STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315128	A. BUILDING _____ B. WING _____	C 05/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT HOLLY REHABILITATION & HEALTHCARE CENTER	62 RICHMOND AVENUE LUMBERTON, NJ 08048

(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
F 000	INITIAL COMMENTS STANDARD SURVEY: Recertification and Complaint CENSUS: 134 SAMPLE: 33 COMPLAINT INTAKE #: NJ155663, NJ155981, NJ156513, NJ157738, NJ157504, and NJ157408 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure 1 (Resident #56) of 7 sampled residents reviewed for nutrition received [redacted] per the physician's orders. During the survey, Resident #56, a resident assessed to be at risk for [redacted] was ordered [redacted]. On [redacted] at 1:13 PM, Resident #56 was provided a glass of [redacted]. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death of residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.60 (Food and Nutrition Services) at a scope and severity of "J."	F 000		

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

Electronically Signed | 06/17/2023

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F 000	Continued From page 1 The IJ began on 05/17/2023 at 1:13 PM, when Resident #56 was not provided thickened liquids. The Administrator and the Regional Director of Clinical Services were notified of the IJ and provided the IJ Template on 05/19/2023 at 2:54 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 05/20/2023 at 5:23 PM. The IJ was removed on 05/20/2023 at 8:25 PM, after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance for F808 remained at the lower scope and severity of isolated potential for harm that was not immediate jeopardy related to the potential for aspiration by Resident #56.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, it was determined that the facility failed to ensure that 1 (Resident #57) of 1 sampled resident reviewed for self-administration of medication was assessed prior to the self-administration of albuterol nebulizing treatment. Findings included: Review of an undated facility policy titled, "Self-Administration of Medications," revealed, "Residents have the right to self-administer	F 554	R57 was evaluated and had no ill effect from the unsupervised administration of the nebulizer treatment. A comprehensive review of incidents was completed by the DON with a look-back period of [redacted] Due to the type of medication that was being administered, a nurse is required at all times to be present during the duration of this medication, the patient is not eligible to self-administer this medication. All residents have the potential to be affected by this practice. An audit was	6/27/23

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F 554	Continued From page 2 medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident." The policy further indicated, "3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan." A review of Resident #57's "Admission Record" revealed the facility admitted the resident on [redacted] with diagnoses that included chronic [redacted] The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. Review of Resident #57's comprehensive care plans revealed a care plan initiated [redacted] that indicated the resident was at risk for altered respiratory status related to a diagnosis of [redacted] This care plan directed staff to administer [redacted] treatments and [redacted] as ordered and to monitor for effectiveness and side effects. The care plan did not indicate the resident was assessed to self-administer any of their medications.	F 554	completed by DON to determine residents who are self-administrating medications to assure that policy Self Administration of Medication has been followed. Any missing steps have been addressed. To prevent the deficient practice from re-occurrence; The Director of Nursing or designee provided education on our policy and procedure “self-administration of medication” to nursing staff. Emphasis was placed on all types of medication including [redacted] treatments and why it is important for nurses to be present all times for the full duration of the treatment. Director of Nursing or designee will audit self-administration of medication process 5 times a weekly X 4 weeks, weekly X 4 week and monthly 3 months to assure compliance with process. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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F 554	Continued From page 3	F 554		

A review of Resident #57's "Order Summary Report," revealed an order, dated [redacted], for [redacted] by way of [redacted] every [redacted] hours as needed for [redacted]

During an observation on 05/16/2023 at 1:38 PM, Resident #57 sat on their bed in their room with a [redacted] in the on position, on the bedside table. Resident #57 had the [redacted], administering the [redacted] treatment. Resident #57 indicated they administered the [redacted] treatment themself daily. Resident #57 stated the nurse brought the [redacted] into their room, turned the machine on, left the room for [redacted] minutes, and then came back after the treatment was completed. There was no nurse present in Resident #57's room or in the hallway. The surveyor left Resident #57's room and found Licensed Practical Nurse (LPN) #1 on another hallway at the medication cart.

During an interview on 05/16/2023 at 1:43 PM, LPN #1 stated the normal process was to bring the [redacted] treatment into the room, turn the machine on, then leave the room and come back to the room after the n[redacted] treatment was finished. LPN #1 agreed the [redacted] was a medication. She stated she did not know if Resident #57 had an assessment to self-administer their [redacted] because she normally took it in the room, let Resident #57 self-administer, and came back to check on Resident #57 when the treatment was completed. LPN #1 stated she expected safe medication administration practices.

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F 554	Continued From page 4 During an interview on 05/18/2023 at 3:45 PM, the Director of Nursing (DON) stated she expected the nurse to stay in the room because [redacted] was considered a medication, and Resident #57 did not have an assessment to self-administer the medication. She stated LPN #1 should not allow Resident #57 to administer the nebulizer treatment by themself. The DON stated she expected nurses to follow safe medication administration practices. During an interview on 05/19/2023 at 12:51 PM, the Administrator stated she considered [redacted] a medication, and LPN #1 should have stayed in the room with Resident #57 during the administration of the [redacted] treatment. The Administrator stated she was not sure if Resident #57 had an assessment to self-administer medications. Per the Administrator, for a resident to self-administer, the facility must obtain a physician's order, complete an assessment, and provide education to the resident. According to the Administrator, she expected nurses to follow safe medication administration practices. New Jersey Administrative Code § 8:39-29.2(c) (1-6)	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		6/27/23

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F 580	Continued From page 5	F 580		

physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 6 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review the facility failed to ensure the physician was timely notified of a change in condition for 1 (Resident #19) of 2 sampled residents reviewed for a change in condition. Specifically, the facility failed to timely notify the physician after staff noted Resident #19 experienced [redacted] on [redacted]. Findings included : Review of a facility policy titled, "Change in a Resident's Condition or Preferences," dated January 2022, revealed, "Our staff promptly notified the resident, the resident representatives, and his or her healthcare professionals and staff, of changes in the resident's medical/mental condition and/or preferences. 1. The licensed nurse will notify the resident's primary care provider when there has been a(an): a. significant change in the resident's health, functional, or psychosocial condition." The policy indicated, "6. Except in medical emergencies, notifications will be made within twenty-four (24) hours of determination of a significant change in the resident's health, functional, or psychosocial conditions." A review of an "Admission Record" indicated the facility admitted Resident #19 on [redacted] with diagnoses that included type [redacted] The quarterly Minimum Data Set (MDS), with an	F 580	R19 was scheduled for a follow-up appointment for [redacted] to evaluate bloody urine as per physician's request. Appointment was scheduled for [redacted] The [redacted] of R19 was notified and made aware of this appointment. On [redacted] of R19 called [redacted] and cancelled this appointment. The physician was made aware of the cancellation of the appointment. All residents with a change in condition have the potential to be affected for this practice. DON completed an audit of all notes in the past 72 hours to identify any changes in condition and to assure that all physicians were notified. The DON/ADON will re-educate all nurses and unit clerks on the change in condition and notification of providers. The Don/designee will review all progress notes to identify change in condition and to assure all physicians are notified daily x5 and weekly x4 and monthly x3 to ensure any patients with a Change in Conditions are appropriately documented and addressed accordingly. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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F 580	Continued From page 7	F 580		

Assessment Reference Date (ARD) of [redacted], revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted] The MDS indicated the resident required limited assistance with toilet use and was frequently [redacted] and [redacted]

Review of Resident #19's care plan initiated [redacted] indicated the resident had [redacted] related to [redacted] and a diagnosis of [redacted] Interventions included revealed the resident used [redacted] and for staff to check the resident as required for [redacted]

Review of Resident #19's" Health Status Note, dated [redacted] at 6:32 AM, indicated a nursing aide assigned to the resident reported Resident #19's [redacted] during activities of daily living (ADL) care.

Review of Resident #19's "Health Status Note," dated [redacted] at 7:25 AM, indicated while morning care was provided by a nursing assistant, the patient had some [redacted] Per the note, the assessment revealed the resident was stable, there was no [redacted], and the incoming supervisor and floor nurse were notified.

A review of Resident #19's "Health Status Note," dated [redacted] at 1:45 PM, indicated a urology appointment was scheduled for the resident to follow up on the resident's [redacted]. The note revealed on [redacted] a certified nursing assistant noted a small amount of [redacted]

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F 580	Continued From page 8 [redacted] in the resident's [redacted]. Per the note, the resident's case would be discussed with Medical Doctor (MD) #19 for further direction. During an interview on 05/18/2023 at 3:28 PM, MD #19 indicated staff should have notified him before [redacted] to discuss Resident #19's continued [redacted], a plan for treatment, and whether a [redacted] appointment would benefit the resident.	F 580		
F 609 SS=D	New Jersey Administrative Code § 8:39-13.1(d) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		6/27/23

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F 609	Continued From page 9 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to report an allegation of misappropriation of resident property to the state licensing/certification agency within 24-hours for 1 (Resident #228) of 3 sampled residents reviewed for abuse. Findings included: Review of a facility policy titled, "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating," revised September 2022, revealed, "All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities I. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility." The policy further indicated, "3. "Immediately" is defined as: a. within two hours of an allegation	F 609	R228 no longer resides at the facility. An event report was completed for the missing [redacted] to the Department of Health on 5.17.23 at 1200. A comprehensive review of incidents was completed by the DON/NHA with a look-back period of [redacted] current for misappropriation of funds to ensure appropriate reports were completed. To prevent the deficient practice from re-occurrence; the NHA/designee will educate the interdisciplinary team on the “Abuse, Neglect, Exploitation or Misappropriation” and the “How to Conduct an Investigation - 3 steps” and “Focus on F-tag 609” on or before the date of compliance. The NHA/designee will audit incident reports and investigations weekly x4 weeks to ensure all allegations of abuse/neglect/misappropriation origin are reported timely. Results will be reviewed with QA&A.	

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F 609	Continued From page 10	F 609		

involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury."

A review of an "Admission Record" indicated the facility admitted Resident #228 on [redacted] with diagnoses to include [redacted].

The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted] indicated Resident #228 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted].

Review of the "Grievance Summaries," for Resident #228 dated [redacted], revealed a family member of the resident came to the facility to collect Resident #228's belongings and when they opened a personal belonging of the resident's, [redacted] was missing.

Review of a typed statement from the Social Services Director dated [redacted] indicated a family member of Resident #228 accused staff of taking [redacted] out of Resident #228's wallet.

During an interview with the Administrator on 05/17/2023 at 12:02 PM, she stated when the grievance related to Resident #228 was requested on [redacted], she realized the allegation had not been reported to the state licensing/certification agency, so she made a report on [redacted].

