STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING _____ B. WING _____	C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD BRICK, NJ 08724**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey 07/12/2024 Census: 143 Sample Size: 29+2 closed records Complaint #: NJ 160508 160607160656, 161600, 163636, 168248, 168274, 170646, 170702, 171127, 174029, 174765 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. In addition, a complaint investigation was completed. The facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care facilities, based on this complaint.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # NJ 160656 Based on interview, record review, and review of other facility documents, it was determined that the facility failed to ensure medications,	F 658	1. Resident #234 NJ Ex Order 26.4(b)(1) at the facility. 2.all residents have the potential to be affected by this deficient practice 3 On 8.5.24 the DON/designee pulled	8/29/24

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

Electronically Signed | 08/05/2024

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F 658	Continued From page 1 treatments, and NJ Ex Order 26.4(b)(1) were administered within the required time frame consistent with professional standards and facility policy. This deficient practice was identified for 1 of 7 residents (Resident # 234) reviewed for medication, treatment, and NJ Ex Order 26.4(b)(1) administration. The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A review of Resident # 234's Admission Record	F 658	audit reports for the last 7 days on residents with orders for an enteral feeding along with other medications to validate timely administration as ordered. Variances were addressed to include documenting reason for the delay along with physician and resident/responsible party notification. The Licensed nursing staff was re-educated by the DON/designee on the need to provide services that meet professional standards which include following physician orders for timely administration of enteral feeding and/or medications as orders. Education also included the need to document the reason for the delay along with physician and resident/ responsible party notification. 4. An audit of 3 residents with orders for an enteral feeding along with other medications will be conducted by the DON/designee to validate that medications and enteral feeding was given timely and as ordered. Review will also validate that documentation related to reason for the delay along with physician and resident/responsible party notification are in place with findings. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Director of Nurses/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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revealed diagnoses which included but were not limited to; [redacted], and [redacted]).

A review of the most recent comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate resident care dated [redacted], included but was not limited to; Section [redacted] documented the resident required staff assistance for [redacted]), and Section [redacted] that the resident required a [redacted] while a resident at the facility.

A review of the Order Summary Report, active orders as of [redacted], included but were not limited to; [redacted] ... every shift [name redacted] via [redacted] per hour X 18 hours or until [redacted]: total [redacted] = [redacted] every 4 hours, 5 times a day; [redacted] 1 tablet via [redacted]) two times a day; [redacted] give 1 tablet via [redacted] two times a day; [redacted] give 1 [redacted] before meals and at bedtime; [redacted] two times a day; [redacted] four times a day; [redacted] give 2 capsules via [redacted] in the evening; and [redacted] by mouth every 6 hours. On [redacted], an order for [redacted] give 1 tablet via [redacted] three times a day for [redacted] until [redacted].

A review of the Medication Admin (Administration) Audit Report dates run [redacted] through

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NJ Ex Order 26.4(b)(1) identified the following as being administered 2 or more hours late:

NJ Ex Order 26.4(b)(1) [name redacted] either NJ Ex Order 26.4(b) times on NJ Ex Order 26.4(b)(1) x 1; NJ Ex Order 26.4(b)(1) x 2; NJ Ex Order 26.4(b)(1) x 2; NJ Ex Order 26.4(b)(1) x 1; NJ Ex Order 26.4(b)(1) x 1; NJ Ex Order 26.4(b)(1) x 2; NJ Ex Order 26.4(b)(1) x 2; NJ Ex Order 26.4(b)(1) x 2; NJ Ex Order 26.4(b)(1) x 1; NJ Ex Order 26.4(b)(1) x 1; and NJ Ex Order 26.4(b)(1) x 1.

NJ Ex Order 26.4(b)(22 times on NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); and NJ Ex Order 26.4(b)(1).

NJ Ex Order 26.4(b)(1) 1 time on NJ Ex Order 26.4(b)(1).

NJ Ex Order 26.4(b)(1) 6 times on NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); and NJ Ex Order 26.4(b)(1).

NJ Ex Order 26.4(b)(13 times on NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); and NJ Ex Order 26.4(b)(1).

NJ Ex Order 26.4(b)(1) 4 time on NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); and NJ Ex Order 26.4(b)(1).

NJ Ex Order 26.4(b)(1) 16 times on NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1) x 2; NJ Ex Order 26.4(b)(1); and NJ Ex Order 26.4(b)(1).

NJ Ex Order 26.4(b)(1) 11 times on NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1);

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F 658	Continued From page 4 NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) 7 times on NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1); and NJ Ex Order 26.4(b)(1). A review of the Progress Notes failed to document medications, treatments, or NJ Ex Order 26 being administered late or the physician and family notification. On 07/09/2024 at 10:42 AM, during an interview with the surveyor, a US FOIA (b)(6) stated the process for NJ Ex Order 26.4(b)(1) was to gather the supplies, prime the NJ Ex Order 26.4, use a NJ Ex Order 26.4(b)(1) to ensure correct placement of the NJ Ex Order 26.4(b)(1), NJ Ex Ord the NJ Ex Or with water, and NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) or medication administration. She further stated that the NJ Ex Order 26.4(b) would be changed daily, and that staff were to provide NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) as close to the ordered time as possible. The US FOIA stated that the staff would only have an hour before or after the ordered times to administer NJ Ex Order 26.4(b) treatments, and medications. On 07/10/2024 at 8:37 AM, the U.S. FOIA (b) (6)) stated it was important to administer NJ Ex Order 26.4(b)(1) in a timely fashion, and that it was "vital to see if the resident could be NJ Ex Order 26.4(b)(1) and if they still need the NJ Ex Order 26 NJ Ex Orde She further stated, "you don't want to it [NJ Ex Order 26.4(b)(1)] if you are late which it shouldn't be, and that staff would have to check for NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) ." When inquired if an NJ Ex Order 26.4(b)(1) was administered	F 658		

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two or more hours late, the U.S. FO stated, "That's a big stretch and it should be documented why it was late." When asked about Resident #234, the U.S. FO stated she was not the U.S. FO at the facility at that time.

On 07/10/2024 at 12:12 PM, during an interview with the surveyor, a second LPN stated the process for administering NJ Ex Order 26.4(b)(or medications NJ Ex Order 26.4(b)(1). She stated that the staff should NJ Ex Order 26.4(b)(1), and check for NJ Ex Order 26.4(and placement. She stated that she was caring for a resident who had NJ Ex Order 26.4(b and was being administered NJ Ex Order 26.4(b)(1) which would be done NJ Ex Order 26.4(b)(1).

On 07/10/2024 at 1:04 PM, the U.S. FOIA (b) (6) stated the nurses should be documenting as they are administering NJ Ex Order 26. , medications, and treatments. She stated the best practice was to check off the medication or treatment at the time it was administered. When asked about the Medication Admin Audit Report, the U.S. FOIA was unable to provide additional information as to why the medications, treatments, and NJ Ex Order 26.4(b)(1) were documented as being administered two or more hours late.

A review of the facility provided policy, "Enteral Nutrition" revised 2018, included but was not limited to; "Policy Statement: Adequate nutritional support through enteral nutrition is provided to residents as ordered."

A review of the facility provided policy, "Administering Medications" undated, included but was not limited to; "Medications are administered in a safe and timely manner, and as

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F 658	Continued From page 6 prescribed." Policy: "4. medications are administered in accordance with prescriber orders, including any required time frame." "7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified ...". "21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR (Medication Administration Record) space provided for that drug and dose. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones." NJAC 8:39-27.1(a)	F 658		
F 689 SS=G	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: C/O # NJ163363 Based on interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to: a) assess a resident (Resident #534) in a timely manner by a US FOIA (b)(6) who had NJ Ex Order 26.4(b)(1) which resulted in the resident experiencing NJ Ex Or and a NJ Ex Order 26.4(b)(1). Resident #534 NJ Ex	F 689	1. Resident #534 NJ Ex Order 26.4(b)(1) at the facility. The identified US FOIA is no longer employed at the facility. Resident #107 was reevaluated for the NJ Ex Order 26.4(b)(1) use by the IDT with orders obtained and care plan updated to include the risk for NJ Ex Order 26.4(b)(1) by the licensed nurse on 7.10.24.	8/29/24

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F 689	Continued From page 7 on [NJ Ex Order 26.4] at approximately 6:00 PM, and was not assessed until the next day at approximately 10:15 AM (over 12 hours) by the [U.S. FOIA (b) (6)]. This deficient practice was identified for 1 of 4 residents reviewed for [NJ Ex Ord] and b) failed to ensure that there was a physician order for the use and [NJ Ex Order 26.4(b)(1)] of a [NJ Ex Order 2] device ([NJ Ex Order 26.4]) used to prevent residents from [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)]) in place. This deficient practice was identified for 1 of 6 residents reviewed for accidents (Resident #107). This deficient practice was evidenced by the following: A review of an undated facility provided policy titled, "Assessing Falls and Their Causes" revealed under "Steps in the Procedure, After a Fall:" 1. If a resident has just fallen or is found without a witness to the event evaluate for possible injuries to the head, neck, spine, and extremities. 3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 5. Notify the resident's attending physician and family in an appropriate time frame. a. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone. The policy also revealed, under "Documentation," that When a resident falls, the following should be recorded:	F 689	2. all residents have potentil to be affected by thei deficient practice 3.The DON/designee reviewed incidents in the last 30 days to validate that timely Licensed Nurse evaluation was completed and services were provided to include pain management on residents status post-fall. No further variances were noted, or variances addressed. The DON/designee reviewed residents with wanderguards in use to validate that orders and, an at risk for elopement care plan was is in place. The MDS Coordinator/ designee reviewed the residents with wanderguards in use to validate the appropriate coding was completed on the most recent MDS. Variances were addressed The Licensed nursing staff was re-educated by the DON/designee on the facility policy and standard of practice for unwitnessed fall, to include but not limited to Facility Supervisor notification, the Registered Nurse conducting a full body assessment, risk report completed, documentation of incident, endorsement of the incident to the following shift, and timely notification to the primary medical doctor and the resident's family. Education also indicated the need to obtain physician□s orders prior to implementing a wanderguard device on a resident and updating the resident care plans to include at risk for elopement based on resident evaluation as indicated. The MDS Coordinator was educated by the DON/designee on MDS coding accuracy to include but not limited to the use of the wanderguard.	

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F 689	Continued From page 8 1. The condition in which the resident was found (e.g., resident found lying on the floor between bed and chair). 2. Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician and family, as indicated. 5. Completion of a falls risk assessment. 6. Appropriate interventions taken to prevent future falls. 7. The signature and title of the person recording the data. 1) According to the Admission Record, Resident #534 was admitted to the facility with diagnoses including but not limited to: NJ Ex Order 26.4(b)(1) [redacted]) and NJ Ex Order 26.4(b)(1) [redacted] According to the Minimum Data Set (MDS), an assessment tool used to facilitate care dated NJ Ex Order 26.4(b)(1), Resident #534 had a Brief Interview for Mental Status (BIMS) score of NJ E/15, indicating NJ Ex Order 26.4(b)(1). Section NJ Ex O indicated that Resident #534 was independent with walking in the corridor.	F 689	4. An audit to include 3 residents post-fall will be conducted to validate the facility policy and standard of practice for unwitnessed falls was followed, to include but not limited to supervisor notification with conducting a full body evaluation, risk reporter completed, documentation of incident, endorsement of the incident was made to the following shift, and timely notification was made to the primary medical doctor and the resident's responsible party. In addition, an audit of 3 residents with wanderguards will be made to validate that physician orders, and at risk for elopement care plan are in place and that the most recent MDS completed was accurately coded related to wanderguard use. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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A review of the Progress Notes revealed the following:

a) On 04/17/2023 at 8:10 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM#2) was alerted by staff that Resident #534 had [NJ Ex Order] on [NJ Ex Order 26.4(b)(1)] at about 6:00 PM. LPN/UM #2 went to check on the resident who was still in bed. Resident #534 stated [NJ Ex] was [NJ Ex Order 2] while pointing to [NJ Ex Order 26.4(b)(1)] which was [NJ Ex Order 26.4(b)(1)]. Resident #534 was [NJ Ex Order 26.4(b)(1)] their [NJ Ex Order 26.4(b)(1)] without [NJ Ex Orde] LPN/UM #2 called the [US FOIA (b)(6)] and received orders for [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 2] and [NJ Ex Order 26.4(b)(1)] and [NJ Ex Or] medication. The [U.S. FOIA (b) (6)] was asked to consult.

b) On [NJ Ex Order 26.4(b)(1)] at 10:15 AM, the [U.S. FO] assessed Resident #534. The resident stated [NJ Ex Order 26.4(b)(1)] was [NJ Ex Order 26.4(b)(1)].

c) On [NJ Ex Order 26.4(b)(1)] at 10:16 AM, the [U.S. FO] ordered the resident to be sent to ER (emergency room) for a [NJ Ex Order 26.4(b)(1)].

d) On [NJ Ex Order 26.4(b)(1)] at 11:19 AM, the resident was transported to the ER.

e) On [NJ Ex Order 26.4(b)(1)] at 18:08 PM (6:08 PM), Resident #534 was admitted to the hospital with a [NJ Ex Order 26.4(b)(1)].

A review of the facility investigation titled "Full QA (Quality Assurance) Report" dated [NJ Ex Order 26.4(b)(1)], revealed the following under the Summary:

Resident # 534 had [NJ Ex Order 26.4(b)(1)] resulting

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in [NJ Ex Order 26.4(b)]. The resident [NJ Ex] in front of the nursing station. Certified Nursing Assistant (CNA #2) heard the resident [NJ Ex] and went to check on the resident. CNA #2 then notified the assigned Licensed Practical Nurse (LPN #2). The resident was brought back to their room and further assessed for [NJ Ex Order] LPN #2 said the resident had [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] noted and was observed without any [NJ Ex Order 26.4(b)(1)]. LPN #2 failed to follow the facility policy and standard of practice for [NJ Ex Order 26.4(b)(1)] and failed to notify the [US FOIA (b)(6)] supervisor to conduct a [NJ Ex Order 26.4(b)] assessment. In addition, LPN #2 also failed to complete a [NJ Ex] report, document in the medical record, endorse the incident to the following shift, and notify primary medical doctor and the resident's family. On [NJ Ex Order 26.4(b)(1)], at approximately 8:00 AM, CNA #2, who was present the night before when the [NJ Ex] happened, approached LPN/UM #2 inquiring about how Resident #534 was doing. LPN/UM #2 immediately assessed the resident who [NJ Ex Order 26.4(b)(1)] to their [NJ Ex Order 26.4(b)(1)], was [NJ Ex Order 26.4(b)(1)] their [NJ Ex Order 26.4(b)(1)] when asked and the [NJ Ex Order 26.4(b)] was noted to be [NJ Ex Order 26.4(b)(1)]. Vitals were obtained, [NJ Ex Order 26.4(b)(1)] checks initiated, [NJ Ex] was applied to [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)] was administered. The [U.S. FOIA (b) (6)]), [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)]), and the resident's family were notified of incident. New orders were given for [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4(b)(1)]; and for [NJ Ex Order 26.4(b)(1)] twice day for [NJ Ex Order] The [U.S. FOIA (b) (6)]) was in the facility at the time and staff requested a consult. An assessment was completed and new orders were received to send the resident to the ER for further evaluation. Resident #534 was admitted with a diagnosis of a [NJ Ex Order 26.4(b)(1)]

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NJ Ex Order 26.4(

The resident did not return to the facility.

During an interview with the surveyor on 07/10/2024 at 10:01 AM, CNA #2 who originally reported the NJ Ex stated, "I don't really remember that night, it was NJ Ex Order 26.4(b)(1)." When asked what would you do if you found a resident NJ Ex Order 26 , CNA #2 replied, "I would call for the nurse and stay with the resident until the nurse got there.

During an interview with the surveyor on 07/10/2024 at 12:05 PM, LPN/UM #2 stated, "I don't remember that incident." The surveyor asked LPN/UM #2 when should a resident be assessed after NJ Ex Order LPN/UM #2 told the surveyor that "Residents should be assessed immediately after NJ Ex Ord by the RN supervisor."

During an interview with the surveyor on 07/10/2024 at 01:12 PM, the U.S. FOIA replied "Yes", when asked if LPN #2 should have notified an US FOIA to assess Resident #534 after the NJ Exc The U.S. FOIA also replied "Yes", when asked if LPN #2 should have reported the NJ Ex at that time. The U.S. FOIA also stated, "The resident should have been assessed right away."

A review of the facility policy titled, "Wander Management and Elopement Prevention," updated March 2022 revealed:

2. The staff will implement a wander management system device, if recommended, as

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F 689	Continued From page 12 a part of the plan of care. 3. Resident care plans will include resident specific interventions to ensure safe wandering and prevent elopement. 4. The wander management system device will be used in conjunction with other resident-specific interventions for the management of unsafe wandering. 2) According to the Admission Record, Resident #107 was admitted with diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) During the initial tour on 07/09/2024 at 09:22 AM, Resident #107 was observed in their room eating breakfast. At that time, a NJ Ex Order 26.4(b)(1) [redacted]) was fastened to NJ Ex Order 26.4(b)(1). A review of Resident #107's Physician Orders did not include a physician order for a NJ Ex Order 26.4 [redacted] device. A review Resident #107's Care Plan did not include a focus area for the Risk for NJ Ex Order 26.4(b)(1) and no indication that a NJ Ex Order 26.4(b)(1) was placed to the NJ Ex Order 26.4(b)(1) A review the most recent MDS dated NJ Ex Order 26.4(b)(1), revealed Resident #107 had NJ Ex Order 26.4(b)(1) [redacted] Under Section NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 there was no documentation that a NJ Ex Order 26.4(b)(1) was used. A review of a Quarterly Evaluation dated	F 689		

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F 689	Continued From page 13 NJ Ex Order 26.4(b)(1), under the NJ Ex Order 26.4(b)(1) Evaluation section, indicated that Resident #107 was assessed and found to have at NJ Ex O including NJ Ex Order 26.4(b)(1) and had actual/potential risk for NJ Ex Order 26.4(b)(1) Included in the interventions was a NJ Ex Order 26.4(b)(1). During an interview with the surveyor on 07/10/2024 at 12:45 PM, LPN/UM #2 verified that Resident #107 did not have a Physician Order or Care Plan for a NJ Ex Order 26.4(b)(1). At that time, LPN/UM #2 indicated that she would "get working on it." During an interview with the surveyor on 7/11/2024 at 01:11 PM, the U.S. FOIA stated that the process for assessing for risk of NJ Ex Order 26.4(b)(1) is done on admission and as needed. The U.S. FOIA stated that if a resident was indicated to be at risk and a NJ Ex Order 26.4(b)(1) was recommended, the Physician would be notified and an order for a NJ Ex Order 26.4(b)(1) would be obtained. In addition, the family is notified and the Care Plan is updated.	F 689		
F 695 SS=D	NJAC 8:39 - 27.1 (a) 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,	F 695		8/29/24

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F 695	Continued From page 14 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to provide the necessary care and maintenance of NJ Ex Order 26.4(b)(1) equipment for 1 of 2 residents reviewed for NJ Ex Order 26.4(b)(1) care (Resident #6). This deficient practice was evidenced by the following: During initial tour on 07/08/2024 at 8:08AM, the surveyor observed Resident # 6 NJ Ex Order 26.4(b)(1) not labeled, and the bag that held the NJ Ex Order 2 when not in use was also not dated. On 07/09/2024 at 09:11 AM during an observation of Resident #6, the NJ Ex Order 26.4(b)(1) was not labeled or dated. On 07/10/24 at 10:12 AM during an observation of Resident #6, the NJ Ex Order 26.4(b)(1) and bag were not labeled or dated. According to the Admission Record, Resident #6 was admitted to the facility with diagnoses including but not limited to, NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b A review of the Order Summary Report revealed a physician order initiated date of NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1) every shift continuous. In addition, for the care of the NJ Ex Order 26.4(b)(1) equipment; Change NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) weekly on Fridays 11-1 shift, and as needed, date and label NJ Ex Order 2 and NJ Ex Order 26.4(b)(1).	F 695	1. Resident #6□s NJ Ex Order 26.4(b)(1) g was changed, labeled and dated by the licensed nurse on 7.11.24 The bag used to store NJ Ex Order 26.4(b)(1 when not in use was also replaced, labeled and dated by the licensed nurses. Resident # 6 was reviewed by the licensed nurse with no s/s of adverse effect related to previously undated NJ Ex Order 26.4(b)(1) or undated bag 2. All residents have the potential to be affected by this deficeint paractice 3 The DON/designee conducted rounds on 7.11.24 and 7.12.24. for residents with oxygen orders to validate that oxygen tubing and storage bags were labeled and dated per facility policy. The licensed nurses were re-educated on the need to label and date oxygen tubing and bags when changed and to validate that oxygen tubing and storage bags were labeled and dated per facility policy on rounds. 4. An audit to include 3 rounds will be conducted by the DON/Designee on nursing units at different times of the day to validate that resident□s with oxygen orders tubing and storage bags were labeled and dated per facility. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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F 695	Continued From page 15 During an interview with the surveyor,on 07/09/2024 at 12:00 PM, LPN/UM #2 stated that the NJ Ex Order 26.4(b)(1) equipment is maintained by nursing. She added that NJ Ex Order 26.4(b)(1) equipment is changed weekly on Fridays night shift. When equipment is changed, it should be documented in the Electronic Record and that the equipment should be dated and initialed. During an interview with the surveyor on 07/11/2024 at 12:10 PM, the U.S. FOIA (b) (6) stated that during infection control rounds on the units, he checks that NJ Ex Order 26.4(b)(1) equipment is properly dated and changed weekly and NJ Ex Order 26.4(b)(1) should be dated. During an interview on 07/11/2024 at 01:28 PM, the U.S. FOIA (b) (6)) stated that all NJ Ex Order 26.4 equipment is to be changed weekly on Friday night shift. She added that the NJ Ex Order 2 and storage bag should be dated with the last change date. A review of a facility policy titled, "Oxygen Administration," with a revised date of 10/2010, revealed, "Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration."	F 695		
F 725 SS=F	N.J.A.C.8:39-27.1(a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		8/29/24

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F 725	Continued From page 16 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: Complaint # NJ00168248, NJ00168274 Based on interviews, review of the Nurse Staffing Report and the PB&J (Payroll Based Journal) report and other facility documentation, it was determined that the facility failed to ensure there was sufficient nursing staff on a 24-hour basis to provide nursing care to the residents. This deficient practice was evidenced by the following: A review of the Facility Assessment revealed	F 725	1. No specific residents were identified. 2. Current residents have the potential to be affected by this deficient practice. Rounds were made by the DON /designee on 7.12.24 and 7.17.24. to validate care and services were provided to residents per plan of care with no concerns noted. Staffing was reviewed with the Staffing Coordinator, Administrator and DON for the next 14 days to validate nursing staff scheduled per facility needs and required	

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F 725	Continued From page 17 under the "Staffing Guidelines" that the facility created a staffing pattern to ensure their residents needs are met on a consistent basis. The assessment went on to indicate that "Our facility staffing pattern provides a base to ensure that the facility has a sufficient number of qualified staff to meet the needs of the residents." We incorporate the State of New Jersey's regulatory requirements for ratios of direct care staff members to residents into our staffing baseline. A review of the Nurse Staffing Reports revealed the following: 1.For the 2 weeks of Complaint staffing from 01/08/2023 to 01/21/2023, the facility was deficient in Certified Nursing Assistant (CNA) staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -01/08/23 had 9 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/09/23 had 10 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/10/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/11/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/12/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/13/23 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/13/23 had 9 total staff for 136 residents on the overnight shift, required at least 10 total staff. -01/14/23 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/15/23 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/16/23 had 10 CNAs for 136 residents on the	F 725	ratios. Variances will be addressed 3. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were re-educated by the Administrator on sufficient staffing based on facility Assessment and state specific ratios. Education also included recruitment and retention strategies to include but are not limited to sign-on bonuses, referral bonuses, pick-up shift bonuses, rate adjustments, and text message campaigns to meet facility staffing needs. Further the staffing coordinator will review staffing during morning meeting and notify the DON and/or Administrator of potential barriers to meeting sufficient staffing requirement. Bonuses, schedule changes will be offered to nursing staff to include clinical leadership to meet resident needs and sufficient staffing requirements. The facility supervisor was re-educated and will contact the Admin/DON on additional staffing needs to meet resident care or minimum requirement as indicated. 4. An audit to include 3 reviews of the nursing staff schedule will be conducted by the Administrator / designee to validate that nursing staffing meets the facility needs and state specific minimums. Variances will be addressed with bonuses and schedule changes offered to nursing staff to include clinical leadership. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and	

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F 725	Continued From page 18 day shift, required at least 17 CNAs. -01/17/23 had 11 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/18/23 had 11 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/19/23 had 12.5 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/20/23 had 11.5 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/21/23 had 11 CNAs for 141 residents on the day shift, required at least 18 CNAs. 2. For the week of Complaint staffing from 02/05/2023 to 02/11/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -02/05/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -02/05/23 had 9 total staff for 137 residents on the overnight shift, required at least 10 total staff. -02/06/23 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -02/07/23 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -02/08/23 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -02/09/23 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -02/10/23 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. -02/11/23 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. 3. For the week of Complaint staffing from 04/16/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -04/16/23 had 10 CNAs for 137 residents on the	F 725	recommendation monthly for 3 months or ongoing until compliance is sustained.	

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day shift, required at least 17 CNAs.
-04/17/23 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-04/18/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-04/19/23 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-04/20/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-04/21/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-04/22/23 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs.

4. For the week of Complaint staffing from 10/08/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:
-10/08/23 had 11.5 CNAs for 133 residents on the day shift, required at least 17 CNAs.
-10/09/23 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs.
-10/10/23 had 12 CNAs for 128 residents on the day shift, required at least 16 CNAs.
-10/11/23 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-10/12/23 had 10 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-10/13/23 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs.
-10/14/23 had 12.5 CNAs for 124 residents on the day shift, required at least 15 CNAs.

5. For the 2 weeks of Complaint staffing from 12/17/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:
-12/17/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs.

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-12/18/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs.
-12/19/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs.
-12/20/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs.
-12/21/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs.
-12/22/23 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-12/23/23 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-12/24/23 had 9 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-12/25/23 had 12.5 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-12/26/23 had 8 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-12/27/23 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-12/28/23 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-12/29/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-12/30/23 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs.

6. For the week of Complaint staffing from 01/21/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:
-01/21/24 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs.
-01/22/24 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs.
-01/23/24 had 11 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-01/24/24 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs.

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-01/25/24 had 11 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-01/26/24 had 11 CNAs for 128 residents on the day shift, required at least 16 CNAs.
-01/27/24 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs.

7. For the week of Complaint staffing from 02/25/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:
-02/25/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-02/26/24 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-02/27/24 had 10 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-02/28/24 had 9 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-02/29/24 had 11 CNAs for 135 residents on the day shift, required at least 17 CNAs.
-03/01/24 had 9 CNAs for 135 residents on the day shift, required at least 17 CNAs.
-03/02/24 had 9 CNAs for 135 residents on the day shift, required at least 17 CNAs.

8. For the 2 weeks of Complaint staffing from 05/12/2024 to 05/25/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:
-05/12/24 had 10 CNAs for 146 residents on the day shift, required at least 18 CNAs.
-05/13/24 had 10.5 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-05/14/24 had 14 CNAs for 143 residents on the day shift, required at least 18 CNAs.
-05/15/24 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-05/16/24 had 15 CNAs for 142 residents on the

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day shift, required at least 18 CNAs.
-05/17/24 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-05/18/24 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-05/19/24 had 12.5 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-05/20/24 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-05/21/24 had 11 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-05/22/24 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-05/23/24 had 10.5 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-05/24/24 had 10 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-05/25/24 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs.

9. For the 1 week of staffing prior to survey from 06/30/2024 to 07/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:
-06/30/24 had 9.5 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-07/01/24 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-07/02/24 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-07/03/24 had 14 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-07/04/24 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-07/05/24 had 11 CNAs for 146 residents on the day shift, required at least 18 CNAs.
-07/06/24 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs.

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During the initial tour on 07/08/2024 at 08:12 AM, the surveyor asked for census and current staffing for the Birch Unit. Licensed Practical Nurse/Unit Manger (LPN/UM #1) said there are 56 residents, 2 nurses and 4 CNA's.

During an interview with the surveyor on 07/08/2024 at 09:45 AM, Resident # 99 said that on weekends they seem short staffed.

During an interview with the surveyor on 07/10/2024 at 11:10 AM, CNA #1 who said we have a heavy workload. I average 15 residents for my shift, and it depends on call outs. Even if we have 5 aides, I still have 12 residents.

During an interview with the surveyor on 07/10/2024 at 12:33 PM, the U.S. FOIA (b) (6) said I also do staffing and payroll. When asked if she was aware of the minimum staffing requirements for CNA's she stated 1:8 for CNA for 7a-3p shift, 1:10 3p-11p, 1:14 for 11p-7a shift. She went on to say when I do the schedule, I try to meet it, but when there are call outs, it puts a damper on the schedule. I do the schedule for the week, if there are call outs we try to call per diems. The U.S. FOIA (b) (6) said that "not all the time meeting the staffing ratio requirements."

During an interview with the surveyor on 07/11/2024 at 09:12 AM, the U.S. FOIA (b) (6)) was asked What is your current staffing pattern that you use for each unit for each unit? The U.S. FOIA relayed the following:

Cedar unit
Day shift- 2 nurses, 1 Unit Manager (UM), and we try to have 3rd nurse depending on census to

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help. For CNA's depends on census and we try to follow CNA ratios per New Jersey Department of Health (NJDOH), of 1-8 and try to go for 5 CNA's.
Evening shift- 2 nurses, 1 Registered Nurse (RN) or Licensed Practical Nurse (LPN) supervisor. There is always an RN in the building on all shifts.
We try to follow 1-10 CNA guidelines. The U.S. FOIA gave no specific number of CNA's.
Night shift- 1 nurse, 1 RN or LPN supervisor to help with morning med pass depending on census. CNA's 1-14 ratio and we try to make sure we have that in place.

Applewood Unit
Days shift- 2 nurses, 1 UM, and follow state guidelines for CNA's as well.
Evening shift-2 nurses, supervisor for house, 1-10 ratio for CNA's.
Night shift- 1 nurse, CNA's 1-14 ratio per state guidelines.

Birch Unit-
Day shift- 2 nurses, 1 UM, CNA's 1-8 based on state guidelines.
Evening shift- 2 nurses, 1 supervisor for house RN or LPN, CNA's 1-10 based on state guidelines.
Night shift- 1 nurse, 1 supervisor for house RN or LPN and CNAs based on state guidelines 1-14.

The surveyor questioned what about supervisors? The U.S. FOIA said, "1 supervisor on evenings and night shift either RN or LPN, but we always have an RN in the building." The U.S. FOIA was asked if there was any difference on the weekends? And the U.S. FOIA replied the only difference is the UMs are not here on weekends so there is a supervisor on 7-3, 3-11 and 11-7.

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F 725	Continued From page 25 During a follow-up interview with the surveyor on 07/11/2024 at 09:23 AM, the U.S. FOIA said we do our best to meet the state requirements and do our best to fill the call outs and if we need to the U.S. FOIA (b) (6), U.S. FOIA (b) UM, and U.S. FOIA (b) (6) are to assist and to support staff. We staff the best we can, and I don't really think weekend call outs are any different then weekday. During an interview with the surveyor on 07/11/2024 at 12:47 PM, CNA #3 said she has 12 residents today. When asked if she feels as though she can take care of residents properly when she has 12 residents CNA #3 stated, "Not all the time." During an interview with the surveyor on 07/11/2024 at 01:34 PM, the U.S. FOIA confirmed the minimum requirement for CNA is 7-3 shift 1-8 ratio, 3-11 shift is 1-10 ratio, and for 11-7 shift is 1-14. We do the best that we can to meet the ratios. The U.S. FOIA again said I don't feel weekends are any worse that weekday.	F 725		
F 758 SS=D	NJAC 8:39-5.1(a), 27.1(a) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		8/29/24

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F 758	Continued From page 26 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 27 Resident #122 Unnecessary Meds, Psychotropic Meds, and Med Regimen Review Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure specific target behaviors were monitored prior to the administration of an NJ Ex Order 26.4(b)(1) medication for a resident who received an NJ Ex Order 26.4(b)(1) medication ([redacted] since [redacted] of [redacted]. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #122), and was evidenced by the following: On 7/8/2024 at 9:45 AM, the surveyor observed Resident #122 in the dayroom seated in a wheelchair. The resident stated they had woken up early and had just come from [redacted] and stated his/her mood was [redacted] The surveyor reviewed the medical record for Resident #122. A review of the Admission Record (an admission summary) reflected the resident was admitted to the facility with diagnoses which included [redacted], NJ Ex Order 26.4(b)(1), [redacted], and [redacted]. A review of the admission Minimum Data Set (MDS), an assessment tool, dated [redacted], reflected that Resident #122 had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated NJ Ex Order 26.4(b)(1). A further review of the MDS indicated Resident #122 had behaviors of NJ Ex Order 26.4(b)(1) occurred	F 758	1. Resident #122 was reviewed with [redacted]. Resident #122□s orders were updated to include monitoring for the behaviors associated with the use of [redacted] and the monitoring of the potential side effects that may be caused using [redacted] 2. Resident on Antipsychotic meds were reviewed by the DON/designee to validate that orders were in place to monitor for the behaviors associated with the use of the antipsychotic medication and the monitoring of the potential side effects that may be caused using the antipsychotic medication was in place. 3. The licensed nurses were re-educated on the need to obtain or validate that orders are in place and implemented to monitor residents for the behaviors associated with the use of the antipsychotic medication and the monitoring of the potential side effects that may be caused using the antipsychotic medication as indicated per facility policy. 4. An audit of 3 residents on antipsychotic medications will be conducted by the DON/Designee to validate that orders were in place to monitor for the behaviors associated with the use of the antipsychotic medication and the monitoring of the potential side effects that may be caused using the antipsychotic medication are in place. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI	

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F 758	Continued From page 28 one to three days and had received NJ Ex Order 26.4(b)(1) medications on a routine basis during the seven day look-back period. A review of the individualized comprehensive care plan included a focus area initiated NJ Ex Order 26.4(b)(1), and a target date of NJ Ex Order 26.4(b)(1) that the resident used NJ Ex Order 26.4(b)(1) medication related to NJ Ex Order 26.4(b) management, and NJ Ex Order 26.4(b) related to NJ Ex Order 26.4(b)(with a goal to show effectiveness of medication use as evidenced by a reduction in NJ Ex Order 26.4(b)(1) symptoms by the review date. Interventions included to administer NJ Ex Order 26.4(b)(1) medication as ordered. Observe for effectiveness and side effects including NJ Ex Order 26.4(b)(NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4 NJ Ex Order 26.4(b)(NJ Ex Order 26 and NJ Ex Order 26.4(b)(1); consult with physician to consider dosage reduction when clinically appropriate; monitor/record occurrence of target behavior; provide redirection from NJ Ex Order 26.4(b)(1); educate me/family/caregivers about the risks, benefits, and side effects of medication being given. A review of the NJ Ex Order 26.4(b)(Order Summary Report (OSR) included the following physician's orders (PO): A PO dated NJ Ex Order 26.4(b)(, for NJ Ex Order 26.4(b)(1) oral tablet; give NJ Ex Order 26.4(by mouth at bedtime for NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(	F 758	Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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A review of the corresponding [NJ Ex Order 26.4(b)(1)] Medication Administration Record (MAR) reflected that the resident received [NJ Ex Order 26.4(b)(1)] on [NJ Ex Order 26.4(b)]; [NJ Ex Order 26.4(b)]; [NJ Ex Order 26.4(b)]; [NJ Ex Order 26.4(b)]; [NJ Ex Order 26.4(b)]; [NJ Ex Order 26.4(b)]; [NJ Ex Order 26.4(b)]; [NJ Ex Order 26.4(b)]; and [NJ Ex Order 26.4(b)].

A review of both the [NJ Ex Order 26.4(b)(1)] OSR and the corresponding [NJ Ex Order 26.4(b)(1)] MAR did not reveal an order to monitor the behaviors associated with the use of [NJ Ex Order 26.4(b)] or the monitoring of the potential side effects that may be caused using [NJ Ex Order 26.4(b)(1)]

A review of Resident #122's Nursing Progress Notes since admission did not reflect nurses were documenting the presence of or lack of behaviors or side effects associated with the use of [NJ Ex Order 26.4(b)] for NJ Ex Order 26.4(b)(1) related to [NJ Ex Order 26.4(b)(1)]

On 7/10/2024 at 11:51 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN #1) who stated the resident had [NJ Ex Order 26.4(b)] but was [NJ Ex Order] with some [NJ Ex Order 26.4(b)(1)] and was taking [NJ Ex Order 26.4(b)] for [NJ Ex Order 26.4(b)] with [NJ Ex Order 26.4(b)(1)]. LPN #1 further stated she had not witnessed any NJ Ex Order 26.4(b)(1) on her shift nor on any other shifts that she knew of. LPN #1 stated residents on medications like [NJ Ex Order 26.4(b)] should be monitored for side effects and [NJ Ex Order 26.4(b)] every shift. When asked by the surveyor, LPN #2 could not recall if Resident #122 had an order to monitor for behaviors or side effects associated with the use of [NJ Ex Order 26.4(b)(1)]

On 7/10/2024 at 11:55 AM, the surveyor interviewed the Licensed Practical Nurse/ Unit

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Manager (LPN/UM #3) who stated the resident had been taking [NJ Ex Order 26.4(b)] since they were admitted to the facility and had not exhibited any behaviors associated with [NJ Ex Order 26.4(b)(1)]. LPN/UM #3 stated all residents on NJ Ex Order 26.4(b)(1) [redacted]) were monitored every shift for behaviors and side effects.

On 7/10/2024 at 12:10 PM, the surveyor, LPN/UM #3 and LPN #1 reviewed the resident's [NJ Ex Order 26.4(b)(1)] MAR and POS. Both LPN/UM #3 and LPN #1 acknowledged there were no physician's orders to monitor for side effects related to the use of [NJ Ex Order 26.4(b)] or to document/monitor behaviors associated with the resident's [NJ Ex Order 26.4(b)(1)] with NJ Ex Order 26.4(b)(1) diagnosis. LPN/UM #3 and LPN #1 confirmed there should be orders for both.

On 7/10/2024 at 12:20 PM, the surveyor and LPN/UM #3 and LPN #1 again reviewed the resident's POS and there was a new order entered for the resident to be monitored for behaviors and side effects associated with the use of [NJ Ex Order 26.4(b)(1)]. When the surveyor asked LPN/UM #3 if she had contacted someone to enter a new order, she acknowledged she had. LPN/UM #3 stated she had contacted the U.S. FOIA (b) (6) [redacted]) to obtain an order for monitoring and further acknowledged there had not been prior to surveyor inquiry.

On 7/10/2024 at 1:03 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated resident's prescribed [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] medications should be monitored for the target behaviors and side effects of those

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WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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medications every shift for the entire duration the resident was prescribed the medication. The U.S. FOIA (b) confirmed there should have been physician's orders for monitoring when the NJ Ex Order 26.4(b) order was initiated, and that monitoring was important to ensure the resident was not taking medications unnecessarily or experiencing unnecessary side effects.

A review of the revised NJ Ex Order 26.4(b)(1 OSR included the following new physician's orders:

A PO dated NJ Ex Order 26.4(b)(1, for Behaviors/Intervention, monitor for NJ Ex Order 26.4(b)(1 Intervention codes: 1. NJ Ex Order 26.4(b)(1) 2. NJ Ex Ord; 3. NJ Ex Order 26.4 4. NJ Ex Orde 5. food/fluid offered; 6. NJ Ex Order 26.4(b)(1); other interventions (specify in progress notes); 8. medication; every shift for monitoring.

A PO dated NJ Ex Order 26.4(b)(1, "Side Effects, monitor for side effects of NJ Ex Order 26.4(b)(1) medications every shift which may include but is not limited to NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1, NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 2 , NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(NJ Ex Or , NJ Ex Order 26.4(b)(1) (specify in progress notes) every shift for monitoring Side Effects codes: Y = Yes, N = No, document side effects in progress notes."

On 7/12/2024 at 10:47 AM, the survey team met with Facility Administration including the facility U.S. FOIA (b) (6)) who stated the nurse was responsible to ensure physician's orders for all NJ Ex Order 26.4(b)(1) medications included orders for behavior monitoring, side effect monitoring, there was a care plan in place and consent for use was obtained from the resident or their Power of Attorney. The U.S. FOIA acknowledged there should

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have been orders for Resident #122's behavior monitoring associated with the use of [NJ Ex Order 26.4(b)] as well as monitoring for side effects. The [U.S. FOIA] further acknowledged that until surveyor inquiry there were no orders for monitoring.

A review of the facility's "Behavioral Assessment, Intervention and Monitoring" policy, dated revised March 2019, included the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practical physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care...the facility will comply with regulatory requirements related to the use of medication to manage behavioral changes...the nursing staff will identify, document, and inform the physician about specific details regarding changes in the individual's mental status, behavior, cognition, including: a. onset, duration, intensity and frequency of behavioral symptoms...interventions will be individualized and part of overall care environment...non-pharmacological approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. When medications are prescribed for behavioral symptoms, documentation will include: rationale for use; potential underlying causes of behavior; other approaches and interventions tried prior to use of antipsychotic medications; potential risk versus benefits of medications; specific target behaviors and expected outcomes; dosage; duration; monitoring for efficacy and adverse consequences...

NJAC 8:39-27.1(a)

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	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 # NJ00168248, NJ00168274, NJ00170702 Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 1. For the 2 weeks of Complaint staffing from 01/08/2023 to 01/21/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts, 2. For the week of Complaint staffing from 02/05/2023 to 02/11/2023, the facility was deficient in CNA	S 560	1. No specific residents were identified. 2. Current residents have the potential to be affected by this deficient practice. Rounds were made by the DON /designee on 7.12.24 and 7.17.24. to validate care and services were provided to residents per plan of care with no concerns noted. Staffing was reviewed with the Staffing Coordinator, Administrator and DON for the next 14 days to validate nursing staff scheduled per facility needs and required ratios. Variances will be addressed 3. The Staffing Coordinator and Director of Nurses were re-educated by the Administrator on sufficient staffing based on facility Assessment and state	8/29/24

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

Electronically Signed | 08/05/24

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S 560	Continued From page 1 staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts, 3. For the week of Complaint staffing from 04/16/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 4. For the week of Complaint staffing from 10/08/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 5. For the 2 weeks of Complaint staffing from 12/17/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, 6. For the week of Complaint staffing from 01/21/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 7. For the week of Complaint staffing from 02/25/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 8. For the 2 weeks of Complaint staffing from 05/12/2024 to 05/25/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, 9. For the 1 week of staffing prior to survey from 06/30/2024 to 07/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10	S 560	specific ratios. Education also included recruitment and retention strategies to include but are not limited to sign-on bonuses, referral bonuses, pick-up shift bonuses, rate adjustments, and text message campaigns to meet facility staffing needs. Further the staffing coordinator will review staffing during morning meeting and notify the DON and/or Administrator of potential barriers to meeting sufficient staffing requirement. Bonuses, schedule changes will be offered to nursing staff to include clinical leadership to meet resident needs and sufficient staffing requirements. The facility supervisor was re-educated and will contact the Admin/DON on additional staffing needs to meet resident care or minimum requirement as indicated. 4. An audit to include 3 reviews of the nursing staff schedule will be conducted by the Administrator / designee to validate that nursing staffing meets the facility needs and state specific minimums. Variances will be addressed with bonuses and schedule changes offered to nursing staff to include clinical leadership. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and
One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.

A review of the Nurse Staffing Reports revealed the following:

1.For the 2 weeks of Complaint staffing from 01/08/2023 to 01/21/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows:

-01/08/23 had 9 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-01/09/23 had 10 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-01/10/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-01/11/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-01/12/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-01/13/23 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs.
-01/13/23 had 9 total staff for 136 residents on the overnight shift, required at least 10 total staff.
-01/14/23 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs.
-01/15/23 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs.
-01/16/23 had 10 CNAs for 136 residents on the day shift, required at least 17 CNAs.
-01/17/23 had 11 CNAs for 138 residents on the

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S 560	Continued From page 3 day shift, required at least 17 CNAs. -01/18/23 had 11 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/19/23 had 12.5 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/20/23 had 11.5 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/21/23 had 11 CNAs for 141 residents on the day shift, required at least 18 CNAs. 2. For the week of Complaint staffing from 02/05/2023 to 02/11/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -02/05/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -02/05/23 had 9 total staff for 137 residents on the overnight shift, required at least 10 total staff. -02/06/23 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -02/07/23 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -02/08/23 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -02/09/23 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -02/10/23 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. -02/11/23 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. 3. For the week of Complaint staffing from 04/16/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -04/16/23 had 10 CNAs for 137 residents on the day shift, required at least 17 CNAs.	S 560		

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S 560	Continued From page 4 -04/17/23 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. -04/18/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. -04/19/23 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. -04/20/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs. -04/21/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs. -04/22/23 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs. 4. For the week of Complaint staffing from 10/08/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/08/23 had 11.5 CNAs for 133 residents on the day shift, required at least 17 CNAs. -10/09/23 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. -10/10/23 had 12 CNAs for 128 residents on the day shift, required at least 16 CNAs. -10/11/23 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs. -10/12/23 had 10 CNAs for 126 residents on the day shift, required at least 16 CNAs. -10/13/23 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/14/23 had 12.5 CNAs for 124 residents on the day shift, required at least 15 CNAs. 5. For the 2 weeks of Complaint staffing from 12/17/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/17/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 5 -12/18/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -12/19/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -12/20/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -12/21/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -12/22/23 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/23/23 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/24/23 had 9 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/25/23 had 12.5 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/26/23 had 8 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/27/23 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/28/23 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/29/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/30/23 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. 6. For the week of Complaint staffing from 01/21/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/21/24 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. -01/22/24 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs. -01/23/24 had 11 CNAs for 129 residents on the day shift, required at least 16 CNAs. -01/24/24 had 12 CNAs for 129 residents on the	S 560		

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day shift, required at least 16 CNAs.
-01/25/24 had 11 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-01/26/24 had 11 CNAs for 128 residents on the day shift, required at least 16 CNAs.
-01/27/24 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs.

7. For the week of Complaint staffing from 02/25/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-02/25/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-02/26/24 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-02/27/24 had 10 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-02/28/24 had 9 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-02/29/24 had 11 CNAs for 135 residents on the day shift, required at least 17 CNAs.
-03/01/24 had 9 CNAs for 135 residents on the day shift, required at least 17 CNAs.
-03/02/24 had 9 CNAs for 135 residents on the day shift, required at least 17 CNAs.

8. For the 2 weeks of Complaint staffing from 05/12/2024 to 05/25/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-05/12/24 had 10 CNAs for 146 residents on the day shift, required at least 18 CNAs.
-05/13/24 had 10.5 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-05/14/24 had 14 CNAs for 143 residents on the day shift, required at least 18 CNAs.
-05/15/24 had 14 CNAs for 142 residents on the

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S 560	Continued From page 7 day shift, required at least 18 CNAs. -05/16/24 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -05/17/24 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs. -05/18/24 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. -05/19/24 had 12.5 CNAs for 142 residents on the day shift, required at least 18 CNAs. -05/20/24 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -05/21/24 had 11 CNAs for 139 residents on the day shift, required at least 17 CNAs. -05/22/24 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -05/23/24 had 10.5 CNAs for 139 residents on the day shift, required at least 17 CNAs. -05/24/24 had 10 CNAs for 139 residents on the day shift, required at least 17 CNAs. -05/25/24 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs. 9. For the 1 week of staffing prior to survey from 06/30/2024 to 07/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -06/30/24 had 9.5 CNAs for 144 residents on the day shift, required at least 18 CNAs. -07/01/24 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. -07/02/24 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. -07/03/24 had 14 CNAs for 144 residents on the day shift, required at least 18 CNAs. -07/04/24 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs. -07/05/24 had 11 CNAs for 146 residents on the day shift, required at least 18 CNAs.	S 560		

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	061518	A. BUILDING: _____ B. WING _____	C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCA	1049 BURNT TAVERN ROAD BRICK, NJ 08724

(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 -07/06/24 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. During the initial tour on 07/08/2024 at 08:12 AM, the surveyor asked for census and current staffing for the Birch Unit. Licensed Practical Nurse/Unit Manger (LPN/UM #1) said there are 56 residents, 2 nurses and 4 CNA's. During an interview with the surveyor on 07/08/2024 at 09:45 AM, Resident # 99 said that on weekends they seem short staffed. During an interview with the surveyor on 07/10/2024 at 11:10 AM, CNA #1 who said we have a heavy workload. I average 15 residents for my shift, and it depends on call outs. Even if we have 5 aides, I still have 12 residents. During an interview with the surveyor on 07/10/2024 at 12:33 PM, the Director of Human Resource said I also do staffing and payroll. When asked if she was aware of the minimum staffing requirements for CNA's she stated 1:8 for CNA for 7a-3p shift, 1:10 3p-11p, 1:14 for 11p-7a shift. She went on to say when I do the schedule, I try to meet it, but when there are call outs, it puts a damper on the schedule. I do the schedule for the week, if there are call outs we try to call per diems. When asked if the facility was consistently meeting the staffing requirements the Director of Human Resources said, "Not all the time are we meeting the staffing ratio requirements."	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
315213 Y1	A. Building B. Wing Y2	8/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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 F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed
LSC	08/29/2024	LSC	08/29/2024	LSC	08/29/2024
ID Prefix F0725	Correction	ID Prefix F0758	Correction	ID Prefix	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. #	Completed
LSC	08/29/2024	LSC	08/29/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/12/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061518		8/30/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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 08/29/2024	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	
7/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING **01** B. WING _____	**07/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD** **BRICK, NJ 08724**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/08/2024 and 07/09/2024, and Willow Springs Rehabilitation and Healthcare Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a two-story building that was built in 1984. It is composed of Type II protected construction. The facility is divided into 10-smoke zones. The facility has a 400 KW Diesel Emergency Generator. The facility is Licensed for 164 beds. The census was 143.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available	K 222		9/11/24

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

Electronically Signed | 08/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING **01** B. WING _____	**07/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD** **BRICK, NJ 08724**

(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
K 222	Continued From page 1 to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 2 by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/08/2024 and 07/09/2024, it was determined that the facility failed to provide 2 of 15 designated exit access /discharge (illuminated exit signs above door) doors with-in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 07/08/2024, during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with 15 designated exit access/ discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024, in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO an inspected of the building was conducted.	K 222	1.The thumb latches identified on deficit door by the entrance way were repaired as of 8/5/24. Facility has a Licensed contractor coming to affix a keypad on the egress door by the smokers bridge. Facility audit was completed on 7/09/24 and no other egress doors were found to be deficient 2 All residents have the potential to be affected by this deficient practice 3 U.S. FOIA (b) (6) was re-educated on egress doors not being equipped with a latch or lock that requires the use of a key or tool 4 Maintenance director and or designee will perform egress door checks to ensure code compliance weekly x 4 weeks, then monthly x2 findings will be reviewed at Monthly QAPI	

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K 222	Continued From page 3 The surveyor observed the following: 1) On 07/08/2024 at approximately 11:08 AM, the surveyor observed the main entrance (illuminated exit sign above the door) automatic front door revealed a thumb turn lock on the egress side of the doors. The thumb turn lock and fastening device on the door could restrict emergency use of the designated exit discharge doors. A review of an emergency evacuation diagram posted in the corridor identify the front doors are the primary doors to reach an exit discharge door in the event of an emergency. 2) On 07/09/2024 at approximately 11:330 AM, the surveyor observed on the second floor outside smoking area porch, the exit access door leading into the building revealed a thumb turn lock on the egress side of the door. The thumb turn lock and fastening device on the door could restrict emergency use of the designated exit access door. A review of an emergency evacuation diagram posted in the corridor identify the front doors are the primary doors to reach an exit discharge door in the event of an emergency. The U.S. FOIA (b) and U.S. FO confirmed the findings at the times of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NJAC 8:39 -31.2 (e)	K 222		

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K 222	Continued From page 4 NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 07/08/2024 and 07/09/2024, in the presence of facility Management it was determined that the facility failed to ensure that 1 of 6 exit access (leading into stairwells) stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2)building with three (3)	K 223	1.The identified door was repaired to have positive latch. A facility audit was completed on 07/09/24 and no other doors were found to be deficient. 2.All residents have the potential to be affected by this deficient practice. 3 U.S. FOIA (b) (6) was re-educated on doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area exposure are self-closing, postivie latching and kept in the closed position. 4.Maintenance director and or designee will perform door checks to ensure positively latching on all doors in facility weekly x4 weeks, then monthly x2. Findings will be reviewed at facility	8/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 223	Continued From page 5 exit stairwells in the facility that Residents, Visitors and Staff could use in the event of an emergency. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted. Along the two (2) day tour the surveyor inspected and conducted closure test of six (6) exit stairwell doors (illuminated exit signs above the doors) leading into exit stairways with the following results, On 07/09/2024: 1) At approximately 10:37 AM, during a closure test of the second (2nd.) floor "Applewood Unit" stairway corridor exit access door next to Resident room #222, when the U.S. FO entered the code to the key pad, the surveyor was able to push on the door and the door opened. This test was repeated two additional times with the same results. When the fire alarm is activated the key pad disengages the door frame's magnetic locking mechanism. The stairwell door would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction and to prevent fire, smoke and poisonous gases to enter the exit stairwells in the event of a fire. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code	K 223	Monthly QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 223	Continued From page 6 survey exit on 07/09/2024 at approximately 1:45 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 223		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/08/2024 and 07/09/2024, in the presence of facility management, it was determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps for 1 of 6 designated exit discharge doors in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. This deficient practice was evidenced by the following: On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with six (6)	K 281	1.A Licensed contractor (NJ Ex Order 26.4(b)(1)) was called and is scheduled to come onsite 8/9/24 for the scope of practice. A facility audit was done and no other exits were deficient in this practice 2. All residents have potential to be affected by this deficient practice 3 U.S. FOIA (b) (6) was re-educated on illumination of egress by having continuous lighting with two lamps for exit discharge doors 4.Maintenance director and or designee will conduct weekly audits x4 and then monthly x2 finding will be reviewed at facility monthly QAPI. contrcat was signed and contractor waiting on parts uploaded work invoice	10/1/24

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K 281	Continued From page 7 designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO an inspected outside of the building of 6 designated exit discharge doors for continuous emergency lighting and observed the following, On 07/08/2024: 1) At approximately 10:55 AM, the surveyor observed outside of the designated (illuminated exit sign) first floor "A" stairwell discharge door, a one single bulb light fixture. There was no supplemental light to ensure area is illuminated should the single bulb or single bulb light fixture fail. The U.S. FOIA (b) and U.S. FO confirmed the findings at the times of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING	K 293		9/19/24

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WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD** **BRICK, NJ 08724**

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K 293	Continued From page 8 Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/08/2024 and 07/09/2024, in the presence of facility management, it was determined that the facility failed to provide five (5) illuminated exit signs to clearly identify the exit access paths to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress:	K 293	1.Licensed Electrical contractor was contacted to install illuminated exit signs above each of the five doors found to be deficient. A facility audit was conducted, and no other doors were found to be deficient in this practice. 2.All residents have the potential to be affected by this deficient practice. 3 U.S. FOIA (b) (6) was re-educated in on access to exits shall be marked by approved, readily visible sign. 4.Maintenance director and or designee will conduit weekly audits x4 and monthly x2 to ensure there is no deficient practice. Finding will be reviewed at facility Monthly QAPI contract signed and contractor is waitin gon parts will update on work commencment, cotract uploaded	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING **01** B. WING _____	**07/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD** **BRICK, NJ 08724**

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K 293	Continued From page 9 "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2)building with two (2) enclosed (surrounded by the building) center courtyards that Residents, visitors and Staff could use on the first floor and a outside "Residents Smokers Bridge" on the second floor. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted.	K 293		

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K 293	Continued From page 10 During the two day building tour, the surveyor observed five (5) locations that failed to have illuminated exit signs to clearly identify the exit access route for Residents, Visitors and Staff to reach an exit in the following locations: On 07/08/2024: 1) At approximately 11:38 AM, the surveyor observed inside the 1st. floor outside enclosed "North Center" courtyard no evidence of two (2) illuminated exit signs to clearly identify the exit access path to reach an exit. 2) At approximately 11:45 AM, the surveyor observed inside the 1st. floor outside enclosed "South Center" courtyard no evidence of two (2) illuminated exit signs to clearly identify the exit access path to reach an exit. On 07/09/2024: 3) At approximately 9:39 AM, the surveyor observed on the 2nd. floor outside "Residents Smokers Bridge" no evidence of one (1) illuminated exit sign to clearly identify the exit access path to reach an exit. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress	K 293		

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K 293	Continued From page 11 Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 07/08/2024 and 07/09/2024, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the	K 341	1.Contracted fire alarm company Allied fire and safety was contacted to install visual and audible devices in north and south courtyards. A facility audit was conducted, and no other area was found to be deficient in this practice 2.All residents have the potential to be affected by this deficient practice. 3.The U.S. FOIA (b) (6) was re-educated on the need for fire alarm notification by audible and visible signal for outdoor courtyards.	9/17/24

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K 341	Continued From page 12 following: On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2)building with two (2) enclosed (surrounded by the building) center courtyards (North and South) on the first floor that Residents, Visitors and Staff could use. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted. On 07/08/2024: 1. At approximately 11:38 AM, the surveyor observed in the "North" enclosed outside courtyard, that the facility failed the have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system. At that time the surveyor asked the U.S. FOIA (b) and U.S. FOI Do you have an audio and visual alarm tied into the buildings fire alarm system. The U.S. FOIA (b) and U.S. FO looked around and told the surveyor, no. 2. At approximately 11:45 AM, the surveyor observed in the "South" enclosed outside courtyard, that the facility failed the have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm	K 341	4.The maintenance director and or designee will perform weekly audits x4 than monthly x2 to ensure courtyards had audible and visual devices. Findings will be reviewed at facility monthly QAPI contract was signed contractor submitted plans to township for approval, contractor will update work start date when known,contract uploaded	

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K 341	Continued From page 13 system. At that time the surveyor asked the U.S. FOIA (b) and U.S. FOI Do you have an audio and visual alarm tied into the buildings fire alarm system. The U.S. FOIA (b) and U.S. FO looked around and told the surveyor, no. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations and facility provided documentation on 07/08/2024 and 07/09/2024, in the presence of U.S. FOIA (b) (6)) it was determined that the facility failed to ensure the inspection and testing of 26 of 26 single station battery operated smoke alarms in Resident rooms were in accordance with NFPA 72 2010	K 345	1.Inspection of battery-operated devices, location placement and functionality will be tracked per manufacture specifications. A facility audit was conducted and now have a track of the locations of the battery operated smoke detectors.	8/26/24

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K 345	Continued From page 14 Edition. This deficient practice had the potential to affect all residents and is evidenced by the following, On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide all mandatory inspections that had been conducted from the last Re-Certification survey of 12/20/2022 for review later. During the two day building tour the surveyor observed single station battery operated smoke detectors in various rooms. Later on 07/08/2024 at approximately 12:31 PM, a review of the mandatory inspections was performed. This review identified that the monthly battery operated smoke detectors did not identify the locations of the 26 battery operated smoke detectors. The report provided did not contain all the required information (locations) of the individual battery operated smoke detectors. The U.S. FO confirmed the finding at the time of review. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO was informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. N.J.A.C. 8:39-31.2 (e).	K 345	2.All residents have the potential to be affected by this deficient practice 3 US FOIA (b)(6) will be re educated on proper maintenance and record keeping procedures for testing battery operated smoke detectors. 4.Maintenance director and or designee will perform monthly audit x6 findings will be reviewed at facility monthly QAPI	
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection	K 347		8/29/24

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K 347	Continued From page 15 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation review of facility provided documentation on 07/08/2024 and 07/09/2024 in the presence of facility management, it was determined that the facility failed to provide smoke detectors in 2 of 5 areas that are open to the exit access corridor, in accordance with National Fire Protection Association (NFPA) 72. Reference: 19.3.6.1 Corridor Separation. Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5 (see also 19.2.5.4), unless otherwise permitted by one of the following: (1) Smoke compartments protected throughout by an approved supervised automatic sprinkler system in accordance with 19.3.5.8 shall be permitted to have spaces that are unlimited in size and open to the corridor, provided that all of the following criteria are met: (a)*The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system	K 347	1.Smoke detectors were ordered to be placed in the identified open corridors. A facility audit was conducted, and no other findings were identified. 2.All residents have the potential to be affected by this deficient practice. 3.The U.S. FOIA (b) (6) will be re-educated on providing smoke detectors in open spaces to corridors. 4.Maintenance director and or designee will audit monthly x6 to ensure code compliance. Findings will be reviewed at facility monthly QAPI photos submitted ad labeled	

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K 347	Continued From page 16 in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. (2) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8, waiting areas shall be permitted to be open to the corridor, provided that all of the following criteria are met: (a) The aggregate waiting area in each smoke compartment does not exceed 600 ft2 (55.7 m2). (b) Each area is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or each area is arranged and located to allow direct supervision by the facility staff from a nursing station or similar space. (c) The area does not obstruct access to required exits. (3)*This requirement shall not apply to spaces for nurses' stations. (4) Gift shops not exceeding 500 ft2 (46.4 m2) shall be permitted	K 347		

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K 347	Continued From page 17 to be open to the corridor or lobby, provided that one of the following criteria is met: (a) The building is protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (b) The gift shop is protected throughout by an approved automatic sprinkler system in accordance with Section 9.7, and storage is separately protected. (5) Limited care facilities in smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 shall be permitted to have group meeting or multipurpose therapeutic spaces open to the corridor, provided that all of the following criteria are met: (a) The space is not a hazardous area. (b) The space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the space is arranged and located to allow direct supervision by the facility staff from the nurses' station or similar location. (c) The space does not obstruct access to required exits. (6) Cooking facilities in accordance with 19.3.2.5.3 shall be permitted to be open to the corridor. (7) Spaces, other than patient sleeping rooms, treatment	K 347		

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K 347	Continued From page 18 rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area, provided that all of the following criteria are met: (a) The space and the corridors onto which it opens, where located in the same smoke compartment, are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4. (b)*Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and arrangement that a fully developed fire is unlikely to occur. (c) The space does not obstruct access to required exits. (8)*Waiting areas shall be permitted to be open to the corridor, provided that all of the following criteria are met: (a) Each area does not exceed 600 ft2 (55.7 m2). (b) The area is equipped with an electrically supervised automatic smoke detection system in accordance with 19.3.4. (c) The area does not obstruct any access to required exits. (9) Group meeting or multipurpose therapeutic spaces, other than hazardous areas, that are under continuous supervision by facility staff shall be permitted to be open to the corridor, provided that all of the following criteria are met:	K 347		

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K 347	Continued From page 19 (a) Each area does not exceed 1500 ft2 (139 m2). (b) Not more than one such space is permitted per smoke compartment. (c) The area is equipped with an electrically supervised automatic smoke detection system in accordance with 19.3.4. (d) The area does not obstruct access to required exits. NFPA 72 -17.5.3 Detector Coverage, Where required by other governing laws, codes, or standards, and unless other-wise modified by 17.5.3.1.1 through 17.5.3.1.5, total coverage of a building or portion thereof, shall include all rooms, halls, storage areas, basements, attics, lofts,, spaces above suspended ceilings and other sub-divisions and accessible spaces. The deficient practice was evidenced by the following: On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2)building with Resident sleeping rooms and Common areas on the first and second floors. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6)	K 347		

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K 347	Continued From page 20 U.S. FOIA (b) (6)) and U.S. FO a tour of the building was conducted. During the two (2) building tour the surveyor observed that the facility failed to provide proper fire alarm and detection (smoke detectors) in the following locations, On 07/08/2024: 1) At approximately 11:13 AM, the surveyor observed no evidence of a smoke detector in the open to the corridor Main Lobby area. 2) At approximately 12:15 PM, the surveyor observed no evidence of a smoke detector in the first floor open to the corridor Nursing Station (across from the Cedar Lounge). The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 347		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		7/22/24

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WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD** **BRICK, NJ 08724**

(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
K 353	Continued From page 21 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on review of facility provided documentation on 07/08/2024 and 07/09/2024, in the presence of the Facility management, it was determined that the facility failed to ensure that their automatic sprinkler system was inspected/tested at the required fifth-year interval according to NFPA 25. This deficient practice was identified for 1 of 1 fire sprinkler systems observed in the facility and could affect all residents residing in the facility and was evidenced by the following: On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide all mandatory inspections for review later. Later at approximately 12:45 PM a review of the mandatory inspections was performed. This review identified that the five year internal obstruction investigation of the fire sprinkler system piping was last inspected on 03/20/2019.	K 353	1.licensed contractor was in to complete the 5 year sprinkler inspection on 7/22/2024, with no deficiencies. A facility audit was done with no deficient findings 2.All residents have the potential to be affected by this deficient practice. 3 U.S. FOIA (b) (6) will be re-educated on ensuring that the automatic sprinkler system is inspected and or tested internally every 5 years. 4.Maintenance director and or designee will do monthly review of documentation for sprinkler documentation x3 months finding will be reviewed at facility monthly QAPI inpopection report uploaded	

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K 353	Continued From page 22 On 07/09/2024 at approximately 8:55 AM the U.S. FC provided a copy of a proposal dated July 03, 2024 to conduct a Sprinkler 5 year Internal Pipe inspection. The internal sprinkler pipe inspection had not been completed. This inspection was 3 months over due. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FC were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NFPA (National Fire Protection Association) 25 requires an internal inspection of the fire sprinkler system piping every 5 years, this is to be conducted to inspect for the "presence of foreign organic material" foreign materials can cause obstructions to pipe and sprinklers. NFPA 13, 25 NJAC 8:39-31.2(e)	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 07/08/2024 and 07/09/2024, in the presence of facility management, it was determined that the facility failed to:	K 355	1.The two identified portable fire extinguishers were placed at code height. A facility audit was completed, and no other portable fire extinguishers were	8/29/24

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K 355	Continued From page 23 1) Perform a monthly examination for 1 of 28 portable fire extinguishers observed and inspected and 2) Install portable fire extinguishers with-in the required height for 2 of 28 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so	K 355	found to be deficient in this practice. The one identified portable fire extinguisher with no monthly visual inspection was inspected upon discovery. A facility audit was completed and no other portable fire extinguishers were found to be deficient. 2.All residents have potential to be affected by this deficient practice 3 U.S. FOIA (b) (6) will be re-educated on monthly visual inspections and code height requirements 4.Maintenance director and or designee will audit fire extinguisher to ensure proper code height monthly x4, and monthly inpections to ensure monthly inspections are done timely. Findings will be reviewed at facility monthly QAPI	

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K 355	Continued From page 24 that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. The findings include the following, On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2)building with 30 Resident sleeping rooms and common areas on the first floor. There are 60 Resident sleeping rooms and common areas on the second floor. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted. During the two day building tour, the surveyor observed twenty-eight (28) portable fire extinguishers in various locations that were last annually inspected March 2024 with the following issues that were identified: On 07/08/2024: 1) At approximately 10:20 AM, One (1) "ABC-Type" fire extinguisher inside the 1st floor Elevator Mechanical room.	K 355		

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K 355	Continued From page 25 This fire extinguisher appeared to be mounted too high. The surveyor observed, measured and recorded this fire extinguisher was mounted 5'-4-1/2" to the center of the pressure indicator gauge. 2) At approximately 10:47 AM, One (1) "ABC-Type" fire extinguisher inside the Boiler room room. This fire extinguisher appeared to be mounted too high. The surveyor observed, measured and recorded this fire extinguisher was mounted 5'-4" to the center of the pressure indicator gauge. 3) At approximately 11:31 AM, One (1) ABC-Type fire extinguisher inside the Employee lounge area last annually inspected March 2024. There was no evidence of monthly visual examination performed and documented for April and May 2024. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO was informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke	K 363		9/24/24

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K 363	Continued From page 26 and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/08/2024 and 07/09/2024, in the presence of facility management it was determined that the facility	K 363	1.Upon review both sets of double doors leading into kitchen will be replaced. the door by the soled utility room on the second floor will be fitted with an	

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K 363	Continued From page 27 failed to ensure that 6 of 32 corridor doors observed and inspected, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was evidenced by the following: On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms, offices and common areas in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building. The first floor has 30 Resident sleeping rooms and common areas. The second floor has 60 Resident sleeping rooms and common areas. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted. The surveyor observed, measured and recorded the following corridor doors in the building that were not smoke resistant: On 07/08/2024: 1. At approximately 10:06 AM, during a closure test of the first floor set of double corridor doors leading into the kitchen (near the housekeeping office), one door did not close into its frame. The	K 363	approved ul code strip on the bottom to close the gap . The laundry room door closer will be reaffixed to frame. Storage room door next to resident room 255 on second floor door will be adjusted to properly latch within frame. Applewood unit dining room door will be affixed with a UL listed auto door closer. Initial audit was performed and no further findings were found other than the ones noted. 2. all residents have the potential to be affected by this deficient practice 3 U.S. FOIA (b) (6) will be re-educated on corridor doors resisting the passage of smoke. 4.Maintenance director and or designee will do weekly audits x4 to ensure doors close properly and monthly x2 findings will be reviewed at facility monthly QAPI	

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K 363	Continued From page 28 surveyor measured and recorded a 12 inch gap between the meeting edges. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2. At approximately 10:10 AM, during a closure test of the first floor set of double corridor doors leading into the kitchen (near the dry goods storage room), one door did not close into its frame. The surveyor measured and recorded a 2-1/2 inch gap between the meeting edges. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 3. At approximately 10:35 AM, during a closure test of the first floor laundry room. The doors automatic door closure was disconnected and did not close into its frame. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. On 07/09/2024: 4 At approximately 9:05 AM, during a closure test of the second floor storage room (near Resident room #255) the door did not latch into its frame and opened leaving an approximately 3 inch opening. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 5. At approximately 10:04 AM, on the second floor Soiled Utility room the surveyor measured and recorded a 1/2 inch gap along the doors edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the	K 363		

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K 363	Continued From page 29 event of a fire. 6. At approximately 10:30 AM,, on the second floor Applewood Unit dining room the surveyor observed the doors automatic closure was disconnected. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. Code requires doors protecting corridors have gaps no larger than 1/8 of an inch around the doors frame and no more than one (1) inch along the doors bottom edge. The U.S. FOIA (b) and U.S. FO confirmed the findings at the times of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for	K 372		8/26/24

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K 372	Continued From page 30 smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 07/08/2024 and 07/09/2024, in the presence of facility management, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for two (2) of ten (10) smoke barrier walls as evidenced by the following: On 07/08/2024 (day one of survey) during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with twelve (12) smoke barrier walls. The first floor has 31 Resident sleeping rooms, common areas, offices, main kitchen, Physical Therapy and service corridor. There are six (6) smoke barrier walls on the first floor. The second floor has 60 Resident sleeping rooms, common areas, Dining room and offices. There are six (6) smoke barrier walls. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024, in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted. Along the two day tour the surveyor observed the	K 372	1.Penetration above corridor doors by DON office was repaired using 3m red fire barrier CP 25wb plus sealant. The penetration in electrical room in second will be patched with 5/8th sheetrock and will be sealed with 3m red fire barrier CP 25wb plus sealant. A facility audit was conducted and no further deficient findings were found. 2.All residents have the potential to be affected by this deficient practice. 3 U.S. FOIA (b) (6) was re-educated on smoke barriers to be constructed to a ¿ hour fire resistant rating. 4.Maintenance director and or designee will audit for penetration facility wide monthly x4 and finding will be reviewed at facility monthly monthly QAPI	

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K 372	Continued From page 31 following smoke barrier walls that failed to maintain the 1/2 hour fire rated construction as required by code in the following location: On 07/08/2024: 1) At approximately 10:01 AM, the surveyor observed above the corridor double smoke doors ceiling tiles on the first (1st.) floor next to the Ladies employee locker room and Director of Nursing office, one approximately 2 by 1" penetration with metal conduit and a white romex wire running through the hole in the smoke barrier wall. On 07/09/2024: 2) At approximately 9:45 AM, the surveyor observed above the corridor double smoke doors ceiling tiles on the second floor electrical room next to elevator #2, one approximately 3" by 3" penetration with one BX electrical cable wire running through the smoke barrier wall. These penetrations were observed indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The U.S. FOIA (b) and U.S. FO confirmed the findings at the times of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		

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K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 07/08/2024 and 07/09/2024 in the presence of facility Management, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire and smoke protection. This deficient practice was identified for 3 of 12 sets of corridor double smoke barrier doors tested. This could effect all Residents who reside on the 1st. and 2nd. floors. The evidence includes the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4	K 374	1.Double smoke doors on the first floor near resident room 118 will be fitted with a fire rated skirt that closes when the fire door closes, closing the gap on the bottom of the door . single smoke door second floor leading into dining room by elevator 1 will be adjusted to ensure proper closure into door frame. Single smoke door second floor leading into dining room by elevator 2 will be affixed to properly close into frame to ensure resistance of passage of smoke. A facility audit was conducted and no further doors were shown to be deficient. 2.All resident can have the potential to be affected with this deficient practice 3 U.S. FOIA (b) (6) will be re-educated on doors in smoke barriers shall close leaving only the minimum clearance necessary for proper operation and shall	10/1/24

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	315213	A. BUILDING **01** B. WING _____	**07/12/2024**

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K 374	Continued From page 33 of an inch. On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2)building with 8 smoke zones. The first floor has 30 Resident sleeping rooms and common areas. The second floor has 60 Resident sleeping rooms and common areas. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted. During the two (2) day tour of the facility the surveyor performed closure tests of the twelve (12) sets of double smoke doors in the corridors with the following results, On 07/08/2024: 1) At approximately 11:17 AM, during a closure test of the double smoke doors on the first floor (next to Resident room #118), when the doors were release from the magnetic hold open device and allowed to self close into their frame. The surveyor observed, measured and recorded a 1 inch gap along the doors bottom edge. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire.	K 374	be without louvers or grills. 4.Maintenance director and or designee will audit doors facility wide weekly x4 than monthly x4. Findings will be presented at facility QAPI. regarding #2 and #3 they are single doors on either side of dining room however they were repaired and photos were uploaded	

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K 374	Continued From page 34 On 07/09/2024: 2) At approximately 9:20 AM, during a closure test of the double smoke doors on the second floor near elevator #1 leading into the Residents Dining/ Lounge room, when the doors were release from the magnetic hold open device and allowed to self close into their frame. The surveyor observed one door got stuck on the floor and did not close into its frame. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. 3) At approximately 9:40 AM, during a closure test of the double smoke doors on the second floor near elevator #2 leading into the Residents Dining/ Lounge room, when the doors were release from the magnetic hold open device and allowed to self close into their frame. The surveyor observed, measured and recorded an approximately 1/2 gap between the doors meeting edges. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. Life Safety Code 101, 2012 Edition. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		

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K 541	Continued From page 35	K 541		
K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observations on 07/08/2024 and 07/09/2024, it was determined that the facility failed to ensure 1 of 2 laundry chute access doors closed and positively latched into their frames to maintain the one-hour fire protection rating of laundry chute doors. This deficient practice was evidenced by the following findings:	K 541	1.Laundry Chute door part was ordered to ensure positive latch when closed. A facility audit was conducted and no other chute was found to be deficient. 2.All residents have the potential to be affected by this deficient practice. 3.The U.S. FOIA (b) (6) was re-educated on positive latch closing for laundry chute to be sealed by fire resistive construction to prevent fire, smoke and	8/26/24

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K 541	Continued From page 36 On 07/08/2024 (day one of survey), during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with 91 Resident sleeping rooms and common areas. Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024, in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted. During the two day tour the surveyor performed a closure test of two (2) laundry chute doors with the following results: On 07/08/2024: 1. At approximately 10:33 AM, an inspection in the 1st. floor laundry chute room was conducted. The surveyor observed that the one-hour fire rated laundry chute door was being held in the opened position with a magnetic hold open device that would release with the activation of the buildings fire alarm system. The surveyor made a request to the U.S. FO to release the fire rated chute door and allow the door to self-close. When the U.S. FO release the door from the magnetic hold open device the door closed and did not positive latch into its frame. This closure test was repeated two additional times with the same results. With the chute door not positive latching into its	K 541	gasses to the second floor. 4.Maintenance director and or designee will audit weekly x4 than monthly x2 to ensure proper closure. Finding will be reviewed at facility monthly QAPI	

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K 541	Continued From page 37 frame, this would allow fire. smoke and poisonous gases to pass from the first floor to the second floor in the event of a fire. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NFPA 101:2012 - 19.5.4 and 9.5 NJAC 8:39-31.2(e)	K 541		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 07/08/2024 and 07/09/2024, in the presence of facility management, it was determined that the facility failed, 1) To ensure that 1 of 11 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required, and 2) To provide proper wire protection on electrical equipment, as per National Electrical Code (NEC) 70. This deficient practice was evidenced by the following:	K 911	1.The GCFI outlet identified was immediately corrected. A facility audit conducted with no other outlets was found to be deficient. A facility audit was conducted on the PTACH units and found 12 other units to be deficient in this practice. A Licensed electrician was contacted to properly wire and install junction boxes for the PTACH units. 2.All residents have potential to be affected by this deficient practice. 3 U.S. FOIA (b) (6) was re-educated	10/7/24

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K 911	Continued From page 38 Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 07/08/2024 during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and common areas in the facility. A review of the facility provided lay-out identified the facility is a two-story (2)building. On the first floor 31 Resident sleeping rooms. On the second floor there are 30 Resident sleeping rooms on the Applewood (Memory Impaired) unit and 30 Resident sleeping rooms on the Long term Care unit.	K 911	on installing and configuring GCFI outlets properly, and to properly in stall wires into junction box for the PTACHS 4.Maintenance director and or designee will audit weekly x4 and then monthly x2. Findings will be reviewed at facility monthly QAPI	

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K 911	Continued From page 39 Starting at approximately 9:44 AM on 07/08/2024 and continued on 07/09/2024 in the presence of the facilities' U.S. FOIA (b) (6) and U.S. FO a tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed electrical hazards in the following locations: On 07/09/2024: 1) At approximately 10:20 AM, the surveyor observed inside Applewood Unit Resident room # NJ Exec one Duplex electrical outlet inside the bathroom when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex Electrical outlet did not de-energize as required by code. The Duplex electrical outlet was identified with the Hot and Neutral wires were reversed. 2) At approximately 10:26 AM, the surveyor observed inside Applewood Unit Resident room # NJ Exec that the electrical wires leading to the rooms Packaged Thermal Air Conditioning (PTAC) unit were exposed with wire nuts connecting the wires from the BX cable to the PTAC unit. These wires were not properly installed into an electrical junction box. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM.	K 911		

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K 911	Continued From page 40 Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918		7/15/24

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K 918	Continued From page 41 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and review of facility provided documentation on 07/08/2024 and 07/09/2024 in the presence of the facility management, it was determined that the facility failed to Exercise the one (1) emergency generator under load for at least 30 minutes in 20- to 40-day intervals, in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: On 07/08/2024 (day one of survey) during the survey entrance at approximately 9:23 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) if the facility had an Emergency Generator, what type of fuel and how often does the facility run the emergency generator. The U.S. FO told the surveyor, yes we have one (1) Diesel Emergency Generator and we run it weekly and run it under load monthly. The surveyor asked the U.S. FOI "Do you document the load dates." The U.S. FO told the surveyor , yes we keep a log. The surveyor requested to review the emergency generator log for the last 12 months (July, August, September, October, November and December 2023, January, February, March, April, May and June 2024) for review later. On 07/09/2024 (day two of survey) during a review of the facility provided generator monthly load tests, the surveyor reviewed the following,	K 918	1.A 30 minute load test was done on the generator. An audit was done with no other findings of this deficient. 2.All residents have the potential to be affected by this deficient practice. 3 U.S. FOIA (b) (6) was re-educated on 30 minute monthly load testing for the generator. 4.Maintenance director and or designee will audit monthly x6 and finding will be reviewed at facility monthly QAPI printout was uploaded	

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K 918	Continued From page 42 - 07/2023: Run Time, does not include warm up or cool down time: 20 minutes. - 08/2023: Run Time, does not include warm up or cool down time: 20 minutes. - 09/2023; Run Time, does not include warm up or cool down time: 20 minutes. - 10/02/2023: Run Time, does not include warm up or cool down time: 20 minutes. - 11/01/2023: Run Time, does not include warm up or cool down time: 20 minutes. - 12/04/2023: Run Time, does not include warm up or cool down time: 20 minutes. - 01/02/2024: Run Time, does not include warm up or cool down time: 20 minutes. - 02/05/2024: Run Time, does not include warm up or cool down time: 20 minutes. - 03/05/2024: Run Time, does not include warm up or cool down time: 20 minutes. - 04/2024: Run Time, does not include warm up or cool down time: 20 minutes. There was no documented test of the Emergency Generator being run under load for 30 minutes for May and June 2024. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of review. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens	K 920		8/29/24

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K 920	Continued From page 43 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not prohibit the use of power strips beyond temporary installation, as a substitute for adequate wiring in accordance with the requirements of NFPA 70, 2011 Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. Findings Include:	K 920	1.Power strip was immediately removed from vicinity. A facility audit was conducted, and no additional findings were found of this deficient practice 2. all residents have the potential to be affected by this deficient practice 3 U.S. FOIA (b) (6) was re-educated on the nonuse of power strips in a patient care area 4.Maintenance director and or designee will do weekly audits x4 and monthly x2.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING **01** B. WING _____	**07/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD** **BRICK, NJ 08724**

(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
K 920	Continued From page 44 On 07/08/2024 at approximately 9:58 AM, the surveyor observed in the Physical therapy area one power strip that had a coffee pot plugged into an electrical outlet, in a patient care vicinity to power non-patient care-related electrical equipment. At that time the surveyor asked the U.S. FOIA (b) (6), "Is this area a patient care area." The U.S. FOIA (b) (6) told the surveyor, yes. The U.S. FOIA (b) and U.S. FO confirmed the findings at the time of review. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FO were informed of the deficiency during the Life Safety Code survey exit on 07/09/2024 at approximately 1:45 PM. NJAC 8:39 -31.2(e)	K 920	Findings will be reviewed at facility QAPI	

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
315213 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	09/11/2024	LSC K0223	08/29/2024	LSC K0281	10/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	09/19/2024	LSC K0341	09/17/2024	LSC K0345	08/26/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0347	08/29/2024	LSC K0353	07/22/2024	LSC K0355	08/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	09/24/2024	LSC K0372	08/26/2024	LSC K0374	10/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0541	08/26/2024	LSC K0911	10/07/2024	LSC K0918	07/15/2024

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

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
315213 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction				
Reg. # NFPA 101	Completed				
LSC K0920	08/29/2024				

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	
7/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO