9/29/2022; on the 3:0 9/1/2022, 9/2/2022, 9 9/10/2022, 9/11/2022 9/21/2022-9/23/2022, and on the 11:00 p.m 9/1/2022, 9/2/2022, 9 9/10/2022, 9/18/2022 9/29/2022. A review of the DSR f documentation of Inter 9/1/2022, 9/2/2022, 9 9/15/2022, 9/18/2022 9/29/2022. A review of the DSR f documentation of Inter 100 atted 9/1/2022 f blank spaces which in	form used for ADL ervention/Tasks, ADL - on Unit/in Hallway, dated D/2022 revealed blank ed the task was not vs: on the 7:00 a.m3:00 2, 9/3/2022, 9/24/2022, 9/25/2022, and 0 p.m11:00 p.m. shift, on /6/2022, 9/8/2022, , 9/16/2022-9/18/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on /11/2022, 9/12/2022, , 9/20/2022, 9/27/2022, and form used for ADL ervention/Tasks, ADL - ted 9/1/2022 through blank spaces which indicated umented as follows: on the hift, on 9/2/2022, 9/3/2022, 9/24/2022, 9/8/2022, 9/24/2022, 9/8/2022, and 9/25/2022-9/18/2022, and 9/25/2022-9/18/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on /6/2022, 9/12/2022, and 0 p.m11:00 p.m. shift, on /6/2022, 9/12/2022, and 9/25/2022-9/18/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on /11/2022, 9/12/2022, and	F	342			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 10/20/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315128	B. WING			_		C 02/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MOUNT H		& HEALTHCARE CENTER			2 RICHMOND AVENUE UMBERTON, NJ 08048	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	9/16/2022-9/18/2022, 9/29/2022; on the 3:0 9/1/2022, 9/2/2022, 9 9/10/2022, 9/2/2022, 9 9/11/2022, 9/2/2022, 9 9/12/2022-9/23/2022, and on the 11:00 p.m. 9/15/2022, 9/2/2022, 9 9/15/2022, 9/2/2022, 9 9/15/2022, 9/18/2022 9/29/2022. A review of the DSR f documentation of Inter mm, dated 9/ revealed blank space was not documented a.m3:00 p.m. shift, c 9/16/2022-9/18/2022, 9/29/2022; on the 3:0 9/1/2022, 9/2/2022, 9 9/10/2022, 9/2/2022, 9 9/10/2022, 9/2/2022, 9 9/11/2022, 9/2/2022, 9 9/12022, 9/2/2022, 9 9/12022, 9/2/2022, 9 9/15/2022, 9/18/2022 9/29/2022. 2. According to the "A Resident #7 was adm diagnoses which incluse According to the MDS #7 had a Brief Intervise score of mm, which . The Resident #7 needed of motion	9/24/2022, 9/25/2022, and 0 p.m11:00 p.m. shift, on /6/2022, 9/8/2022, , 9/16/2022-9/18/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on /11/2022, 9/12/2022, and orm used for ADL ervention/Tasks, ADL - 1/2022 through 9/30/2022, s which indicated the task as follows: on the 7:00 on 9/2/2022, 9/3/2022, 9/24/2022, 9/3/2022, 9/24/2022, 9/3/2022, and 9/25/2022-9/18/2022, and 9/25/2022-9/30/2022; 7:00 a.m. shift, on /11/2022, 9/12/2022, , 9/20/2022, 9/27/2022, and dimission Record (AR)," itted on with ided but were not limited to	F	842				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		315128	B. WING				02/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER			2 RICHMOND AVENUE LUMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 842	further reveals that Re and required staff ass seated to a and figure and reveals that Re and required staff ass seated to a and figure and reveals mobility and was at ris The Surveyor reviewed documented by the C shift. The DSR from N 31, 2022, revealed th A review of the DSR f documentation of Inte figure dated 5/1/20 revealed blank space was not documented a.m3:00 p.m. shift, of 5/26/2022-5/30/2022; shift, on 5/19/2022, 5/21/20 5/28/2022. A review of the DSR f documentation of Inte figure dated 5/1/20 revealed blank space was not documented a.m3:00 p.m. shift, of 5/26/2022-5/30/2022; shift, on 5/19/2022, 5/21/20 revealed blank space was not documented a.m3:00 p.m. shift, of 5/26/2022-5/30/2022; shift, on 5/19/2022, 5/21/2022 A review of the DSR f documentation of Inte	esident #7 was not steady sistance for moving from a g on surface-to-surface transfer. for sk for Adv 1, 2022, through May e following: form used for ADL ervention/Tasks, ADL - 22 through 5/31/2022, s which indicated the task as follows: on the 7:00 on 5/20/2022-5/24/2022 and c on the 3:00 p.m11:00 p.m. /20/2022, 5/28/2022, and e 11:00 p.m7:00 a.m. shift, 022, 5/23/2022, and form used for ADL ervention/Tasks, ADL - 22 through 5/31/2022, s which indicated the task as follows: on the 7:00 on 5/20/2022-5/24/2022 and c on the 3:00 p.m11:00 p.m. /20/2022, 5/28/2022, and form used for ADL ervention/Tasks, ADL - 22 through 5/31/2022, s which indicated the task as follows: on the 7:00 on 5/20/2022-5/24/2022 and c on the 3:00 p.m11:00 p.m. /20/2022, 5/28/2022, and 1:00 p.m7:00 a.m. shift, on , 5/23/2022, and 5/28/2022.	F	842			

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 10/20/2023 FORM APPROVEI IB NO. 0938-039	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION) DATE SURVEY COMPLETED	
		315128	B. WING				C 03/02/2023	
	ROVIDER OR SUPPLIER OLLY REHABILITATION	& HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIF 62 RICHMOND AVENUE LUMBERTON, NJ 08048			•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	the task was not doci 7:00 a.m3:00 p.m. s and 5/26/2022-5/30/2 p.m. shift, on 5/19/202 and 5/29/2022; and c shift, on 5/19/2022; 5 5/28/2022. A review of the DSR documentation of Inte 5/31/2022 revealed b the task was not doci 7:00 a.m3:00 p.m. s and 5/26/2022-5/30/2 p.m. shift, on 5/19/2022; and c shift, on 5/19/2022; and c f/31/2022 revealed b the task was not doci 7:00 a.m3:00 p.m. s and 5/26/2022-5/30/2 p.m. shift, on 5/19/2022; and c shift, on 5/19/2022; and c shif	umented as follows: on the shift, on 5/20/2022-5/24/2022 2022; on the 3:00 p.m11:00 22, 5/20/2022, 5/28/2022, on the 11:00 p.m7:00 a.m. /21/2022, 5/23/2022, and form used for ADL ervention/Tasks, ADL - ated 5/1/2022 through lank spaces which indicated umented as follows: on the shift, on 5/20/2022-5/24/2022 2022; on the 3:00 p.m11:00 22, 5/20/2022, 5/28/2022, on the 11:00 p.m7:00 a.m. /21/2022, 5/23/2022, and form used for ADL ervention/Tasks, ADL - ated 5/1/2022 through lank spaces which indicated umented as follows: on the shift, on 5/20/2022-5/24/2022 2022; on the 3:00 p.m11:00 22, 5/20/2022, 5/28/2022, on the 11:00 p.m7:00 a.m. /21/2022, 5/23/2022, and	F	842				

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
		315128	B. WING		0.	C 3/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/02/2023
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER		62 RICHMOND AVENUE LUMBERTON, NJ 08048		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 842	shift, on 5/19/2022, 5 5/29/2022; and the 1 5/19/2022, 5/21/2022 A review of the DSR t documentation of Inte documentation of Inte revealed blank space	/20/2022, 5/28/2022, and 1:00 p.m7:00 a.m. shift, on 2, 5/23/2022, and 5/28/2022. form used for ADL ervention/Tasks, ADL - 2022 through 5/31/2022, is which indicated the task	F 84	42		
	a.m3:00 p.m. shift, c 5/26/2022-5/30/2022; shift, on 5/19/2022, 5	as follows: on the 7:00 on 5/20/2022-5/24/2022 and ; on the 3:00 p.m11:00 p.m. /20/2022, 5/28/2022, and e 11:00 p.m7:00 a.m. shift, 022, 5/23/2022, and				
	on through 5/31/2022 re- indicated the task wa follows: on the 7:00 a 5/20/2022-5/24/2022 on the 3:00 p.m11:0	ervention/Tasks, ADL - , dated 5/1/2022 vealed blank spaces which s not documented as 3:00 p.m. shift, on and 5/26/2022-5/30/2022; 0 p.m. shift, on 5/19/2022, and 5/29/2022; and on the shift, on 5/19/2022,				
	, da 5/31/2022, revealed b the task was not docu 7:00 a.m3:00 p.m. s and 5/26/2022-5/30/2 p.m. shift, on 5/19/20 and 5/29/2022; and o	form used for ADL ervention/Tasks, ADL - ated 5/1/2022 through blank spaces which indicated umented as follows: on the shift, on 5/20/2022-5/24/2022 2022; on the 3:00 p.m11:00 22, 5/20/2022, 5/28/2022, on the 11:00 p.m7:00 a.m. /21/2022, 5/23/2022, and				

Facility ID: NJ60310

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315128	B. WING				C 102/2023
NAME OF PI	ROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER			62 RICHMOND AVENUE LUMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page 24 A review of the DSR form used for ADL documentation of Intervention/Tasks, ADL - Use, dated 5/1/2022 through 5/31/2022 revealed blank spaces which indicated the task was not documented as follows: on the 7:00 a.m3:00 p.m. shift, on 5/20/2022-5/24/2022 and 5/26/2022-5/30/2022; on the 3:00 p.m11:00 p.m. shift, on 5/19/2022, 5/20/2022, 5/28/2022, and 5/29/2022; and on the 11:00 p.m7:00 a.m. shift, on 5/19/2022, 5/21/2022, 5/23/2022, and 5/28/2022.		F	842			
	, dated 5, revealed blank space was not documented a.m3:00 p.m. shift, o 5/26/2022-5/30/2022; shift, on 5/19/2022, 5,	ervention/Tasks, ADL - (1/2022 through 5/31/2022, s which indicated the task as follows: on the 7:00 on 5/20/2022-5/24/2022 and c on the 3:00 p.m11:00 p.m. (20/2022, 5/28/2022, and e 11:00 p.m7:00 a.m. shift,					
	documented by the C	ed Resident #7's DSR NAs during their assigned lune 1, 2022, through June e following:					
	dated 6/1/20 revealed blank space was not documented a.m3:00 p.m. shift, o 6/5/2022, 6/7/2022/ 6 the 3:00 p.m11:00 p	Form used for ADL ervention/Tasks, ADL - 122 through 6/30/2022, s which indicated the task as follows: on the 7:00 on 6/2/2022, 6/4/2022, /10/2022, and 6/15/2022; on .m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022;					

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	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		(X3) DAT	O. 0938-039 E SURVEY IPLETED
	CONTECTION			G		C
		315128	B. WING			3/02/2023
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 62 RICHMOND AVENUE	Ξ	
				LUMBERTON, NJ 08048		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 842	F 842 Continued From page 25 F 842		42			
	and on the 11:00 p.m 6/1/2022, 6/2/2022, 6 6/11/2022.	ı7:00 a.m. shift, on //4/2022 - 6/6/2022, and				
	, dated 6/1/20 revealed blank space was not documented a.m3:00 p.m. shift, o 6/5/2022, 6/7/2022/ 6 the 3:00 p.m11:00 p 6/4/2022-6/12/2022, and on the 11:00 p.m.	ervention/Tasks, ADL - 22 through 6/30/2022, es which indicated the task as follows: on the 7:00 on 6/2/2022, 6/4/2022, 6/10/2022, and 6/15/2022; on o.m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022; a7:00 a.m. shift, on 6/4/2022 - 6/6/2022, and				
	documentation of Inte 6/30/2022 revealed b the task was not docu 7:00 a.m3:00 p.m. s 6/5/2022, 6/7/2022/ 6 the 3:00 p.m11:00 p 6/4/2022-6/12/2022, and on the 11:00 p.m.	ervention/Tasks, ADL - dated 6/1/2022 through lank spaces which indicated umented as follows: on the shift, on 6/2/2022, 6/4/2022, 6/10/2022, and 6/15/2022; on o.m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022;				
	A review of the DSR i documentation of Inte 6/30/2022 revealed b the task was not docu 7:00 a.m3:00 p.m. s 6/5/2022, 6/7/2022/ 6 the 3:00 p.m11:00 p	form used for ADL ervention/Tasks, ADL - dated 6/1/2022 through lank spaces which indicated umented as follows: on the shift, on 6/2/2022, 6/4/2022, 6/10/2022, and 6/15/2022; on o.m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022;				

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 10/20/202 DRM APPROVE NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		315128	B. WING				C 03/02/2023
	ROVIDER OR SUPPLIER OLLY REHABILITATION	& HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP 62 RICHMOND AVENUE LUMBERTON, NJ 08048				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 842	and on the 11:00 p.m 6/1/2022, 6/2/2022, 6 6/11/2022. A review of the DSR documentation of Inte documentation of Inte minimum of the task was not doc 7:00 a.m3:00 p.m. s 6/5/2022, 6/7/2022/ 6 the 3:00 p.m11:00 p.m 6/4/2022-6/12/2022, and on the 11:00 p.m 6/1/2022, 6/2/2022, 6 6/11/2022. A review of the DSR documentation of Inte minimum, dated 6// revealed blank space was not documented a.m3:00 p.m. shift, 6 6/5/2022, 6/7/2022/ 6 the 3:00 p.m11:00 p.m 6/1/2022. A review of the DSR documentation of Inte minimum, dated 6/1/2 commentation of Inte minimum, dated 6/1/2 revealed blank space was not documented a.m3:00 p.m. shift, 6 6/5/2022, 6/7/2022/ 6 the 3:00 p.m. shift, 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	A7:00 a.m. shift, on 6/4/2022 - 6/6/2022, and form used for ADL ervention/Tasks, ADL - ated 6/1/2022 through blank spaces which indicated umented as follows: on the shift, on 6/2/2022, 6/4/2022, 6/10/2022, and 6/15/2022; on 0.m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022; a7:00 a.m. shift, on 6/4/2022 - 6/6/2022, and form used for ADL ervention/Tasks, ADL - CNA 1/2022 through 6/30/2022 es which indicated the task as follows: on the 7:00 on 6/2/2022, 6/4/2022, 6/10/2022, and 6/15/2022; on 0.m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022; on 0.m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022; on 0.m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022; on 0.m. shift, on 6/1/2022, and	F	342			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/20/2023 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		315128	B. WING				C 1 02/2023	
	ROVIDER OR SUPPLIER OLLY REHABILITATION	& HEALTHCARE CENTER		62	IREET ADDRESS, CITY, STATE, ZIP CODE 2: RICHMOND AVENUE UMBERTON, NJ 08048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 842	and on the 11:00 p.m 6/1/2022, 6/2/2022, 6 6/11/2022. A review of the DSR t documentation of Inter of 6/1/2022 through 6/30 spaces which indicate documented as follow p.m. shift, on 6/2/202 6/7/2022/ 6/10/2022, p.m11:00 p.m. shift, 6/4/2022-6/12/2022, 6 6/11/2022, 6/2/2022, 6 6/11/2022. A review of the DSR t documentation of Inter of 30/2022 revealed b the task was not docu 7:00 a.m3:00 p.m. s 6/5/2022, 6/7/2022/ 6 the 3:00 p.m11:00 p. 6/4/2022-6/12/2022, 6 ch11/2022. A review of the DSR t documentation of Inter of 300 p.m. s 6/5/2022, 6/2/2022, 6 ch11/2022. A review of the DSR t documentation of Inter of 300 p.m. s 6/1/2022. A review of the DSR t documentation of Inter of 300 p.m. s 6/1/2022. A review of the DSR t documentation of Inter of 300 p.m. s f f documentation of Inter of 300 p.m. s f f documented as follow p.m. shift, on 6/2/202	7:00 a.m. shift, on //4/2022 - 6/6/2022, and form used for ADL ervention/Tasks, ADL - on 1 , dated 0/2022 revealed blank ed the task was not vs: on the 7:00 a.m3:00 2, 6/4/2022, 6/5/2022, and 6/15/2022; on the 3:00 on 6/1/2022, 6/14/2022, and 6/15/2022; 7:00 a.m. shift, on //4/2022 - 6/6/2022, and form used for ADL ervention/Tasks, ADL - ated 6/1/2022 through lank spaces which indicated umented as follows: on the shift, on 6/2/2022, 6/4/2022, 6/14/2022, and 6/15/2022; 7:00 a.m. shift, on m. shift, on 6/1/2022, 6/14/2022, and 6/15/2022; 7:00 a.m. shift, on form used for ADL ervention/Tasks, ADL - 1 , and 6/15/2022; 7:00 a.m. shift, on form used for ADL ervention/Tasks, ADL - 1 , and 6/15/2022; 7:00 a.m. shift, on form used for ADL ervention/Tasks, ADL - 1 , and 6/15/2022; 7:00 a.m. shift, on form used for ADL ervention/Tasks, ADL - 1 , and 6/15/2022; and 6/15/2022; on the 3:00	F	842				

Facility ID: NJ60310

If continuation sheet Page 28 of 31

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/20/2023 MAPPROVED O. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY PLETED	
		315128	B. WING			C 6/ 02/2023	
	ROVIDER OR SUPPLIER OLLY REHABILITATION	& HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 62 RICHMOND AVENUE LUMBERTON, NJ 08048			00/02/2020	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 842	6/4/2022-6/12/2022, and on the 11:00 p.m 6/1/2022, 6/2/2022, 6 6/11/2022. A review of the DSR documentation of Inte management (a.m3:00 p.m. shift, 6 6/5/2022, 6/7/2022/ the 3:00 p.m11:00 p 6/4/2022-6/12/2022, and on the 11:00 p.m 6/1/2022, 6/2/2022, 6 6/11/2022. During an interview of CNA #1, in the prese there are gaps in the it means that the wor forgot to document of During an interview of CNA #2, in the prese she documents in the blank without initials, During an interview of CNA #3 stated that n documents their work During an interview of the Licensed Practica CNAs should round a residents at least even their assigned patien	6/14/2022, and 6/15/2022; a7:00 a.m. shift, on 6/4/2022 - 6/6/2022, and form used for ADL ervention/Tasks, ADL - /1/2022 through 6/30/2022, as which indicated the task as follows: on the 7:00 on 6/2/2022, 6/4/2022, 6/10/2022, and 6/15/2022; a7:00 a.m. shift, on 6/14/2022, and 6/15/2022; a7:00 a.m. shift, on 6/4/2022 - 6/6/2022, and on 2/23/2022 at 3:10 p.m., nce of CNA #2, stated that if documentation, sometimes k was done and the CNA r that the work was not done. on 2/23/2022 at 3:10 p.m., nce of CNA #1, stated that e computer, and if the slot is it was not done. on 2/23/2023 at 3:15 p.m., ot everyone [CNAs] a because "they forget." on 2/22/2022 at 11:25 a.m., al Nurse (LPN) stated that and see their assigned ery two hours. After they do	F 84	2			

Facility ID: NJ60310

If continuation sheet Page 29 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	
		315128	B. WING				02/2023
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER			2 RICHMOND AVENUE .UMBERTON, NJ 08048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	done if it is not docum During an interview o the Director of Nursin CNAs sometimes dor don't know the passw she fired two CNAs ye their tasks. If there is they should put a cod to write a note. A review of Resident medical records did n outcomes as a result documented. Resider longer at the facility. A review of the undate "Charting and Docum Statement," included: Resident, progress to any changes in the R functional or psychos documented in the Re Under "Policy Interpre- included: "2. The folic documented in the re c. Treatments or serv Certified nursing assis the Resident's medica care tasks and activiti documented in the PO location as determine A review of the undate "Activities of Daily Liv under "Policy Stateme	don't know if the task was hented. n 2/23/2022 at 12:05 p.m., g (DON) stated that agency n't document because they yord to the POC. She said esterday for refusing to do a gap in the documentation, le for refusal or tell the nurse #2 and Resident #7's not reveal any adverse of the ADLs not being nt #2 and Resident #7 are no ed facility policy titled tentation," under "Policy "All services provided to the ward the care plan goals, or esident's medical, physical, ocial condition shall be esident's medical record." etation and Implementation," owing information is to be sident medical record: [] ices performed. [] 5. stants may make entries in al record related to resident ies of daily living, which are DC module and/or other eta by the director of nursing."	F	842			
	A review of the undate "Activities of Daily Liv under "Policy Stateme	ed by the director of nursing." ed facility policy titled: ing, (ADLs), Supporting"					

Facility ID: NJ60310

If continuation sheet Page 30 of 31

CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE			FORM	0: 10/20/2023 MAPPROVED 0: 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				
		315128	B. WING		_		C 02/2023
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST 2 RICHMOND AVENUE	ATE, ZIP CODE		
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CENTER		UMBERTON, NJ 0804	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	carry out activities of Residents who are un daily living independene necessary to maintain and personal and ora Interpretation and Imp Resident's ability to presupport provided during resident-specific tasks shift by Certified Nursing medical record (i.e. Presuppose of Your Job primary purpose of Your Job p	in or improve their ability to daily living (ADLs). nable to carry out activities of ently will receive the services in good nutrition, grooming I hygiene." Under "Policy blementation: [] 3. The articipate in ADL's and the ng ADL care and s will be documented each sing Assistants in the OC)." ed facility document titled sistant" job description under Position" included: "The bur job position is to provide d residents with routine daily vices in accordance with the it and care plan, and as may upervisors." Under "Personal ns" included: "Assist ental and mouth care, [] bath functions (i.e. bed bath, tc.) as directed. [] Assist ag/undressing as necessary. ry (i.e., change gown, then it becomes wet or esident with bowel and ., take to bathroom, offer le commode, etc.). [] dents clean and dry. [] ing, moving, positioning, dents into and out of beds,	F 842		JEFICIENCY)		

Facility ID: NJ60310

If continuation sheet Page 31 of 31

New Jersey Department of Health						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						`
		00040	B. WING		С	
		60310	D. WING		03/0	02/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
				,		
MOUNT H	OLLY REHABILITATION	& HEALTHCARE CE				
		LUMBERT	ON, NJ 08048			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORTORT	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	DATE
				,		
S 000	Initial Comments		S 000			
		NOT IN COMPLIANCE				
		RDS IN THE NEW JERSEY				
		ODE, CHAPTER 8:39,				
	STANDARDS FOR L	ICENSURE OF LONG				
	TERM CARE FACILI	TIES. THE FACILITY MUST				
	SUBMIT A PLAN OF	CORRECTION,				
	INCLUDING A COMF	PLETION DATE, FOR EACH				
	DEFICIENCY AND E	NSURE THAT THE PLAN IS				
	IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE					
	WITH THE PROVISION					
		RATIVE CODE, TITLE 8,				
	CHAPTER 43E, ENF					
	LICENSURE REGUL	LATIONS.				
S 560	8:39-5.1(a) Mandator	ry Access to Care	S 560			4/5/23
		-				
	(a) The facility shall c	comply with applicable				
	Federal, State, and lo					
	regulations.	, , , , , , ,				
	rogulationo.					
		Γ is not met as evidenced				
				No residents were offected by not		
	COMPLAINT #: NJ15	55889, NJ 157751		-No residents were affected by not		
				meeting the State of New Jersey minir	num	
				staffing requirements.		
				-All residents could be affected by this		
	-	ument review on 2/24/2023,		area of concern.		
		2023, it was determined that		-Recruitment efforts continue to includ	e:	
		nsure staffing ratios were		-Daily Staffing meetings		
	met to maintain the re	equired minimum		-Care Champion mentor program	to	
		as mandated by the State of		support retention		
		staffing for 25 of 28 day		-Culture committee to improve and	ł	
	shifts, and for 14 of 2			maintain staff morale		
	required 1/2 CNAs.			-Recruitment Bonus and Sign-On		
				Bonuses offered		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

New Jersey Department of Health

TITLE

(X6) DATE

03/28/23

STATE FORM

Electronically Signed

6899

If continuation sheet 1 of 4

New Jers	ey Department of Hea	Ith				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		60310	B. WING		C 03/0	; 2/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
MOUNT		62 RICHMO	OND AVENUE			
MOUNTH	OLLY REHABILITATION	& HEALTHCARE CE	ON, NJ 08048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S 560	Continued From page	e 1	S 560			
S 560	Reference: New Jers (NJDOH) memo, date with N.J.S.A. (New Je 30:13-18, new minim nursing homes," indic Governor signed into codified at N.J.S.A. 3 established minimum nursing homes. The f effective on 02/01/202 One Certified Nurse A residents for the day member to every 10 r shift, provided that no members shall be sign nurse aide and shall p and One direct care s residents for the nigh direct care staff mem CNA and perform CN DAY SHIFT 08/21/2022 Dayshift (residents. Staffing sh 08/23/2022 Dayshift (residents. Staffing sh 08/24/2022 Dayshift (residents. Staffing sh 08/24/2022 Dayshift (residents. Staffing sh	ey Department of Health ed 01/28/2021, "Compliance ersey Statutes Annotated) um staffing requirements for cated the New Jersey law P.L. 2020 c 112, 0:13-18 (the Act), which staffing requirements in ollowing ratio(s) were 21: Aide (CNA) to every eight shift. One direct care staff residents for the evening of ewer than half of all staff IAs, and each direct staff ed in to work as a certified perform nurse aide duties; staff member to every 14 t shift, provided that each ber shall sign in to work as a A duties. CNA Staff was 10 for 115 nould have been 14 CNA Staff was 12 for 111 nould have been 14 CNA Staff was 12 for 111	S 560	-Utilizing outside staffing agencies fulfill staffing needs -Orientation Classes -Prize raffles for staff picking up sh -Daily interviews being scheduled conducted -Director of Nursing will monitor staffir daily for 1 week, weekly for 3 weeks, a monthly for 3 months to maintain ongo compliance. The Director of Nursing w report the results to the Quality Initiative committee. The Quality Initiative committee consists of the Administrato Director of Nursing and the Medical Director.	hifts and g and bing vill ve	
	residents. Staffing sh	CNA Staff was 7 for 111 nould have been 14 CNA Staff was 8 for 105				

New Jersey Department of Health

FH7V11

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE COM			E SURVEY PLETED
			A. BUILDING:			0
		60310	B. WING		03	C 6/ 02/2023
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, 2	ZIP CODE		
IOUNT HO	OLLY REHABILITATION	& HEALTHCARE CE	MOND AVENUE RTON, NJ 08048			
(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 DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 560	Continued From page	e 2	S 560			
	residents. Staffing sh					
	-	CNA Staff was 11 for 105				
	residents. Staffing sh	rould have been 13 CNA Staff was 10 for 105				
	residents. Staffing sh					
	-	CNA Staff was 12 for 105				
	residents. Staffing sh					
		CNA Staff was 11 for 109				
	residents. Staffing sh	rould have been 14 CNA Staff was 11 for 141				
	residents. Staffing st					
		CNA Staff was 12 for 141				
	residents. Staffing sl					
		CNA Staff was 14 for 141				
	residents. Staffing sh					
	residents. Staffing st	CNA Staff was 14 for 141				
	-	CNA Staff was 12 for 141				
	residents. Staffing sh					
		CNA Staff was 11 for 143				
	residents. Staffing sh					
	-	CNA Staff was 11 for 145				
	residents. Staffing sh	CNA Staff was 7 for 144				
	residents. Staffing sh					
	-	CNA Staff was 14 for 141				
	residents. Staffing sh					
		CNA Staff was 12 for 141				
	residents. Staffing sh					
	residents. Staffing st	CNA Staff was 13 for 141				
		CNA Staff was 13 for 141				
	residents. Staffing sh					
		CNA Staff was 13 for 141				
	residents. Staffing sh					
	-	CNA Staff was 12 for 143				
	residents. Staffing sh	nouid have been 18				

FH7V11

STATEMEN	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		60310	B. WING		03/02/2023	
AME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE		
IOUNT H	OLLY REHABILITATION	& HEALTHCARE CE	MOND AVENUE RTON, NJ 08048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET E DATE	
S 560	Continued From pag	e 3	S 560			
	CNAs as follows:					
	residents. Staffing si 08/29/2022 Evening residents. Staffing si 09/03/2022 Evening residents. Staffing si 09/03/2022 Evening residents. Staffing si 02/05/2023 Evening residents. Staffing si 02/10/2023 Evening residents. Staffing si 02/11/2023 Evening residents. Staffing si 02/12/2023 Evening residents. Staffing si 02/12/2023 Evening residents. Staffing si 02/13/2023 Evening residents. Staffing si 02/14/2023 Evening residents. Staffing si 02/16/2023 Evening residents. Staffing si 02/16/2023 Evening residents. Staffing si 02/17/2023 Evening residents. Staffing si 02/17/2023 Evening residents. Staffing si 02/17/2023 Evening residents. Staffing si	CNA Staff was 9 for 105 hould have been 11 CNA Staff was 9 for 105 hould have been 11 CNA Staff was 11 for 109 hould have been 12 CNA Staff was 7 for 141 hould have been 11 CNA Staff was 13 for 141 hould have been 14 CNA Staff was 7 for 143 hould have been 11 CNA Staff was 9 for 145 hould have been 10 CNA Staff was 8 for 144 hould have been 10 CNA Staff was 8 for 144 hould have been 10 CNA Staff was 8 for 141 hould have been 12 CNA Staff was 9 for 141 hould have been 12 CNA Staff was 9 for 141 hould have been 11 CNA Staff was 8 for 141 hould have been 13 CNA Staff was 7 for 143				

FH7V11

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
60310 _{Y1}	B. Wing	Y2	4/18/2023	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
MOUNT HOLLY REHABILITATION	& HEALTHCARE CENTER	62 RICHMOND AVENUE				
		LUMBERTON, NJ 08048				

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		DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix	S0560	Correction	ID Prefix	Correctio	n ID Prefix	Correction
Reg. #	8:39-5.1(a)	Completed	Reg. #	Complete	ed Reg. #	Completed
LSC		04/12/2023	LSC		LSC	
ID Prefix		Correction	ID Prefix	Correctio	n ID Prefix	Correction
Reg. #		Completed	Reg. #	Complete		Completed
LSC					LSC	
ID Prefix		Correction	ID Prefix	Correctio	n ID Prefix	Correction
Reg. #		Completed	Reg. #	Complete	ed Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correctio	n ID Prefix	Correction
Reg. #		Completed	Reg. #	Complete	ed Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correctio	n ID Prefix	Correction
Reg. #		Completed	Reg. #	Complete	ed Reg. #	Completed
LSC			LSC		LSC	
REVIEWED BY REVIEWED BY STATE AGENCY (INITIALS)		DATE SIGNATURE OF SURVEYOR		DATE		
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/2/2023			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			