Review of the "LTC Reportable Event Survey," dated [redacted], indicated the facility notified the state licensing/certification agency of an allegation of misappropriation of resident property

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F 609	Continued From page 11 related to Resident #228's missing [redacted]	F 609		
F 644 SS=D	New Jersey Administrative Code § 8:39-5.1(a) Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review it was determined that the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) was updated for 2 (Resident #61 and Resident #69) of 3 sampled residents reviewed for PASARRs who had new diagnoses of [redacted] Findings included: Review of an undated facility policy titled,	F 644	R61 and R69 both still reside at the facility. Neither resident had any ill effect from the PASSR not being updated. PASSARs have been updated. All residents can be affected by this deficient practice. The Vice President of Care Navigation audited all resident files to assure that residents with new diagnosis of serious mental disorder had an updated PASARR.	6/27/23

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(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
F 644	Continued From page 12 "Admission Criteria," revealed "9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process." The policy did not address updating the PASARR for a newly evident or possible serious mental disorder. 1. A review of an "Admission Record," indicated the facility admitted Resident #61 on [redacted] with a diagnosis that included an [redacted] due to a known [redacted]. According to the admission record, [redacted] were added on [redacted] A review of "Med [Medication] Management Note," dated [redacted], indicated Resident #61 had diagnoses of [redacted] and [redacted] and was seen by a physician for medication management. A review of "Med Management Note," dated [redacted], indicated Resident #61 had a diagnosis of [redacted] and was seen by a physician for medication management. A review of Resident #61's comprehensive care plans revealed a care plan initiated [redacted] that indicated the resident took [redacted] medication related to a diagnosis of [redacted]. Another care plan initiated [redacted], indicated Resident #61 took [redacted] medication related to a diagnosis of [redacted]. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted] revealed Resident #61 had a Brief	F 644	The Vice President of Care Navigation re-educated the Director of Social Services on the process for all Social Workers to ensure timely and appropriate completion and updates of PASSR as directed by state and CMS regulations. The NHA/designee will audit the Coordination of PASSRs and Assessments Daily x5 weekly x4 and monthly X 3 to ensure all PASSRs needing corrections/changes are implemented timely. . Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director	

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	315128	A. BUILDING _____ B. WING _____	C 05/20/2023

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F 644	Continued From page 13 Interview for Mental Status (BIMS) score of [redacted], which indicated Resident #61 was [redacted]. The MDS indicated Resident #61 had active diagnoses to include [redacted]. Further review of the MDS, revealed the resident received [redacted], and [redacted] medications. A review of Resident #61's "Pre-Admission Screening and Resident Review Level 1 Screen," dated [redacted], indicated Resident #61 had diagnoses of [redacted]. The resident's diagnosis of [redacted] was not listed on the PASARR. 2. A review of an "Admission Record," indicated the facility admitted Resident #69 on [redacted] with diagnoses to include [redacted]. According to the admission record, diagnoses of [redacted] were added on [redacted] A review of Resident #69's "Pre-Admission Screening and Resident Review Level 1 Screen," dated [redacted] indicated Resident #69 had a diagnosis of [redacted]. The resident's diagnosis of [redacted] was not listed on the PASARR. A review of Resident #69's comprehensive care plans revealed a care plan initiated [redacted] that indicated the resident took [redacted] and [redacted] medications related to diagnoses of [redacted]. A review of "Med [Medication] Management Note," dated [redacted] indicated Resident #69	F 644		

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F 644	Continued From page 14 had a diagnosis of [redacted] and was seen by an advanced practice registered nurse for medication management. A review of quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #69 had modified [redacted] for [redacted] per the Staff Assessment for Mental Status. The MDS indicated Resident #69 had active diagnoses to include [redacted] and [redacted]. During an interview on [redacted] at 1:15 PM, the Social Services Director indicated a resident's PASARR screen should be updated with any new [redacted] diagnosis. In an interview on 05/20/2023 at 12:16 PM, the Director of Nursing stated she had nothing to do with the PASARR, that it was the responsibility of the social services department. During an interview on 05/20/2023 at 6:29 PM, the Administrator indicated the resident's PASARR should be updated by the social worker when a resident had a new [redacted] diagnosis.	F 644		
F 645 SS=D	New Jersey Administrative Code §8:39-5.1(a) PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on	F 645		6/27/23

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F 645	Continued From page 15	F 645		

or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

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F 645	Continued From page 16 (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined that the facility failed to ensure Preadmission Screening and Resident Review (PASARR) was completed accurately upon admission for 1 (Resident #58) of 3 sampled residents reviewed for PASARRs. Findings included: Review of an undated facility policy titled, "Admission Criteria," specified, "9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a	F 645	R58 still resides at the facility. Neither resident had any ill effect from the PASSR not being completed. PASSAR has since been completed. All residents can be affected by this deficient practice. The Vice President of Care Navigation audited all resident files to assure that all residents have PASSAR completed accurately upon admission. The Vice President of Care Navigation re-educated the Director of Social Services on the process for all Social Workers to ensure timely and appropriate completion and updates of	

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F 645	Continued From page 17 Level I PASAR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. b. If the Level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority." A review of an "Admission Record" indicated the facility admitted Resident #58 on [redacted] with diagnoses that included [redacted] A review of Resident #58's "Med [Medication] Management Note," dated [redacted], indicated Resident #58 had a diagnosis of [redacted] and was seen by a physician for medication management. A review of Resident #58's care plan initiated [redacted], indicated Resident #58 had a diagnosis of [redacted]. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of [redacted], revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated Resident #58 had [redacted] The MDS indicated Resident #58 had active diagnoses to include [redacted]. Further review of the MDS, revealed	F 645	PASSR as directed by state and CMS regulations. The NHA/designee will audit the Coordination of PASSRs and Assessments Daily x5 weekly x4 and monthly X 3 to ensure all PASSRs needing corrections/changes are implemented timely. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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F 645	Continued From page 18 the resident received [redacted] medication. A review of Resident #58's undated "Pre-Admission Screening and Resident Review Level I Screen" revealed Resident #58 did not have a diagnosis or evidence of a [redacted] During an interview on 05/18/2023 at 1:15 PM, the Social Services Director (SSD) indicated a PASARR should be correct upon admission. Per the SSD, if the PASARR was not correct, a request would be made to the admitting entity to redo the screening and ensure it was correct. The SSD stated Resident #58 was not on the unit where she worked when the resident was admitted, and she was not involved in Resident #58's admission process. In an interview on 05/20/2023 at 12:16 PM, the Director of Nursing stated she had nothing to do with the PASARR, that it was the responsibility of the social services department. During an interview on 05/20/2023 at 6:29 PM, the Administrator indicated the PASARR should be correct upon admission and if it was not, a request should be made for it to be corrected prior to admission.	F 645		
F 657 SS=D	New Jersey Administrative Code § 8:39-5.1(a) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		6/27/23

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F 657	Continued From page 19 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility policy review, and interviews, it was determined that the facility failed to have evidence [redacted] care plan meetings were conducted for 3 (Residents #48, #53, and #110) of 33 sampled residents. Findings included: Review of an undated facility policy titled, "Care Planning - Interdisciplinary Team," revealed, "1. Resident care plan are developed according to the timeframes and criteria established by § 483.21." Per the policy, "5. Care plan meetings are scheduled at the best time of the day for the	F 657	R48, R53 and R110 still reside at the facility. None of the residents had any ill effect from the [redacted] care plan meetings not being conducted. All three care plan meetings have been completed. All residents can be affected by this deficient practice. The Vice President of Care Navigation audited all resident files to assure that all residents [redacted] care plan meetings have been conducted. Any meeting not completed and documented has been scheduled.	

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F 657	Continued From page 20 resident and family when possible." 1. A review of an "Admission Record" indicated the facility admitted Resident #53 on [redacted] with diagnoses that included [redacted] and [redacted]. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted] revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted] A review of the quarterly MDS, with an ARD of [redacted], revealed Resident #53 had a BIMS score of [redacted] which indicated the resident had [redacted]. On 05/19/2023 at 12:30 PM, the Social Services Director (SSD) stated care plan meetings/conferences should be held [redacted]. The surveyor requested documentation of all care plan meetings for the timeframe of [redacted] through [redacted]. On 05/19/2023 at 1:05 PM, the SSD provided a "IDT [Interdisciplinary Team] Care Plan Meeting Review" for Resident #53, dated [redacted]. The SSD stated she was unable to locate documentation of any other [redacted] care plan meetings for Resident #53. 2. A review of an "Admission Record" indicated the facility admitted Resident #48 on [redacted] with diagnoses that included [redacted] of the [redacted] and [redacted]	F 657	The Director of Social Services was educated by the Vice President of Care Navigation on the process for all Social Workers to ensure timely and appropriate completion [redacted] care plan meetings as directed by state and CMS regulations. The NHA/designee will audit the completion of [redacted] care plan meetings Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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F 657	Continued From page 21 A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. A review of the quarterly MDS, with an ARD of [redacted], revealed Resident #48 had a BIMS score of [redacted], which indicated the resident was [redacted]. On 05/19/2023 at 12:30 PM, the Social Services Director (SSD) stated care plan meetings/conferences should be held [redacted] The surveyor requested documentation of all care plan meetings for the timeframe of [redacted] through [redacted] On 05/19/2023 at 1:05 PM, the SSD provided a "IDT [Interdisciplinary Team] Care Plan Meeting Review" for Resident #48, dated [redacted]. The SSD stated she was unable to locate documentation of any other [redacted] care plan meetings for Resident #48. 3. A review of an "Admission Record" indicated the facility admitted Resident #110 on [redacted] with diagnoses that included [redacted] The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/21/2023, revealed Resident #110 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted].	F 657		

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F 657	Continued From page 22 On 05/19/2023 at 12:30 PM, the Social Services Director (SSD) stated care plan meetings/conferences should be held [redacted] The surveyor requested documentation of all care plan meetings for the timeframe of [redacted] through [redacted] On 05/19/2023 at 1:05 PM, the SSD provided a "IDT [Interdisciplinary Team] Care Plan Meeting Review" for Resident #110, dated [redacted] The SSD stated she was unable to locate documentation of any other [redacted] care plan meetings for Resident #110. During an interview on 05/20/2023 at 6:42 PM, the Director of Nursing (DON) stated she expected care plan meetings to be held on a [redacted] basis.	F 657		
F 676 SS=D	New Jersey Administrative Code § 8:39-11.1 Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b)	F 676		6/27/23

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F 676	Continued From page 23 of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review and interviews, it was determined that the facility failed to provide necessary services to ensure 1 (Resident #110) of 2 sampled residents reviewed for [redacted] Specifically, Resident #110 did not speak [redacted] and the facility failed to provide [redacted] services and a [redacted] board as required by the resident's care plan. Findings included: Review of an undated facility policy titled [redacted] of Facility Services" specified "This facility's [redacted]	F 676	R110 still resides at the facility. The residents did not have any ill effect from not having a [redacted] board. A [redacted] board is now at the resident's bedside and the [redacted] is available 24 hours a day/7 day a week. All residents whose [redacted] is not [redacted] can affected by this deficient practice. The NHA audited all resident files to identify whose [redacted] is not [redacted] to assure [redacted] boards are at each bedside.	

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F 676	Continued From page 24 access programs will ensure that individuals with limited [redacted] shall have meaningful access to information and services provided by the facility." The policy indicated "9. When written translation of vital information is unavailable, or impractical, the facility shall attempt to provide oral [redacted] of vital documents. 10. Competent oral [redacted] of vital information that is not available in written translation, and non-vital information shall be provided in a timely manner and at no cost to the resident through the following means (as available to the facility) a. A staff member who is trained and competent in the skill of interpreting; b. A staff interpreter who is trained and competent in the skill of [redacted]; c. Contracted [redacted] service; d. Voluntary community [redacted] who are trained and competent in the skill of interpreting; and e. Telephone [redacted] service. 11. [redacted] and translators must be appropriately trained in trained in medical terminology, confidentiality of protected health information, and ethical issues that may arise in communicating health-related information. 12. Family members and friends shall not be relied upon to provide [redacted] services for the resident, unless explicitly requested by the resident. If family or friends are used to [redacted], the resident must provide written consent for disclosure of protected health information. 13. It is understood that providing meaningful access to services provided by this facility requires also that the LEP resident's needs and questions are accurately communicated to the staff. Oral [redacted] services therefore include interpretation from the LEP resident's [redacted] back to [redacted]. 14. It is understood that in order to provide meaningful access to services provided by this facility,	F 676	The NHA will re-educate all staff as it relates to the Translation and/or [redacted] of Facility Service policy. This policy includes [redacted] services. The NHA/designee will audit to ensure that [redacted] services are available to all residents whose primary language is not [redacted] Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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	315128	A. BUILDING _____ B. WING _____	C 05/20/2023

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F 676	Continued From page 25 [redacted] and/or [redacted] must be provided in a way that is culturally relevant and appropriate to the [redacted] individual." A review of an "Admission Record" indicated that the facility admitted Resident #110 on [redacted] with diagnoses that included [redacted], and [redacted] The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #110 had a Brief Interview for Mental Status (BIMS) of 9, which indicated the resident had [redacted]. According to the MDS, the resident's primary language was [redacted] and Resident #110 needed or wanted an [redacted] to communicate with a doctor or health care staff. Review of Resident #110's care plan initiated on [redacted], revealed the resident required the services of an [redacted] because their primary language was not [redacted]. Per the care plan, the resident's [redacted] was [redacted] The goals were for the resident to be able to communicate adequately with the care team and for the resident's needs to be met. The care plan directed staff to provide a [redacted] board with common words in [redacted] and the resident's [redacted] to aid in [redacted] for simple daily needs. The care plan also directed staff to use the language line (phone service) as needed to provide adequate [redacted] with the Resident #110. An observation on 05/16/2023 at 3:12 PM, revealed Resident #110 did not speak [redacted]	F 676		

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F 676	Continued From page 26	F 676		

The surveyor was unable to [redacted] with the resident.

An interview with Certified Nursing Assistant (CNA) #3 on 05/18/2023 at 11:22 AM, revealed the facility did not have a way to translate for Resident #110. CNA #3 stated that it had to be a struggle for Resident #110 and there needed to be a better way to [redacted] with the resident. The CNA stated a [redacted] chart would be helpful for this resident.

In an interview on 05/18/2023 at 1:55 PM, Licensed Practical Nurse (LPN) #14 stated Resident #110 was able to understand more [redacted] than the resident was able to speak. LPN #14 stated the resident spoke [redacted]. According to LPN #14, a phone application used for [redacted] did not work for this resident.

The Social Services Director (SSD) was interviewed on 05/18/2023 at 3:14 PM. The SSD stated Resident #110 was able to take care of their personal needs with little supervision. The SSD stated Resident #110 understood [redacted]" and was able to [redacted] to things to help staff understand their needs. The SSD stated an interpreter phone line was available and a [redacted] board was provided to Resident #110 on admission to the facility.

In an interview on 05/18/2023 at 3:36 PM, CNA #5 stated she had worked at the facility since [redacted]. She stated Resident #110 pointed to items as needed and it had been difficult at times to [redacted] with the resident. CNA #5 stated if staff was unable to determine the resident's needs, staff called the resident's family member. CNA #5 stated there

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F 676	Continued From page 27 was not a [redacted] board available for Resident #110. During an interview on 05/19/2023 at 3:20 PM, LPN #32 stated Resident #110 understood some things and could ask for coffee or medication. LPN #32 stated Resident #110 did not have a [redacted] board. The LPN stated, if necessary, the unit manager would call the resident's family to help with translation. In an interview on 05/19/2023 at 3:56 PM, Registered Nurse (RN) #20, a unit manager stated there had not been a situation where the staff could not meet Resident #110's needs. RN #20 stated the resident had a [redacted] board and staff were able to [redacted] with Resident #110 to provide for the resident's needs. In an interview on 05/20/2023 at 5:30 PM, CNA #33 stated she had never seen a [redacted] board for Resident #110. According to CNA #33, when Resident #110 activated the call light, the resident pointed to what they wanted the CNA to do. During an interview on 05/20/2023 at 5:33 PM, LPN #21 stated she gave medication to Resident # 110 but did not have a conversation with the resident. In an interview on 05/20/2023 at 5:34 PM, CNA #34 stated Resident #110 was able to [redacted] to things, but she had never seen a [redacted] board for Resident #110. On 05/20/2023 at 6:10 PM, RN #20 informed the surveyor that there was a [redacted] paper, used for communication, in the drawer of Resident	F 676		

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F 676	Continued From page 28 #110's room. During an interview on 05/20/2023 at 7:09 PM, the Administrator stated Resident #110 was able to signal for help with staff and get what they needed. Per the Administrator, a [redacted] was also available to call if needed.	F 676		
F 689 SS=G	New Jersey Administrative Code § 8:39-13.3(b) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to ensure 1 (Resident #17) of 4 sampled residents reviewed for accidents was provided assistance with transfers. Specifically, on [redacted], Resident #17 was found on the floor after they attempted to transfer themself due to a lack of staff available to assist the resident back to bed. Resident #17 sustained a [redacted] that required [redacted]. Findings included: Review of an undated facility policy titled, "Falls and Fall Risk, Managing," indicated, "Based on previous evaluations and current data, the staff	F 689	R17 still resides at the facility. The resident who had sustained [redacted] during the [redacted] has healed and is now back to baseline. The following intervention was added to the residents plan of care: I am unable to transfer myself to bed. Most nights I like to be in bed by 8 pm. If I am in bed and [redacted], ask me if I want to get OOB. Place me in a chair and ask every hour if I want to return to bed. All residents needing assistance with transfers have the potential to be affected by this deficient practice. DON audited all residents level of transfer assistance needed and care plans to assure care	6/27/23

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F 689	Continued From page 29 will identify interventions related to the resident's specific risks and causes to try to prevent the resident from [redacted] and to try to minimize complications from [redacted] Review of an "Admission Record" indicated the facility admitted Resident #17 on [redacted] with diagnoses that included [redacted], and gout. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated Resident #17 had [redacted]. The MDS indicated Resident #17 required [redacted] with [redacted]. The MDS indicated Resident #17 was not steady and only able to stabilize with staff assistance when moving from seated to standing position and during surface-to-surface transfers. Review of Resident #17's care plan, with an initiation date of [redacted], revealed Resident #17 was at [redacted] due to [redacted] and [redacted], and [redacted]. Interventions directed staff to anticipate and meet the resident's needs, provide hands on assistance when the resident moved from place to place, and encourage the resident to use the call lights to request assistance. A review of Resident #17's "Health Status Note," dated [redacted] at 11:15 PM, revealed Resident #17 was in a [redacted] and attempted to ambulate back to bed. Per the note, the resident was found [redacted] on the floor, [redacted] from their [redacted]. The note indicated the resident was sent to the hospital emergency department.	F 689	plan and kardex match the needs of the patient. The Director of Nursing re-educated all nurses and CNAs on resident individual level of transfer needed. The Education included when and how to obtain additional assistance with transfers as needed. The DON/designee will audit all new transfer orders to assure that all nurses and CNAs are aware of resident individual levels of transfer and assistance needed for each daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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F 689	Continued From page 30 A review of Resident #17's "Health Status Note," dated [redacted] at 11:48 PM, written by Registered Nurse (RN) #40, revealed Resident #17 was found on the [redacted] at 11:05 PM between the [redacted] of their [redacted] and their [redacted]. Per the note, Resident #17 had a [redacted] on their [redacted] A review of Resident #17's "Full QA [Quality Assurance] Report," dated [redacted] revealed Resident #17 had [redacted] and was found on the [redacted] with their [redacted] and [redacted] on the floor around 11:00 PM. The report indicated the resident [redacted] that required [redacted]. The report indicated Resident #17 "attempted to [redacted] and f[redacted] The report indicated a causal and contributing factors to the [redacted] was that the resident "wanted to get into bed and cna [certified nursing assistant] was with another patient." The report indicated the root cause of the [redacted] was "[Resident #17] was out of [the resident's] routine and became [redacted] [sic] and attempted to [redacted] and [redacted] During an interview with RN #40 on 05/19/2023 at 4:07 PM, she stated Resident #17 was found on the floor between their [redacted] and [redacted]. Per RN #40, Resident #17 wanted to go back to bed, but the CNA that worked did not have help to get the resident back into their bed. During an interview with the Director of Nursing (DON) on 05/20/2023 at 12:19 PM, she stated that on [redacted], during the time that Resident #17 would normally go to bed, there was plenty of staff to assist the resident. Per the DON, the resident did not want to go to bed at their usual	F 689		

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F 689	Continued From page 31 time and when Resident #17 was ready to go to bed, later that night, there was not enough staff to assist Resident #17. New Jersey Administrative Code § 8:39-5.1(a)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility policy review, it was determined the facility failed to ensure a physician's order was obtained for the use [redacted] therapy for 1 (Resident #112) of 3 sampled residents reviewed for [redacted] care. Findings included: A review of the facility's undated policy titled, [redacted] Administration," indicated, "The purpose of this procedure is to provide guidelines for safe [redacted] administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for [redacted] administration." A review of an "Admission Record," indicated the facility admitted Resident #112 on [redacted],	F 695	R112 still resides at the facility. The resident did not have any ill effect from not having a physician order for [redacted]. The physician was notified and an order for [redacted] was given. All residents with oxygen can be affected by this deficient practice. DON audited all residents with [redacted] to assure that orders were obtained. Physician will be notified of any resident with [redacted] and does not have an order. The Director of Nursing will re-educate all nurses on the process administration of [redacted] and includes having a physician order. The DON/designee will audit all	6/27/23

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F 695	Continued From page 32 with diagnoses to include [redacted] A review of Resident #112's "Health Status Note," dated [redacted] at 7:49 PM, revealed Resident #112 arrived at the facility at approximately 4:00 PM. Per the note, the resident was [redacted] therapy in place by way of [redacted] The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/28/2023, revealed Resident #112 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted]. The MDS indicated the resident received [redacted] therapy. Review of Resident #112's "Health Status Note," dated [redacted] at 9:32 PM, indicated Resident #112 was [redacted] with [redacted] on due to feeling [redacted]. A review of Resident #112's "Health Status Note," dated [redacted] at 7:57 PM, indicated the resident continued [redacted] therapy at [redacted] by way of [redacted]. Review of Resident #112's care plan dated [redacted], revealed the resident had a [redacted]. The interventions directed staff to provide [redacted] as ordered. Review of Resident #112's "MD [Medical Doctor] Progress Note," dated [redacted] at 2:14 PM, revealed the resident had no [redacted] but was still on [redacted] therapy.	F 695	residents with [redacted] to assure that orders were obtained Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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During the initial tour on 05/16/2023 at 9:37 AM, Resident #112 was observed sitting up in their bed, brushing their teeth. The resident had [redacted] on by way of a [redacted] at [redacted]

On 05/18/2023 at 1:33 PM, the surveyor observed Resident #112 in their bed eating lunch. The resident was not utilizing [redacted] therapy. Resident #112 stated they [redacted] and had to be placed on [redacted] Resident #112 stated the facility had been [redacted] them off [redacted].

A review of Resident #112's "Order Summary Report" revealed the resident did not have a physician order for the use of [redacted] n therapy, prior to [redacted].

In an interview on 05/18/2023 at 1:46 PM, Registered Nurse (RN) #26 reported a physician's order was required for a resident's use of [redacted] therapy and weekly [redacted] changes. RN #26 reviewed Resident #112's physician's orders and reported there was not a physician's order for the use of the [redacted] therapy or an order to wean the resident off [redacted] therapy. RN #26 stated the resident should have had those orders.

During an interview on 05/20/2023 at 9:24 AM, the Director of Nursing (DON) reported the facility could apply [redacted] therapy at [redacted] and [redacted] if the resident had a change in condition. The DON stated a physician's order would be obtained after the crisis event had resolved.

In an interview on 05/20/2023 at 4:45 PM, the Administrator reported she was not familiar with

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F 695	Continued From page 34 the facility's policy and would have to refer to the DON and read the policy. New Jersey Administrative Code § 8:39-11.2(a)	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, it was determined the facility failed to ensure an assessment for the use of [redacted] was completed and informed consent was obtained for the use of [redacted] for 1 (Resident #56) of 4 sampled residents reviewed for accidents.	F 700	R56 still resides at the facility. The residents had no ill effect from the [redacted]. The patient was assessed, and the [redacted] were removed. All residents can be affected by this deficient practice. DON/designee audited	6/27/23

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F 700	Continued From page 35 Findings included: Review of the facility's undated policy titled, "Bed Safety and [redacted]," indicated "3. The use of bed rails or side rails (including temporarily raising the [redacted] for episodic use during care) is prohibited unless the criteria for use of [redacted] have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent." The policy further indicated "8. Before using [redacted] for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with [redacted] and obtain informed consent." A review of an "Admission Record" indicated the facility admitted Resident #56 on [redacted] with diagnoses including [redacted]) affecting [redacted] and history of [redacted]. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted] indicated the resident had [redacted] based on the Staff Assessment for Mental Status. The MDS indicated the resident did not have behaviors and required [redacted] with [redacted], [redacted]. The resident required physical help in part of the bathing activity. The MDS indicated the resident had [redacted] on [redacted] of both [redacted]. The	F 700	all residents with bed rails to assure that assessments, orders, and consents were obtained. Corrections were made as identified. The Director of Nursing will re-educate all nurses and CNAs on the process for assessing residents for [redacted] The DON/designee will audit all new residents to assure that assessment to determine if [redacted] are needed, and that orders and consents were obtained Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT HOLLY REHABILITATION & HEALTHCARE CENTER	62 RICHMOND AVENUE LUMBERTON, NJ 08048

(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
F 700	Continued From page 36 MDS indicated [redacted] were not being used as a [redacted]t. Review of Resident #56's care plan, dated 02/17/2023, indicated the resident had an activity of daily living (ADL) self-care performance deficit related to activity intolerance and [redacted]. Interventions included and dated [redacted] directed the staff to put the two [redacted] up to enable increased bed mobility and patient preference. A review of Resident #56's medical record was completed. The record did not contain an assessment for the use of the [redacted], including risks and benefits. The record did not contain an informed consent for the use of [redacted] On 05/16/2023 at 11:00 AM, Resident #56 was observed lying on the bed. [redacted] were observed in the raised position. The resident's bed was observed to have an [redacted]. The resident could not be interviewed due to the resident's [redacted]. On 05/17/2023 at 9:25 AM, Resident #56 was observed lying on the bed with all [redacted] in the raised position. The resident was observed with the head of the bed up. The overbed table was across the bed, and the resident was eating their breakfast meal. On 05/18/2023 at 2:34 PM, Certified Nursing Assistant (CNA) #35 and CNA #36 were observed providing care for Resident #56. The CNAs reported the resident had been sitting in the [redacted]) since 10:30 AM or 11:00 AM. The	F 700		

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F 700	Continued From page 37	F 700		

CNAs, with one on each side of the resident, were observed to hook their arms under the resident's arms and transfer the resident from the [redacted] into the bed. The resident was observed to [redacted] during the transfer. During the care, the resident was physically repositioned side to side by the CNAs. The resident never attempted to utilize the [redacted] to assist with repositioning. CNA #35 and CNA #36 were interviewed regarding the [redacted] being utilized; the CNAs reported the resident did not utilize the [redacted] for repositioning. CNA #36 reported the resident had [redacted] up due to the resident being at risk [redacted]

On 05/18/2023 at 2:47 PM, Registered Nurse (RN) #37, a unit manager, was interviewed regarding Resident #56 having [redacted] up on the resident's bed. The RN reported four bed rails were not allowed, and Resident #56 should not have [redacted] up. The RN reported the resident had as-needed staff assigned yesterday, and the as-needed staff needed to be updated on [redacted]. The RN reported observing [redacted] in the raised position when arriving to the unit that morning.

On 05/18/2023 at 3:32 PM, the Director of Nursing (DON) was interviewed and reported Resident #56 should only have [redacted] in the raised position. The DON indicated the side rails had not been assessed and there was no informed consent for the use of the [redacted].

On 05/20/2023 at 4:45 PM, the Administrator was interviewed and reported Resident #56 should only have [redacted] in the up position, and [redacted] use required an assessment and a consent.

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F 700	Continued From page 38	F 700		
F 725 SS=G	New Jersey Administrative Code § 8:39-5.1(a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to provide adequate staffing to prevent falls for 1 (Resident	F 725	R17 still resides at the facility. The resident who had sustained a [redacted] during the [redacted] has healed and is now back to baseline. The following intervention was	6/27/23

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F 725	Continued From page 39 #17) of 4 sampled residents reviewed for accidents. Specifically, on [redacted], Resident #17 was found on the floor after they attempted to transfer themself due to a lack of staff available to assist the resident back to bed. Resident #17 sustained a [redacted] to their [redacted] that required [redacted]. Findings included: Review of a facility policy titled, "Staffing, Sufficient, and Competent Nursing," with a revision date of August 2022, revealed, "Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care for all residents in accordance with resident care plans and the facility assessment." Review of an "Admission Record" indicated the facility admitted Resident #17 on [redacted] with diagnoses that included [redacted] Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated Resident #17 had [redacted]. The MDS indicated Resident #17 required extensive assistance with bed mobility and transfers. The MDS indicated Resident #17 was not steady and only able to [redacted] when moving from seated to standing position and during surface-to-surface transfers. Review of Resident #17's care plan, with an initiation date of [redacted], revealed Resident #17 was at risk [redacted] due to [redacted]	F 725	added to the residents plan of care: I am [redacted] myself to bed. Most nights I like to [redacted]. If I am in bed and [redacted] ask me if I want to get [redacted] Place me in a chair and ask every hour if I want to return to bed. When R17 states she is ready to be put back to bed, she will be placed back to bed immediately. All residents have the potential to be affected by this area of concern. Recruitment efforts continue to include: Daily Staffing meetings Care Champion mentor program to support and retain staff Culture Committee to promote and improve staff morale Recruitment Bonuses, Sign On Bonuses and Vacant Shift Bonuses offered Utilizing multiple outside staffing agencies to fulfill staffing needs Ongoing job fairs onsite On-demand orientation classes Prize raffles for staff picking up extra shifts. Daily interviews being conducted with any walk ins The Director of Nursing will audit all upcoming shifts to ensure all daily state staffing ratios are met. This includes all shifts for a rolling 7 days. The DON/designee will audit all staffing daily x5 for all shifts, weekly x4 for all shifts, and monthly x3 for all shifts to maintain	

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F 725	Continued From page 40 [redacted]. Interventions directed staff to anticipate and meet the resident's needs, provide hands on assistance when the resident moved from place to place, and encourage the resident to use the call lights to request assistance. A review of Resident #17's "Health Status Note," dated [redacted] at 11:15 PM, revealed Resident #17 was in a [redacted] and attempted to ambulate back to bed. Per the note, the resident was found [redacted] on the floor, [redacted]. The note indicated the resident was sent to the hospital emergency department. A review of Resident #17's "Health Status Note," dated [redacted] at 11:48 PM, written by Registered Nurse (RN) #40, revealed Resident #17 was found on the floor at [redacted] PM between the foot end of their bed and their [redacted]. Per the note, Resident #17 had a [redacted] their [redacted]. A review of Resident #17's "Full QA [Quality Assurance] Report," dated [redacted], revealed Resident #17 had [redacted] and was found on the ground with their [redacted] on the floor around 11:00 PM. The report indicated the resident sustained a [redacted] that required [redacted]. The report indicated Resident #17 "attempted to [redacted] and [redacted] The report indicated a causal and contributing factors to the [redacted] was that the resident "wanted to get into bed and cna [certified nursing assistant] was with another patient." The report indicated the root cause of the [redacted] was "[Resident #17] was out of [the resident's] routine and became [redacted] [sic] and attempted to [redacted] and [redacted]"	F 725	ongoing staffing compliance. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director	

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F 725	Continued From page 41 During an interview with RN #40 on 05/19/2023 at 4:07 PM, she stated Resident #17 was still in their wheelchair around [redacted] PM on [redacted] because there was not enough staff to assist the resident into their bed at that time. During an interview with the Director of Nursing (DON) on 05/20/2023 at 12:19 PM, she stated that on [redacted], during the time that Resident #17 would normally go to bed, there was plenty of staff to assist the resident. Per the DON, the resident did not want to go to bed at their usual time and when Resident #17 was ready to go to bed, later that night, there was not enough staff to assist Resident #17.	F 725		
F 755 SS=D	New Jersey Administrative Code § 8:39-5.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		6/27/23

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F 755	Continued From page 42 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, it was determined the facility failed to ensure medications were available for administration for 1 (Resident #191) of 10 residents observed for medication administration. Specifically, the facility failed to ensure [redacted] al medication used to treat a [redacted], and a [redacted] health, were available for Resident #191. Findings included: Review of the facility policy titled, "Unavailable Medications," dated June 2021, specified, "In conjunction with the contracted pharmacy, the facility will make every effort to ensure that a medication ordered for the resident is available to meet their needs. Procedure 1. Upon receipt of information from pharmacy regarding a medication that is unavailable, nursing staff shall: a. Notify the physician of the unavailable medication, explain the circumstances, report the	F 755	R191 still resides at the facility. The resident was assessed and did not sustain any ill effects. The physician was notified of unavailable medications and new orders were obtained. All residents with unavailable medications can be affected by this deficient practice. DON audited all residents MARs/TARs to assure that medications were available. Physicians was notified of any medications not available, and recommendations will be obtained. The Director of Nursing re-educated all nurses on the “Administering Medication” policy. Policy includes steps to be taken if medication is not available; notifying a supervisor, determine if unavailable medication is available in back up med bank, notify pharmacy to obtain missing medication. If medication	

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F 755	Continued From page 43 date of expected availability, and provide the alternative medication(s) recommended by pharmacy. i. Obtain a new order and discontinue the prior order, or ii. Obtain a hold order for the unavailable medication. b. Notify the pharmacy, if applicable. 2. In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: a. Contact the pharmacy regarding the unavailable medication. b. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication, explain the circumstances, report the date of expected availability, and provide the alternative medication(s) recommended the pharmacy. i. Obtain a new order and discontinue prior order, or ii. Obtain a hold order for the unavailable medication. d. Notify the pharmacy, if applicable." A review of the "Admission Record" for Resident #191 indicated the facility admitted the resident on [redacted] with diagnoses including a [redacted]. The record revealed the resident had a recent hospital stay from [redacted] through [redacted]. A review of Resident #191's hospital "After Visit Summary" revealed the resident was discharged on [redacted] with orders for [redacted] milligrams (mg) tablet, [redacted] tablets by mouth daily for [redacted] days and [redacted] mg/unit/micrograms, [redacted] tablet twice a day by mouth. A review of Resident #191's "Order Summary Report," indicated a physician's order, dated	F 755	cannot be administered timely, physician will be notified, and documentation will be recorded. Unavailable Medication process, physician notification and required documentation. The DON/designee will audit all Medication Administration Records to assure all medications are available for administration. This audit will be completed Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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F 755	Continued From page 44 [redacted], for [redacted] mg tablet, give three tablets by mouth daily [redacted] time a day until [redacted]. There was also an order, dated [redacted], for [redacted] oral capsule [redacted] micrograms, [redacted] tablet by mouth [redacted] times a day. During medication administration observation on 05/18/2023 at 8:36 AM, Licensed Practical Nurse (LPN) #29 stated the [redacted] oral capsule and [redacted] were not available for administration. During an interview with LPN #23 on 05/20/2023 at 8:55 AM, she stated staff should check the facility's automated medication dispensing system if a medication was not available. Per LPN #23, if the medication was not available in the dispensing system, staff should contact the resident's physician. On 05/18/2023 at 10:17 AM, Registered Nurse (RN) #26, a unit manager stated when medications were unavailable, staff should check the facility's automated medication dispensing system. RN #26 stated if a medication was not available, the pharmacy should be called to see if the medication had been shipped, and staff should place the medication on hold, so the computer did not continue to show that it needed to be administered. RN #26 stated she was not aware Resident #191's medications were not available in the facility for administration. In an interview on 05/20/2023 at 9:24 AM, the Director of Nursing (DON) stated medications should be available in either the facility's floor stock or in over-the-counter medication. Per the DON, if the medications were not available in	F 755		

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F 755	Continued From page 45 those areas, staff should contact the DON or the Assistant Director of Nursing, and the pharmacy, The DON stated the pharmacy had not sent Resident #191's [redacted] medication because the pharmacy wante [redacted] results before distribution of the medication. The DON stated staff should have called the pharmacy to see why the medications had not been received in the facility. During an interview on 05/20/2023 at 4:45 PM, the Administrator stated the expectation was that medications be available, and the goal was to have residents' medications at the facility prior to the resident's admission to the facility.	F 755		
F 770 SS=D	New Jersey Administrative Code § 8:39-29.6(a) Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, document review, and facility policy review, the facility failed to ensure ordered laboratory work was obtained for 1 (Resident #19) of 2 sampled residents reviewed for a change in condition. Findings included:	F 770	R19 still resides at the facility. The resident was assessed and did not sustain any ill effects. The labs were re-ordered and obtained. All residents with lab orders can be affected by this deficient practice. DON	6/27/23

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F 770	Continued From page 46 Review of an undated facility policy titled, "Lab [Laboratory] and Diagnostic Test Results - Clinical Protocol" revealed, "1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests." A review of an "Admission Record" indicated the facility admitted Resident #19 on [redacted] with diagnoses that included typ [redacted] The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted] revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had [redacted]. The MDS indicated the resident required [redacted] with toilet use and was frequently [redacted] l and [redacted] Review of Resident #19's care plan initiated [redacted] indicated the resident had [redacted] and a diagnosis of [redacted] Interventions included revealed the resident used [redacted] and for staff to check the resident as required for [redacted] A review of Resident #19's "Order Summary Report," revealed an order dated [redacted] for a [redacted] and [redacted]	F 770	audited all residents' orders to assure that labs were obtained. Physicians will be notified of any labs not completed and recommendations will be obtained. The Director of Nursing re-educated all nurses on "Medication and Treatment Orders" policy which includes, completing physician orders and notification of physician when labs are not drawn, and/or a patient refusal. Notifying the physician if any lab orders cannot be redrawn that day due to being unable to draw the lab or a patient refusal. The DON/designee will audit all lab orders to assure all orders are completed. This audit will occur Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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F 770	Continued From page 47 ([redacted]), one time only [redacted] A review of laboratory log labeled "Rehabilitation Centers," dated [redacted]3, revealed a note date[redacted] related to Resident #19's laboratory work. The note indicated Resident #19 was to have a [redacted], but the sample was not obtained due to the resident having [redacted]. There was no documentation to indicate staff attempted to obtain the sample again at a later date and/or time. During an interview with Medical Doctor (MD) #19 on [redacted] at 3:28 PM, he confirmed it looked as though the laboratory work ordered for Resident #19 on [redacted] did not get done. During an interview on 05/19/2023 at 10:57 AM, with Registered Nurse (RN) #37, she explained when a nurse receives an order for laboratory work it is entered into the electronic health record and logged in the lab book on a lab slip. RN #37 revealed it looked like they had unsuccessfully attempted to obtain a sample for the laboratory work ordered on [redacted], but then there was no further follow-up. During an interview with the Director of Nursing (DON) on 05/20/2023 at 12:16 PM, she confirmed the laboratory order did not get completed as ordered because Resident #19 refused when the staff initially attempted to obtain the sample. The DON stated staff should have documented this and either put the order on hold or made another attempt to obtain the sample. During an interview with the Administrator on 05/20/2023 at 6:29 PM, she confirmed the	F 770		

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MOUNT HOLLY REHABILITATION & HEALTHCARE CENTER	62 RICHMOND AVENUE LUMBERTON, NJ 08048

(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
F 770	Continued From page 48 laboratory order should have been attempted again after Resident #19 refused to allow the sample to be obtained. New Jersey Administrative Code § 8:39-5.1(a)	F 770		
F 808 SS=J	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure 1 (Resident #56) of 7 sampled residents reviewed for nutrition received [redacted] per the physician's orders. During the survey, Resident #56, a resident assessed to be at risk for [redacted] was ordered [redacted] liquids. On 0[redacted] at 1:13 PM, Resident #56 was provided a glass of [redacted]. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death of residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.60 (Food and Nutrition Services) at a scope and severity of	F 808	Resident #56 was affected by this deficient practice. A nursing assessment was completed on [redacted] and no negative outcomes were found. Care plan was reviewed and updated. The assessment included vital signs and [redacted] assessment. On [redacted] results of the nursing assessment were reviewed with Resident #56's physician. No new orders at that time. As a follow up, with Resident #56's physician, he ordered a [redacted] on [redacted] with results the same day. The [redacted]y results were, "There is no [redacted] There are [redacted]." Follow up monitoring consists of [redacted] assessments, and vital signs, every shift	6/27/23

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F 808	Continued From page 49 "J." The IJ began on [redacted] at 1:13 PM, when Resident #56 was not provided thickened liquids. The Administrator and the Regional Director of Clinical Services were notified of the IJ and provided the IJ Template on [redacted] at 2:54 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on [redacted] at 5:23 PM. The IJ was removed on [redacted] at 8:25 PM, after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance for F808 remained at the lower scope and severity of isolated potential for harm that was not immediate jeopardy related to the potential for aspiration by Resident #56. Findings included: Review of a facility policy titled, "[redacted]," dated February 2023, revealed, "[redacted] are prepared and served as prescribed by the physician. General Guidelines 1. A physician's order is required for therapeutic diets, including [redacted]." The policy further indicated, "Levels of [redacted] 1. [redacted]: Approximately as [redacted] as a [redacted] Should pour in a continuous stream without breaking into drops, such as fruit nectars, eggnog, maple syrup, tomato juice, V-8 juice, cream-based soup and commercially prepared [redacted] products." Review of an "Admission Record" indicated the facility admitted Resident #56 on [redacted] with diagnoses that [redacted]	F 808	for 72 hours. Any changes will be immediately communicated with the physician. Eleven residents have the potential to be affected. On [redacted], the Director of Nursing and the clinical team completed an audit of all 11 current residents that have [redacted]. The audit consisted of comparing physician orders against the residents' cardex, as well as the residents' care plans. Vital signs and respiratory assessments were completed on 05/20/2023, by the Director of Nursing and Unit Managers, on each of the 11 residents. On 05/17/2023, the Director of Nursing re-educated Certified Nursing Assistant #15. The education included, why residents may be on different liquid consistencies, reviewing the cardex for resident specific [redacted] and speak to the nurse when unsure of [redacted] y, how to identify [redacted] and where to obtain ready [redacted]. On 05/17/2023, the Director of Nursing and Assistant Director of Nursing provided one-on-one education with all nurses and all certified nursing assistants who were working the shift of 7am-3pm. For each shift thereafter no nurse or CNA started their work until they received the education. The education included, why residents may be on different liquid consistencies, reviewing the cardex for resident specific [redacted] and speak to the nurse when unsure of [redacted], how to	

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F 808	Continued From page 50 [redacted] The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted] indicated Resident #56 had [redacted] based on the Staff Assessment for Mental Status. The MDS indicated the resident required limited, [redacted] with eating and had functiona[redacted] on [redacted] and [redacted]. The MDS revealed, the resident [redacted] or had [redacted] during meals or when [redacted] medications, had complaints of [redacted], and received a therapeutic and [redacted] diet. Review of Resident #56's comprehensive care plans revealed a care plan, initiated on [redacted] that indicated the resident had a [redacted]. This care plan included an intervention that specified, "If resident is able to eat, make sure diet is the correct [redacted] to facilitate safe [redacted]" Review of Resident #56's "Order Summary Report" revealed an order, dated [redacted] for [redacted]." Per the report, on [redacted] the resident received an order for a consistent [redacted] of [redacted], with [redacted] Review of Resident #56's "[redacted] Test," dated [redacted] 3, revealed a [redacted] test was ordered for Resident #56 to	F 808	identify [redacted] and where to obtain ready [redacted]. They were also in-service on reviewing the cardex for the order [redacted] prior to the start of their shift. Nurses were given one-on-one education regarding their role in assuring the accuracy of [redacted] is in accordance with physician orders prior to fluid hydration pass. Nurses were educated regarding their role and must supervise and oversee certified nursing assistants The DON/designee will audit all diet orders and medication passes and hydration passes to assure all orders are completed, and that patients are receiving the correct consistency. This audit will be completed Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director.	

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rule out [redacted] and to judge the resident's current [redacted] to provide recommendations for proper [redacted] care. The report indicated the resident had previously been on a [redacted] with [redacted] liquids, and the reason for the referral was to determine if the resident was ready for an [redacted] The report indicated Resident #56 experienced [redacted] with [redacted] ([redacted]). The report further indicated the contributing factors to this resident's [redacted] consisted of the following: resident exhibited [redacted], and [redacted] at times, as well as a history of [redacted], [redacted] The report included a recommendation for a [redacted] with [redacted]. The report also listed, the staff should assist and observe the resident with [redacted]

On 05/17/2023 at 1:13 PM, Resident #56 was observed in their bed in their room with the head of the bed raised, eating their lunch meal. Next to the resident's meal tray was a plastic cup that contained ice water, with a lid and straw. At 1:24 PM, Licensed Practical Nurse (LPN) #16 entered the resident's room and removed the lunch tray from the resident's over-bed table. The nurse informed the resident the cup of [redacted] would have to be removed, because the resident was supposed to have [redacted]. As the nurse left the room, LPN #16 and the surveyor observed the straw in the cup of [redacted] had food debris on the outside of the straw. LPN #16 reported it appeared the resident drank some of the ice water that was not [redacted] and the resident was supposed to have [redacted] LPN #16 stated she did not know who provided

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Resident #16 with the [redacted]. LPN #16 indicated the certified nursing assistants should check the assignment sheet that reflected which residents required [redacted]

On 05/17/2023 at 1:35 PM, LPN #16 reported to the surveyor that Certified Nursing Assistant (CNA) #15 was the staff member that distributed the [redacted] to Resident #56.

During an interview on 05/17/2023 at 1:42 PM, CNA #15 said the CNAs knew which residents were to receive [redacted] by looking at the assignment sheet that was provided at the beginning of the shift. CNA #15 referred to her assignment sheet and said it only listed Resident #56's name and room number and did not have any information about the resident's [redacted] status. However, CNA #15 acknowledged she was aware Resident #56 required [redacted] because the nurse told her at the beginning of the shift. CNA #15 said she provided the ice water to the resident by mistake and said Resident #56 should not have received it.

On 05/20/2023 at 11:34 AM, Registered Nurse (RN) #37, a unit manager, reported the assignment sheet, which informed the staff of the residents who required [redacted], had not been updated with Resident #56's [redacted] due to the unit secretary being off with a death in the family. RN #37 said she did not have access to the software needed to add Resident #56's [redacted] to the assignment sheet.

On 05/20/2023 at 11:42 AM, the Director of Nursing (DON) indicated the staff were informed at the beginning of their shift who was on [redacted] liquids by the assignment sheet. The

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DON reported all nurses could update the assignment sheets when there were new admissions or diet changes.

On 05/17/2023 at 1:59 PM, the Director of Rehabilitation reported Resident #56 had been discharged from rehabilitation services with an order for a [redacted] with [redacted] liquids. The Director of Rehabilitation stated she had discussed Resident #56 with the Speech Language Pathologist (SLP), who confirmed the resident should only be provided [redacted] without [redacted]

In a follow-up interview on 05/18/2023 at 2:47 PM, RN #37 reported the night shift nurse, LPN #17, had reported Resident #56 could have [redacted] liquids, but had to be watched closely.

During an interview on 05/19/2023 at 4:34 AM, LPN #17 said the first time she was assigned to care for Resident #56, the resident refused their [redacted], so she provided the resident with some sips of [redacted] that was located on the resident's bedside table.

During a follow-up interview on 05/19/2023 at 10:20 AM, LPN #17 said RN #37 had informed her Resident #56 was to receive [redacted] as ordered, until re-evaluated by speech therapy.

During an interview with Resident #56's primary physician, Medical Doctor (MD) #19, on 05/19/2023 at 11:53 AM, MD #19 reported the resident required [redacted] due to a [redacted], likely due to [redacted]. MD #19 said Resident #56 was at [redacted] for [redacted] and likely [redacted] during their last

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F 808	Continued From page 54 [redacted] MD #19 indicated his expectation was that staff would provide Resident #56 with [redacted] as currently ordered. In an interview on 05/20/2023 at 4:45 PM, the Administrator reported the expectation was that staff would pay attention and follow the physician's orders to ensure [redacted] were distributed correctly. Removal Plan "I. Resident #56 was affected by this deficient practice. A nursing assessment was completed on [redacted] and no negative outcomes were found. The assessment included vital signs and respiratory assessment. On [redacted], results of the nursing assessment were reviewed with Resident #56's physician. No new orders at that time. As a follow up, with Resident #56's physician, he ordered a [redacted] on [redacted] with results the same day. The [redacted] results were, "There is [redacted]. [redacted]. There are [redacted]." Follow up monitoring consists of [redacted] assessments, and vital signs, every shift for 72 hours. Any changes will be immediately communicated with the physician. 2. Eleven residents have the potential to be affected. Vital signs and [redacted] assessments were completed on [redacted], by the Director of Nursing and Unit Managers, on each of the 11 residents.	F 808		

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F 808	Continued From page 55 3. On [redacted] the Director of Nursing and the clinical team completed an audit of all 11 current residents that have [redacted] The audit consisted of comparing physician orders against the residents' kardex, as well as the residents' care plans. 4. For residents identified as having [redacted], nursing updated their individual care plans to meet the residents' [redacted] nly. The care plans were completed on [redacted]. 5. Residents with [redacted] were assessed on [redacted] to assure that the correct consistency has been provided. No other residents were found to have incorrect [redacted]. No additional assessments were needed. If any negative findings were found, they would have been immediately reported to the physician. 6. The center clinical leadership, which consists of the Director of Nursing and Assistant Director of Nursing were notified of the incident and initiated an investigation. Center leadership, Nursing Home Administrator, and Director of Nursing conducted an Ad Hoc Quality Assessment and Performance Improvement plan meeting on 05/17/2023, to develop a quality assurance process improvement action plan. The committee consisted of the Administrator, Director of Nursing, Regional Director of Clinical Services, Regional Director of Operations, and the Medical Director. 7. On 05/17/2023, the Director of Nursing	F 808		

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re-educated Certified Nursing Assistant #15. The education included, why residents may be on different [redacted], reviewing the kardex
for resident specific liquid consistency and speak to the nurse when unsure of [redacted], how to identify [redacted], and how to prepare each level of [redacted] and what to do if they identify incorrect [redacted]. There was also a demonstration of each [redacted] to ensure the certified nursing assistant knows how to prepare each liquid. The certified nursing assistant should review the kardex at the beginning of each shift. All clinical staff will receive an
updated report generated from Point Click Care [electronic health record system] diet type report to update the daily [redacted] report as it relates to [redacted]. This report will include resident name, room number, and [redacted] Staff will use this report to review prior to providing [redacted] to residents. This report will also be used as part of shift-to-shift reporting to assure that all licensed nurses and certified nursing assistants have the most up to date information.

8. On 05/17/2023, the Director of Nursing and Assistant Director of Nursing provided one-on-one education with all nurses and all certified nursing assistants who were working the 7-3 shift.
Inservice educational content included: how to identify [redacted] and how to prepare each [redacted] and what to do if they identify incorrect [redacted]. They were also inserviced on reviewing the kardex for the order [redacted] prior to the start of their shift.
Nurses were given one-on-one education

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regarding their role in assuring the accuracy of liquid consistencies is in accordance with physician orders prior to fluid hydration pass. Nurses were educated regarding their role and must supervise and oversee certified nursing assistants. All clinical staff will receive an updated report generated from Point Click Care diet type report to update the daily [redacted] report as it relates to [redacted]. This diet type report is given to staff by the Director of Nursing or Assistant Director of Nursing. All licensed nurses and certified nursing assistants were given education and in-service on the diet type report. This report will be given by the Director of Nursing, the unit manager, or the supervisor. This report will include resident name, room number, and liquid consistency. Staff will use this report to review prior to providing [redacted] to residents. This report will also be used as part of shift-to-shift reporting to assure that all licensed nurses and certified nursing assistants have the most up to date information. The Director of Nursing also in-serviced all nursing staff that nurses are responsible for the oversight of certified nursing assistants.

Also, on 05/17/2023, the Director of Nursing and Assistant Director of Nursing started education of all licensed nurses and certified nursing assistant on residents on [redacted]. Educational content included: how to identify [redacted], how to prepare each [redacted], and what to do if they identify incorrect liquid consistency. They were also in-service on reviewing

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the kardex for the order [redacted] prior to the start of their shift. Nurses were given one-on-one education regarding their role in assuring the accuracy of [redacted] is in accordance with physician orders prior to fluid hydration pass. Nurses were educated regarding their role and must supervise and oversee certified nursing assistants. The Director of Nursing also in-serviced all nursing staff that nurses are responsible for the oversight of certified nursing assistants.

Education included full-time, part-time, per diem, and agency licensed nurses and certified nursing assistant staff. Before the start of each shift, education will be given to all clinical staff, including agency staff. All clinical staff will be educated prior to the start of their next shift by the Director of Nursing, Assistant Director of Nursing, or unit managers and supervisors. No licensed nurse or certified nursing assistant will work until education is completed.

9. The Director of Nursing and clinical leadership will review all new admissions, readmits, and residents who may experience a change of condition as part of the morning clinical meeting, to
determine[redacted]. All clinical staff will receive an updated report generated from Point Click Care diet type report to update the daily [redacted] report as it relates to liquid consistency. This report will include resident name, room number, and[redacted].
Staff will use this report to review prior to providing[redacted] to residents. This report will also be
used as part of the shift-to-shift reporting to assure that all licensed nurses and certified

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nursing
assistants have the most up to date information. Auditing of this process will occur Monday through Friday, until three (3) months of 100% compliance is achieved, weekly until three (3) months of 100% compliance is achieved, and monthly until three (3) months of 100% compliance is achieved. The Director of Nursing is responsible for the oversight of this process.

10. The Administrator or the Director of Nursing will audit fluid hydration pass and medication pass to ensure the correct liquids are given, three times weekly until 100% compliance is achieved for 3 consecutive months. The Director of Nursing will bring findings from audits to the Quality Assurance and Process Improvement Committee meetings monthly for review until 100% compliance is achieved for 3 consecutive months.

11. The Administrator is responsible for the implementation and oversight of this plan.

12. The Medical Director was notified of the IJ on 05/19/2023 and was also involved in the development of the removal plan and also approved the removal plan.

13. All corrections were completed on [redacted]

14. The immediacy of the IJ was removed on [redacted]."

Onsite Validation:

The survey team verified the implementation of the facility's Removal Plan as follows. Onsite

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F 808	Continued From page 60 verification began on [redacted] at 5:29 PM . 1. Review of Resident #56's progress notes dated [redacted] revealed the resident's vital signs were checked and [redacted] assessments were completed. A review of the [redacted] for Resident #56, dated [redacted], revealed findings of no [redacted]. 2. During the IJ process, one of the [redacted] residents on [redacted] had died and [redacted] was in the hospital. The facility, at the time of the validation, had [redacted] residents on [redacted] [redacted] The electronic medical records were reviewed for the [redacted] residents, including vital signs and [redacted] assessments. 3. Reviews of the "Diet Type Report" dated [redacted], the resident's Kardex, care plans, and physician orders were compared and found to be consistent with the ordered [redacted] [redacted] 4. The care plans for the nine residents on [redacted] were reviewed and found to reflect the resident's [redacted] status. 5. Observations were made of [redacted], in resident rooms, for the [redacted] residents with orders for [redacted]. 6. Review of the Ad Hoc (created or done for a particular purpose as necessary) quality assurance and performance improvement (QAPI) minutes dated [redacted] and interviews with the Director of Nursing and Administrator revealed the AD Hoc QAPI meeting had been conducted and the IJ concerns had been discussed on [redacted]	F 808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315128	A. BUILDING _____ B. WING _____	C 05/20/2023

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MOUNT HOLLY REHABILITATION & HEALTHCARE CENTER	62 RICHMOND AVENUE LUMBERTON, NJ 08048

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F 808	Continued From page 61 7. Review of the in-service attendance record were reviewed, which included CNA #15. The in-services had been initiated on [redacted] and continued unti[redacted]. 8. Review of the in-service attendance logs indicated the staff had been re-educated on "Knowing Diet Orders for Residents, Diet [redacted] Report." During the validation process, current staff and oncoming staff were interviewed regarding the process for [redacted] determination. 9. The Director of Nursing was interviewed on 05/20/2023 regarding the process for new admission, readmits, and diet changes. 10. The Director of Nursing and Administrator were interviewed on 05/20/2023 related to hydration passes and ensuring [redacted] were correct. 11. The Administrator was interviewed regarding the plan for the oversight and process. 12. A signed document was reviewed that revealed the Medical Director (MD) #18 had been informed of the IJ on [redacted]. The Director of Nursing reported the MD had been involved in the development of the plan of removal and ordered resident follow-up as needed. 13. The survey team verified all corrections were completed on [redacted]. The IJ was removed on [redacted] at 8:25 PM, after the survey team performed onsite verification that the Removal Plan had been	F 808		

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F 808	Continued From page 62 implemented. New Jersey Administrative Code § 8:39-27.1(a)	F 808		

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S 000	Initial Comments Census:134 Sample Size: 33 TYPE OF SURVEY: Recertification and Complaint The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint Intake ##NJ157408 and #NJ157738 Based on interviews, facility document review, and a New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing on 13 of 14 day shifts and deficient in CNAs to total staff on 9 of 14 evening shifts for the weeks of	S 560	R17 still resides at the facility. The resident who had sustained a laceration during the fall has healed and is now back to baseline. The following intervention was added to the residents plan of care: I am unable to transfer myself to bed. Most nights I like to be in bed by 8 pm. If I am in bed and restless, ask me if I want to get OOB. Place me in a chair and ask every hour if I want to return to bed. When R17	6/27/23

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

Electronically Signed | 06/17/23

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S 560	Continued From page 1 06/12/2022 - 06/18/2022 and 06/19/2022 - 06/25/2022. The facility was deficient in CNA staffing for 19 of 28 day shifts and deficient in CNAs to total staff on 6 of 28 evening shifts for the weeks 07/03/2022 - 07/09/2022, 07/10/2022 - 07/16/2022, 07/17/2022 - 07/23/2022, and 07/24/2022 - 07/30/2022. The facility was deficient in CNA staffing for residents on 18 of 21 day shifts and deficient in CNAs to total staff on 17 of 21 evening shifts for the week of 08/14/2022 - 08/20/2022, 08/21/2022 - 08/27/2022, and 08/28/2022 - 09/03/2022. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in CNAs to total staff on 14 of 14 evening shifts for the week of 04/30/2023 - 05/06/2023 and 05/07/2023 - 05/13/2023. This deficient practice had the potential to affect all residents. Findings included: 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 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 certified nurse aides, and each direct staff member shall be signed in to work as a certified	S 560	states she is ready to be put back to bed, she will be placed back to bed immediately. All residents have the potential to be affected by this area of concern. Recruitment efforts continue to include: Daily Staffing meetings Care Champion mentor program to support and retain staff Culture Committee to promote and improve staff morale Recruitment Bonuses, Sign On Bonuses and Vacant Shift Bonuses offered Utilizing multiple outside staffing agencies to fulfill staffing needs Ongoing job fairs onsite On-demand orientation classes Prize raffles for staff picking up extra shifts Daily interviews being conducted with any walk ins The Director of Nursing will audit all upcoming shifts to ensure all daily state staffing ratios are met. This includes all shifts for a rolling 7 days. The DON/designee will audit all staffing daily x5 for all shifts, weekly x4 for all shifts, and monthly x3 for all shifts to maintain ongoing staffing compliance. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director	

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S 560	Continued From page 2	S 560		

nurse aide and shall perform nurse aide duties.

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 certified nurse aide and perform certified nurse aide duties.

1. A review of the "Nurse Staffing Report," completed by the facility for the week of 06/12/2022 - 06/18/2022 and 06/19/2022 - 06/25/2022, revealed the facility was deficient in CNA staffing for residents on 13 of 14 day shifts and deficient in CNAs to total staff on 9 of 14 evening shifts as follows:

- 06/12/2022 had 7 CNAs for 102 residents on the day shift, required 13 CNAs.
- 06/12/2022 had 3 CNAs to 10 total staff on the evening shift, required 5 CNAs.
- 06/13/2022 had 5 CNAs for 98 residents on the day shift, required 12 CNAs.
- 06/14/2022 had 11 CNAs for 98 residents on the day shift, required 12 CNAs.
- 06/15/2022 had 11 CNAs for 98 residents on the day shift, required 12 CNAs.
- 06/15/2022 had 7 CNAs to 17 total staff on the evening shift, required 8 CNAs.
- 06/16/2022 had 11 CNAs for 98 residents on the day shift, required 12 CNAs.
- 06/17/2022 had 8 CNAs for 102 residents on the day shift, required 13 CNAs.
- 06/19/2022 had 12 CNAs for 102 residents on the day shift, required 13 CNAs.
- 06/19/2022 had 8 CNAs to 20 total staff on the evening shift, required 10 CNAs.
- 06/20/2022 had 7 CNAs for 106 residents on the day shift, required 13 CNAs.
- 06/20/2022 had 6 CNAs to 20 total staff on the evening shift, required 10 CNAs.

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S 560	Continued From page 3 - 06/21/2022 had 8 CNAs for 106 residents on the day shift, required 13 CNAs. - 06/21/2022 had 9 CNAs to 27 total staff on the evening shift, required 13 CNAs. - 06/22/2022 had 12 CNAs for 106 residents on the day shift, required 13 CNAs. - 06/22/2022 had 6 CNAs to 22 total staff on the evening shift, required 11 CNAs. - 06/23/2022 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. - 06/23/2022 had 11 CNAs to 26 total staff on the evening shift, required 13 CNAs. - 06/24/2022 had 12 CNAs for 106 residents on the day shift, required 13 CNAs. - 06/24/2022 had 9 CNAs to 26 total staff on the evening shift, required 13 CNAs. - 06/25/2022 had 11 CNAs for 105 residents on the day shift, required 13 CNAs. - 06/25/2022 had 10 CNAs to 28 total staff on the evening shift, required 14 CNAs. 2. The week of 07/03/2022 - 07/09/2022, 07/10/2022 - 07/16/2022, 07/17/2022 - 07/23/2022, and 07/24/2022 - 07/30/2022, revealed staff-to-resident rations that did not meet the minimum requirements. The facility was deficient in CNA staffing for 19 of 28 day shifts and deficient in CNAs to total staff on 6 of 28 evening shifts as follows: - 07/03/2022 had 12 CNAs for 112 residents on the day shift, required 14 CNAs. - 07/03/2022 had 11 CNAs to 30 total staff on the evening shift, required 15 CNAs. - 07/05/2022 had 9 CNAs for 109 residents on the day shift, required 14 CNAs. - 07/08/2022 had 10 CNAs to 26 total staff on the evening shift, required 13 CNAs. - 07/09/2022 had 12 CNAs for 107 residents on the day shift, required 13 CNAs.	S 560		

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S 560	Continued From page 4 - 07/09/2022 had 9 CNAs to 23 total staff on the evening shift, required 11 CNAs. - 07/10/2022 had 11 CNAs for 108 residents on the day shift, required 13 CNAs. - 07/12/2022 had 12 CNAs for 104 residents on the day shift, required 13 CNAs. - 07/13/2022 had 12 CNAs for 104 residents on the day shift, required 13 CNAs. - 07/14/2022 had 11 CNAs for 104 residents on the day shift, required 13 CNAs. - 07/15/2022 had 10 CNAs for 104 residents on the day shift, required 13 CNAs. - 07/16/2022 had 10 CNAs for 104 residents on the day shift, required 13 CNAs. - 07/17/2022 had 9 CNAs for 104 residents on the day shift, required 13 CNAs. - 07/18/2022 had 8 CNAs for 108 residents on the day shift, required 13 CNAs. - 07/19/2022 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. - 07/20/2022 had 12 CNAs for 107 residents on the day shift, required 13 CNAs. - 07/23/2022 had 12 CNAs for 103 residents on the day shift, required 13 CNAs. - 07/24/2022 had 9 CNAs for 102 residents on the day shift, required 13 CNAs. - 07/24/2022 had 10 CNAs to 24 total staff on the evening shift, required 12 CNAs. - 07/25/2022 had 10 CNAs for 102 residents on the day shift, required 13 CNAs. - 07/25/2022 had 9 CNAs to 21 total staff on the evening shift, required 11 CNAs. - 07/28/2022 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. - 07/28/2022 had 9 CNAs to 22 total staff on the evening shift, required 11 CNAs. - 07/29/2022 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. - 07/30/2022 had 8 CNAs to 99 residents on the day shift, required 12 CNAs.	S 560		

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S 560	Continued From page 5 3. The week of 08/14/2022 - 08/20/2022, 08/21/2022 - 08/27/2022, and 08/28/2022 - 09/03/2022, revealed staff-to-resident rations that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 18 of 21 day shifts and deficient in CNAs to total staff on 17 of 21 evening shifts as follows: - 08/14/2022 had 8 CNAs for 117 residents on the day shift, required 15 CNAs. - 08/14/2022 had 9 CNAs to 24 total staff on the evening shift, required 12 CNAs. - 08/15/2022 had 12 CNAs for 117 residents on the day shift, required 15 CNAs. - 08/15/2022 had 8 CNAs to 24 total staff on the evening shift, required 12 CNAs. - 08/16/2022 had 13 CNAs for 115 residents on the day shift, required 14 CNAs. - 08/16/2022 had 10 CNAs to 26 total staff on the evening shift, required 13 CNAs. - 08/17/2022 had 11 CNAs for 115 residents on the day shift, required 14 CNAs. - 08/17/2022 had 11 CNAs to 24 total staff on the evening shift, required 12 CNAs. - 08/18/2022 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. - 08/18/2022 had 10 CNAs for 24 total staff on the evening shift, required 12 CNAs. - 08/19/2022 had 9 CNAs for 113 residents on the day shift, required 14 CNAs. - 08/19/2022 had 9 CNAs to 23 total staff on the evening shift, required 11 CNAs. - 08/20/2022 had 8 CNAs for 113 residents on the day shift, required 14 CNAs. - 08/21/2022 had 11 CNAs for 113 residents on the day shift, required 14 CNAs. - 08/22/2022 had 10 CNAs for 111 residents on the day shift, required 14 CNs. - 08/22/2022 had 12 CNAs to 26 total staff on the	S 560		

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S 560	Continued From page 6	S 560		

evening shift, required 13 CNAs.
- 08/23/2022 had 12 CNAs for 111 residents on the day shift, required 14 CNAs.
- 08/23/2022 had 11 CNAs to 26 total staff on the evening shift, required 13 CNAs.
- 08/24/2022 had 12 CNAs for 111 residents on the day shift, required 14 CNAs.
- 08/24/2022 had 11 CNAs to 24 total staff on the evening shift, required 12 CNAs.
- 08/25/2022 had 12 CNAs for 111 residents on the day shift, required 14 CNAs.
- 08/25/2022 had 9 CNAs to 23 total staff on the evening shift, required 12 CNAs.
- 08/26/2022 had 7 CNAs for 111 residents on the day shift, required 14 CNAs.
- 08/26/2022 had 9 CNAs to 23 total staff on the evening shift, required 12 CNAs.
- 08/27/2022 had 10 CNAs to 24 total staff on the evening shift, required 12 CNAs.
- 08/28/2022 had 9 CNAs to 24 total staff on the evening shift, required 12 CNAs.
- 08/29/2022 had 9 CNAs to 28 total staff on the evening shift, required 14 CNAs.
- 08/30/2022 had 8 CNAs for 105 residents on the day shift, required 13 CNAs.
- 08/30/2022 had 9 CNAs to 22 total staff on the evening shift, required 11 CNAs.
- 08/31/2022 had 11 CNAs for 105 residents on the day shift, required 13 CNAs.
- 09/01/2022 had 10 CNAs for 105 residents on the day shift, required 13 CNAs.
- 09/02/2022 had 12 CNAs for 112 residents on the day shift, required 14 CNAs
- 09/02/2022 had 10 CNAs to 24 total staff on the evening shift, required 12 CNAs.
- 09/03/2022 had 11 CNAs for 112 residents on the day shift, required 14 CNAs.
- 09/03/2022 had 12 CNAs to 28 total staff on the evening shift, required 14 CNAs.

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S 560	Continued From page 7 4. The week of 04/30/2023 - 05/06/2023 and 05/07/2023 - 05/13/2023, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in CNAs to total staff on 14 of 14 evening shifts as follows: - 04/30/2023 had 8 CNAs for 130 residents on the day shift, required 16 CNAs. - 04/30/2023 had 6 CNAs to 21 total staff on the evening shift, required 10 CNAs. - 05/01/2023 had 8 CNAs for 128 residents on the day shift, required 16 CNAs. - 05/01/2023 had 6 CNAs to 20 total staff on the evening shift, required 10 CNAs. - 05/02/2023 had 12 CNAs for 128 residents on the day shift, required 16 CNAs. - 05/02/2023 had 11 CNAs to 24 total staff on the evening shift, required 12 CNAs. - 05/03/2023 had 15 CNAs for 128 residents on the day shift, required 16 CNAs. - 05/03/2023 had 11 CNAs to 27 total staff on the evening shift, required 13 CNAs. - 05/04/2023 had 13 CNAs for 128 residents on the day shift, required 16 CNAs. - 05/04/2023 had 13 CNAs to 30 total staff on the evening shift, required 15 CNAs. - 05/05/2023 had 9 CNAs for 128 residents on the day shift, required 16 CNAs. - 05/05/2023 had 9 CNAs to 23 total staff on the evening shift, required 12 CNAs. - 05/06/2023 had 8 CNAs for 128 residents on the day shift, required 16 CNAs. - 05/06/2023 had 9 CNAs to 27 total staff on the evening shift, required 13 CNAs. - 05/07/2023 had 7 CNAs for 140 residents on the day shift, required 18 CNAs. - 05/07/2023 had 5 CNAs to 24 total staff on the evening shift, required 12 CNAs.	S 560		

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MOUNT HOLLY REHABILITATION & HEALTHCARE CE	62 RICHMOND AVENUE LUMBERTON, NJ 08048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 8 - 05/08/2023 had 12 CNAs for 138 residents on the day shift, required 17 CNAs. - 05/08/2023 had 5 CNAs to 20 total staff on the evening shift, required 10 CNAs. - 05/09/2023 had 9 CNAs for 138 residents on the day shift, required 17 CNAs. - 05/09/2023 had 7 CNAs to 24 total staff on the evening shift, required 12 CNAs. - 05/10/2023 had 12 CNAs for 138 residents on the day shift, required 17 CNAs. - 05/10/2023 had 8 CNAs to 25 total staff on the evening shift, required 12 CNAs. - 05/11/2023 had 10 CNAs for 138 residents on the day shift, required 17 CNAs. - 05/11/2023 had 13 CNAs to 29 total staff on the evening shift, required 14 CNAs. - 05/12/2023 had 9 CNAs for 138 residents on the day shift, required 17 CNAs. - 05/12/2023 had 9 CNAs to 25 total staff on the evening shift, required 12 CNAs. - 05/13/2023 had 9 CNAs for 136 residents on the day shift, required 17 CNAs. - 05/13/2023 had 10 CNAs to 23 total staff on the evening shift, required 11 CNAs. During an interview on 05/19/2023 at 12:55 PM, the Staffing Coordinator (SC) stated she was aware that during the weeks from 04/30/2023 to 05/13/2023 the staffing was below the mandated New Jersey (NJ) minimum staffing ratios. The SC stated staff did not show up or called in indicating they were going to be absent. Per the SC, most of the time, the facility scheduled enough staff but then scheduled staff called in or did not show up. According to the SC, the evening shift was particularly difficult to staff. The SC stated she was aware of the NJ minimum staffing ratios, and it was the expectation that the NJ minimum staffing ratios be followed.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60310	A. BUILDING: _____ B. WING _____	C 05/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT HOLLY REHABILITATION & HEALTHCARE CE	62 RICHMOND AVENUE LUMBERTON, NJ 08048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 9 During an interview on 05/20/2023 at 5:33 PM, the Director of Nursing (DON) stated she was aware of NJ minimum staffing ratios. The DON stated that for the weeks of 04/30/2023 to 05/13/2023, the facility lost several nurses and certified nursing assistants (CNA) to a competitor without notice. Per the DON, she expected the NJ minimum staffing ratios to be followed and the facility to be sufficiently staffed. During an interview on 05/20/2023 at 6:38 PM, the Administrator stated she created the schedule according to census and mandated minimum staffing ratios. For the weeks of 04/30/2023 to 05/13/2023, the Administrator stated the facility had call ins, and that was why the facility was short staffed. The Administrator stated she expected the facility to follow the NJ minimum staffing ratios and to be sufficiently staffed.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315128 Y1	A. Building B. Wing Y2	7/19/2023 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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0554	Correction	ID Prefix	F0580	Correction	ID Prefix	F0609	Correction
Reg. #	483.10(c)(7)	Completed	Reg. #	483.10(g)(14)(i)-(iv)(15)	Completed	Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC		06/27/2023	LSC		06/27/2023	LSC		06/27/2023
ID Prefix	F0644	Correction	ID Prefix	F0645	Correction	ID Prefix	F0657	Correction
Reg. #	483.20(e)(1)(2)	Completed	Reg. #	483.20(k)(1)-(3)	Completed	Reg. #	483.21(b)(2)(i)-(iii)	Completed
LSC		06/27/2023	LSC		06/27/2023	LSC		06/27/2023
ID Prefix	F0676	Correction	ID Prefix	F0689	Correction	ID Prefix	F0695	Correction
Reg. #	483.24(a)(1)(b)(1)-(5)(i)-(iii)	Completed	Reg. #	483.25(d)(1)(2)	Completed	Reg. #	483.25(i)	Completed
LSC		06/27/2023	LSC		06/27/2023	LSC		06/27/2023
ID Prefix	F0700	Correction	ID Prefix	F0725	Correction	ID Prefix	F0755	Correction
Reg. #	483.25(n)(1)-(4)	Completed	Reg. #	483.35(a)(1)(2)	Completed	Reg. #	483.45(a)(b)(1)-(3)	Completed
LSC		06/27/2023	LSC		06/27/2023	LSC		06/27/2023
ID Prefix	F0770	Correction	ID Prefix	F0808	Correction	ID Prefix		Correction
Reg. #	483.50(a)(1)(i)	Completed	Reg. #	483.60(e)(1)(2)	Completed	Reg. #		Completed
LSC		06/27/2023	LSC		06/27/2023	LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
60310	A. Building B. Wing	7/28/2023

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 (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/25/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO