STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315309	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	**23 SCHOOLHOUSE ROAD WHITING, NJ 08759**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00153397, NJ00154875, NJ00170569, NJ00156118 Survey Date: 03/18/24-03/27/24 Census: 130 Sample: 29 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		4/30/24

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

Electronically Signed | 04/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined the facility failed to maintain a comfortable and homelike environment for resident rooms on 3 of 3 nursing units of the facility observed (1 East, 2 East, and 2 West). The evidence of this deficient practice includes: 1.) On 03/18/2024 from 9:33 AM to 11:41 AM, during the initial tour of the 2 West nursing unit, the surveyor made the following observations: The vinyl wall covering in resident room 300 behind bed "B" was partially removed and pulled away falling off the wall. Room 302 the plastic/vinyl wall bumper behind bed "A" was broken with pointed edges. The bath tub in room 305 contained brown and grey stains and the overflow plate was covered with a white crusty material.	F 584	I. Element 1 Corrective Action Room # 300 wall was fixed. Room # 302 wall bumper was fixed. Room # 305 bathtub was cleaned and coated. Room # 306 was painted and the holes in the walls were pathed. Room # 312 holes in the wall were patched and painted. Room # 316 door knob was fixed and painted, the call bell control panel was fixed. Room 220, trash bag was placed. Room # 212, privacy curtain was removed and replaced. Room 224, broken dresser was repaired. Room # 224 baseboard and drywall were repaired. Room # 228 tiles were replaced. II. Element 2 Identification of Others	

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F 584	Continued From page 2 The wall behind bed "A" in room 306 had an approximately 12 inch by 4 inch area with gouges missing paint and revealing the bare drywall. Room 312 had four holes approximately one inch in diameter in the wall directly under the ceiling and to the right of the bathroom door. Room 316 bathroom door was missing a door knob with a hole where the door knob would be placed and had the paint removed along the edge of the door by the door knob opening, the call bell control panel was hanging down off of the mounting bracket on the wall exposing the wires in the wall, and the wall behind bed "A" was damaged with two large holes approximately four to five inches wide and peeled wallpaper. On 3/25/2024 at 12:35 PM, the surveyor, in the presence of the survey team, interviewed the US FOIA (b)(6)), who stated that environmental concerns fall under the maintenance department's responsibility. He included that maintenance department is notified of reeded repairs through an electronic work order program utilized by the facility. The US FOIA (b) was presented with photos of the above observations, and he acknowledged the need for repairs. Review of the facility's undated "Maintenance Service" policy included but was not limited to: "maintenance service shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The following functions are performed by maintenance, but are not limited to: ...b. maintaining the building in good repair and free from hazards ...g. maintaining the paging system	F 584	An assessment of the risk this could present to the residents was completed, and all residents could have been affected by this practice. III. Element 3 Systemic Changes All items fixed and cleaned upon findings. New non-clinical checklist was handed to maintenance to do rounds daily. Staff in-serviced on resident homelike environment. Staff in-serviced on electronic work order system TELS will notify maintenance. Maintenance department educated on insuring maintenance related concerns to be addressed as soon as possible and check TELS daily. IV. Element 4 Quality Assurance Administrator or designee will complete weekly rounds of 5 random rooms for 4 weeks. Then monthly for 2 months to ensure residents are provided a safe homelike environment while residing in the facility. The results of these findings with be reported at monthly QAPI meeting for 3 months and then as needed thereafter for any recommendations.	

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in good working order"

NJAC 8:39-4.1(a)

Complaint # NJ152908, NJ156248, NJ152672

2.) On 03/18/2024 at 10:29 AM during the initial tour of the facility, Surveyor # 2 observed resident room 220. At that time, there was no trash bag in the garbage can.

On the same date at 11:24 AM during the initial tour of the facility, Surveyor # 2 observed room 212. At that time, Surveyor # 2 observed stains on the privacy curtain that was located between the beds in the room.

On 03/20/2024 at 1:29 PM, Surveyor # 2 observed room 224. At that time, Surveyor # 2 observed the dresser in the room. The front of the bottom drawer was detached and left leaning against the side of the dresser. In addition, Surveyor # 2 observed the floor base board was missing behind the bed and in the corner near the bathroom door. The unfinished dry wall was exposed.

On 03/25/2024 at 12:30 PM, during an interview with Surveyor # 2, the US FOIA (b)(6) confirmed that if a dresser or bed was broken it would be maintenance's responsibility to fix it. The US FOIA (b)(6) said he was unaware of the broken dresser and missing floor base board in room 224. He concluded by saying he will have his staff repair it immediately.

On 03/25/2024 at 12:44 PM during an interview

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with Surveyor # 2, the US FOIA (b)(6) said that resident rooms are cleaned every day. He further said that privacy curtains are changed once a month or as needed. Lastly, he confirmed that his staff are to put a new trash bag in a garbage can when they empty it.

A review of the facility provided document titled, "Work Order #4648" revealed a note, "REPAIRED DRESSER DRAWER" with a completed status of 03/26 at 12:58 PM. The document confirmed the repair was completed after the surveyor brought the observations to the attention of the Director of Maintenance.

A review of the undated facility provided document titled, "Maintenance Service" revealed under, "Policy Interpretation and Implementation" that, "1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times."

On 03/19/2024 at 11:20 AM Surveyor #3 observed Resident #71 in his/her room and noted seven missing floor tiles in front of the sink. Resident #71 stated the tiles were missing "forever" and it bothers him/her as the wheelchair gets stuck and hard to propel with the difference in the floors.

On 03/21/2024 at 10:34 AM Surveryor #3 noted seven floor tiles remain missing in Resident #71's room in front of the sink

On 03/25/2024 09:49 AM Surveyor #3 noted seven missing floor tiles in Resident #71's room

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F 584	Continued From page 5 in front of sink. On 03/25/24 at 12:30 PM Surveyor #3 interviewed the US FOIA (b)(6), who stated when the staff sees something, they put it in TELS, (TELS is a building management platform designed for Senior Living with integrated Asset Management, Life Safety, and Maintenance solutions), and then it comes to him. He stated that he was not aware of anything needing attention in room 228. He also stated there was nothing in TELS regarding this room. He further stated that the tiles should not be pulled up like that. On 03/27/24 at 10:12 AM Surveyor #3 reviewed facility provided work order #4651 indicates work order was created on 03/26/24 at 12:53pm. A review of the undated facility provided document titled, "Maintenance Service" revealed under, "Policy Interpretation and Implementation" that, "2. b. Maintaining the building in good repair and free from hazards."	F 584		
F 623 SS=D	N.J.A.C. 8:39-4.1(a)11, 31.4(a) Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 623		4/30/24

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facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;

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(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is

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F 623	Continued From page 8 the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to notify the resident and/or resident representative in writing of the reason for NJ ex order 26.4b1 [redacted] for 3 of 3 residents reviewed for NJ ex order 26.4b1 Residents #43, #129, and #230. This deficient practice was evidenced by the following: 1.) On 03/20/24 the surveyor reviewed the Electronic Medical Record (EMR) which indicated Resident #129 was admitted to the facility for NJ ex order 26.4b1 . Further review showed there was a NJ ex order 26.4b1 Minimum Data Set (MDS), an assessment tool completed on NJ ex order 26.4b1 following a NJ ex order 26.4b1 [redacted] Review of the Admission Record indicated Resident #129 had medical diagnoses which included but were not limited to the following: NJ ex order 26.4b1 [redacted] On 03/20/24 at 12:58 PM, review of the progress notes showed that on NJ ex order 26.4b1 at 9:00 PM	F 623	I. Element 1 Corrective Action NJ ex order 26.4b1 were sent to resident/Resident representative for Resident # 43, #129, and #230. II. Element 2 Identification of Others An assessment of the risk this could present to residents discharged to the hospital could have been affected by this practice. III. Element 3 Systemic Changes Social Services were educated on notifications. The receptionists were in-serviced to send notice to ombudsman / family upon discharge / transfer to the hospital in writing, and a new form was created that will be sent to all families and ombudsman upon discharge/transfer. The form consists of where and when and why the patient is being discharged to. IV. Element 4 Quality Assurance The Director of Social Work, or designee,	

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F 623	Continued From page 9 Resident #129 was found in the room on the floor. The resident NJ ex order 26.4b1 The resident's physician and family were notified via telephone and NJ ex order 26.4b1 Further review of the progress notes showed that on 12/22/23 at 09:00 AM, the resident NJ ex order 26.4b1 Resident #129 was NJ ex order 26.4b1 on NJ ex order 26.4b1 following the NJ ex order 26.4b1 On 03/25/24 at 01:01 PM, the surveyor interviewed the US FOIA (b)(6) regarding notification of NJ ex order 26.4b1 in writing to the resident and/or resident representative and ombudsman. The US FOIA (b) stated, "The last receptionist would send the hospitalization to the Ombudsman's office in bulk at the end of the month". The US FOIA (b) could not locate the confirmation of the faxes. The surveyor asked about the notification to the resident and/or resident representative in writing. The US FOIA (b) stated, "The receptionist was supposed to do both resident representative and ombudsman, but she wasn't doing that. The receptionist is now going to be sending it to the resident representative". On 03/27/24 at 11:53 AM, the surveyor reviewed the policy titled Preparing a Resident for Transfer or Discharge, an undated policy. The policy statement revealed that the facility shall prepare a resident for a transfer or a discharge. Number three of the policy indicated that the	F 623	will review discharges to the hospital weekly for 4 weeks then monthly for 2 months to ensure discharge notifications are sent to the resident or resident representative. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations determined by the QAPI Committee	

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receptionist would send out an email notice of the discharge. The policy did not indicate who received the email notice.

2.) On 03/25/2024 the surveyor reviewed Resident #43's EMR. Review of the Admission Record indicated Resident #43 was admitted to the facility with diagnosis which included but were NJ ex order 26.4b1

Further review indicated NJ ex order 26.4b1 anticipated MDS for NJ ex order 26.4b1 ollowing NJ ex order 26.4b1 after NJ ex order 26.4b1 The surveyor reviewed the most recent MDS which revealed the resident had a Brief Interview of Mental Status of NJ ex out of 15 indicating NJ ex order 26.4b1

Review of the progress notes showed that on NJ Exec Order 2 at 12:56 PM, the resident was NJ ex order 26.4b1 with NJ ex order 26.4b1 and another progress note dated NJ ex order 26.4b1 at 10:46 PM, which indicated the NJ ex order 26.4b1

3.) On 03/21/2024, the surveyor reviewed Resident #230's NJ ex order. Review of the progress notes indicated that Resident #230 was admitted

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to the facility for NJ ex order 26.4b1 following a NJ ex order 26.4b1 which included NJ ex order 26.4b1 [redacted] The notes further indicated that NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted] Resident #230's physician was notified, and the resident NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted].

Review of the admission MDS, dated NJ ex order 26.4b1 indicated a BIMS of NJ ex, indicating NJ ex order 26.4b1.

Further review showed there was a NJ ex order 26.4b1 MDS completed on NJ ex order 26.4b1 following the NJ ex order 26.4b1

On 03/25/24 at 01:01 PM, the surveyor interviewed the US FOIA (b)(6) regarding notification of NJ ex order 26.4b1 in writing to the resident and/or resident representative and ombudsman.

The US FOIA (b) stated, NJ ex order 26.4b1 [redacted] The US FOIA (b) could not locate the confirmation of the faxes.

The surveyor asked about the notification to the resident and/or resident representative in writing. The US FOIA (b) stated, "The receptionist was supposed to do both resident representative and ombudsman, but she wasn't doing that. The receptionist is now going to be sending it to the resident representative".

On 03/27/24 at 11:53 AM, the surveyor reviewed

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F 623	Continued From page 12 the policy titled Preparing a Resident for Transfer or Discharge, an undated policy. The policy statement revealed that the facility shall prepare a resident for a transfer or a discharge. Number three of the policy indicated that the receptionist would send out an email notice of the discharge. The policy did not indicate who received the email notice.	F 623		
F 640 SS=D	NJAC 8:39-9.6 (e) Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		4/30/24

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	315309	A. BUILDING _____ B. WING _____	C 03/27/2024

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F 640	Continued From page 13 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interviews, review of medical records, and other facility documentation, it was determined that the facility failed to electronically transmit the Minimum Data Set (MDS, an assessment tool), within 14 days of completing the resident's assessment. This deficient practice was identified for 1 of 1 unsampled resident, (Resident # 95) reviewed in the Resident Assessment Task for MDS record over NJ Exec Order 26.4b1. On 03/20/2024 the surveyor reviewed the MDS history in the electronic medical record which	F 640	T F640 I. Element 1 Corrective Action NJ Ex Order 26.4b1 Assessment for Resident #95 was submitted and accepted II. Element 2 Identification of Others An assessment of the risk this could present to the residents was completed, and all discharged residents could have been affected by this practice.	

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F 640	Continued From page 14 revealed: Resident #95 was NJ ex order 26.4b1 on NJ ex order 26.4b1. Resident #95's NJ ex order 26.4b1 [redacted] The history indicates that Resident #95's NJ ex order 26.4b1 [redacted]. On 03/21/2024, the surveyor interviewed the US FOIA (b)(6) [redacted]), who stated that the NJ ex order 26.4b1 on Resident #95 NJ ex order 26.4b1 [redacted]. She also stated, "it's late" and "the MDSs are usually transmitted once they're completed, this one got missed." Review of facility provided policy "MDS Submission Timeframes" included: The following submission timeframe for MDS records will be observed by this facility: Discharge - final completion date + 14 days According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2023, page 2-17, discharge return-not anticipated must be completed no later than the discharge date + 14 calendar days with the transmission date no later than MDS completion date +14 days. On 03/27/2024, the surveyor interviewed the US FOIA (b)(6) who provided a QAPI and stated that the QAPI was done the day the surveyor brought the issue to their attention. NJAC 8:39-11.2 (e) 3	F 640	III. Element 3 Systemic Changes MDS coordinators were educated on submitting MDS assessments in a timely manner according to CMS guidelines. IV. Element 4 Quality Assurance MDS coordinator / designee will review MDS assessments weekly for 4 weeks and then monthly for 2 months to ensure all MDS assessments are completed in a timely manner. Results will be reported at monthly QAPI for 3 months and then as needed thereafter for any additional recommendations.	
F 644 SS=D	Coordination of PASARR and Assessments	F 644		4/30/24

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F 644	Continued From page 15 CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to conduct a new NJ Exec Order 26.4b1 assessment after a resident was newly diagnosed with NJ Exec Order 26.4b1. This deficient practice was identified in 1 of 3 residents reviewed for PASRRs (Resident #71) and was evidenced by the following: On 03/19/2024 the surveyor reviewed Resident #71's Electronic Medical Record (EMR) which included review of the NJ ex order 26.4b1 which NJ ex order 26.4b1	F 644	F644 I. Element 1 Corrective Action Resident #77 NJ Exec Order 26.4b was updated. II. Element 2 Identification of Others All residents who require and updated PASARR have the potential to be affected. III. Element 3 Systemic Changes The social worker was educated on the new PASSAR Policy. Social Serviced was in-serviced all with	

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F 644	Continued From page 16 Review of the Admission Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b1 indicated a Brief Interview of Mental Status (BIMS) score of NJ ex order 26.4b1 15, indicating NJ ex order 26.4b1 and review of section I NJ ex order 26.4b1 A review of the Quarterly MDS dated NJ ex order 26.4b1 indicated NJ ex order 26.4b1 noted in Section NJ A review of the Quarterly MDS dated NJ ex order 26.4b1, indicated NJ ex order 26.4b1 noted in Section NJ A review of Resident #71's care plans revealed a focus of NJ ex order 26.4b1 with a goal of NJ ex order 26.4b1 nd a focus of NJ ex order 26.4b1 NJ ex order 26.4b1 including the NJ ex order 26.4b1 On 03/19/24 the surveyor interviewed the US FOIA (b)(6) who stated that th NJ ex order 26 On 03/25/24 the surveyor reviewed the facility provided policy pertaining to PASRR which does not address a resident with a new psychological diagnosis after admission. On 03/25/24 at 01:29 PM the surveyor interviewed the US FOIA (b) who stated prior to surveyor inquiry, it was not in their policy to redo the NJ Exec Order 26 upon new diagnosis.	F 644	new diagnosis need a new level 1 PASSAR regardless of discharge or not. The Director of Social Work reviewed all PASARRs in house immediately and updated them IV. Element 4 Quality Assurance The Director of Social Work or designee will review all admissions for PASARR needs and accuracy weekly for 4 weeks then monthly for 2 months. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations determined by the QAPI Committee	

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F 644	Continued From page 17 On 03/27/24 at 10:48 AM the surveyor interviewed the US FOIA (b)(6) who stated that after surveyor inquiry an updated NJ Exec Order 26 as completed for Resident #71 and the US FOIA (b)(6) did an audit of the entire building.	F 644		
F 658 SS=D	NJAC 8:39.5.1(a) 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: Based on observations, interview, and review of facility documentation it was determined that the facility failed to 1. Obtain physician orders for a resident's discharge home, 2. follow physicians' orders during medication observation and 3. follow physician orders by NJ ex order 26.4b1 [redacted]. This deficient practice was identified for 3 of 29 residents reviewed (Resident #61, #96 and #128) and was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. 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	F 658	I. Element 1 Corrective Action Physicians order NJ ex order 26.4b1 NJ ex order 26.4b1 Resident #128, Resident #61 NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 and Resident #96 NJ ex order 26.4b1 II. Element 2 Identification of Others All residents who are discharged home without an order, have an eye drop order for one eye, and/or have an order for an air mattress in place have the potential to be affected. III. Element 3 Systemic Changes Education was provided for Nursing staff	4/30/24

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F 658	Continued From page 18 counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 1.On 03/20/24 at 10:15 AM, the surveyor reviewed Resident #128 Minimum Data Set (MDS) list, an assessment tool. The MDS list revealed that Resident #128 was admitted to the facility on NJ ex order 26.4b1 and a NJ ex order 26.4b1 [redacted] Review of the Admission Record indicated that Resident #128 had medical diagnoses which NJ ex order 26.4b1 [redacted] On 03/20/24 at 10:31 AM, the surveyor reviewed the progress notes which showed the following physician note written on NJ ex order 26.4b1 The resident is NJ Exec Order 26.4b1 [redacted] assessment, evaluation of current NJ Exec Order 2 medical conditions, and for NJ Exec Order 26.4b1 prior to a planned discharge as requested by the US FOIA (b)(6) and the disciplinary team. Another note written on NJ Exec Order 26.4b by the US FOIA (b) [redacted] showed the following: Note Text: NJ ex order 26.4b1 at 2 PM. NJ ex order 26.4b1 [redacted]	F 658	on obtaining a discharge order, following physician orders and ensuring air mattresses are in place. IV. Element 4 Quality Assurance The Director of Nursing, or designee, will review 5 residents who were discharged, have eye drop order, and/or an air mattress order -5 days a week for 4 weeks then weekly for 8 weeks for order accuracy. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations determined by the QAPI Committee.	

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On 03/20/24 at 10:36 AM, the surveyor reviewed the progress notes which showed the following note documented on NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted] reviewed with resident. Medication list explained, resident NJ Exec Order 26.4b1. Folder with medication list and NJ ex order 26.4b1 placed in black computer bag. At 01:30pm the resident was picked up by NJ Exec O NJ ex order 26.4b1 [redacted] NJ ex o [redacted]

On 03/20/24 at 10:46 AM, the surveyor reviewed the care plan which showed the following focus:
NJ ex order 26.4b1 [redacted]
NJ ex order 26.4b1 [redacted]

On 03/21/24 at 10:08 AM, the surveyor reviewed documentation provided by the facility which included progress notes, physician orders, and the physician NJ ex order 26.4b1 . NJ ex order 26.4b1 [redacted] The surveyor could not locate a physician's order for NJ ex order 26.4b1 after review of the physician orders.

On 03/25/24 at 1:11 PM, the surveyor interviewed the US FOIA (b)(6)) regarding residents being discharged home. The surveyor asked what a resident would need to be discharged home. The US FOIA (b) stated that residents should have a discharge order, medications should be arranged, and discharge instructions reviewed with the resident or resident representative. The surveyor asked about the need for a discharge order for Resident #128 and the US FOIA (b) responded, "Definitely should have a physician order for discharge, we started in-servicing making sure

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the discharge orders are in the chart".

A review of the policy titled, "Preparing a Resident for Transfer or Discharge", an undated policy. The policy statement was that the facility shall prepare a resident for a transfer or discharge. Under the section policy interpretation and implementation, the policy did not include obtaining a physician order as part of the policy.

2. On 03/21/2024 at 9:14 AM, during medication administration observations, the surveyor observed Registered Nurse (RN) #1 administer medication to Resident #61. Along with other ordered medications, RN #1 administered one NJ Exec Order 26.4b1 nto the resident's and into the resident's

At 9:16 AM, the surveyor, along with RN #1, reviewed the physician's order (PO) for in the electronic medical record (EMR). At this time RN #1 confirmed the PO indicated for to be administered in the , and not . RN #1 at this time acknowledged that medications should be administered as ordered.

A review of Resident #61's Admission Record indicated the resident was NJ ex order 26.4b1

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NJ ex order 26.4b1

A review of the physician Order Summary Report (POS) indicated an active order with start date of NJ ex order 26.4b1 for NJ ex order 26.4b1 A second order was initiated dated NJ ex order 26.4b1 .

A review of the resident's care plan indicated a care focus initiated NJ ex order 26.4b1 for NJ ex order 26.4b1

A review of the NJ ex order 26.4b1 and NJ ex order 26.4b1 Medication Administration Record (MAR) indicated NJ ex order 26.4b1 and signed by the nursing staff twice daily.

On 03/25/24 at 1:15 PM, the surveyor interviewed the US FOIA (b) who stated nurses should follow physician's orders when administering medication. She acknowledged it was not appropriate for RN #1 to administer the NJ ex order 26.4b1 if the order called for NJ ex order 26.4b1

3. On 3/18/24 at 10:21 AM, during the initial tour of the facility, the surveyor observed Resident #96 in their room, laying in their bed. The resident was laying on a mattress NJ Exec Order 26.4b1 and was observed to be a NJ Exec Order 26.4b1 mattress with NJ Exec Order 26.4b1 The resident informed the

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surveyor that they NJ ex order 26.4b1

On 3/20/24 the surveyor reviewed Resident #96's EMR. Review of the Admission Record indicated the resident NJ ex order 26.4b1

A review of the most recent Quarterly MDS dated NJ ex order 26.4b indicated the resident had a Brief Interview of Mental Status score of NJ ex out of 15 indicating NJ Exec Order 26.4b1.

A review of the physician Order Summary Report (POS) indicated an active order with start date NJ ex order 26.4b for an NJ ex order 26.4b1

A review of the resident's care plan revealed a care focus area for required use of an NJ ex with revision date NJ ex order 26.4b1 with interventions including to NJ Exec Order 26 each time when entering the room. Further review of the care plan indicated a focus area for NJ Exec Order 26.4b1 with revision date NJ ex order 26.4b and intervention including NJ Ex every shift.

A review of the NJ ex order 26.4b1 Treatment Administration Record (TAR) revealed NJ Exec Order 26.4b1 checks were conducted and signed as completed by the nursing staff every shift as ordered.

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On 3/21/24 at 8:36 AM, the surveyor observed Resident #96 in bed with a NJ Exec Order 26.4b mattress and NJ Exec Order 26.4b1 .

On 3/25/24 at 10:50 AM, the surveyor observed Resident #96 in bed with a NJ Exec Order 26.4b mattress and NJ Exec Order 26.4b1 .

At 10:53 AM, the surveyor asked RN #1 to identify the type of mattress being used for the resident. RN #1 along with the surveyor entered the resident's room at which point RN #1 acknowledged the mattress being used was not an NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 as ordered. RN #1 further stated she was going to notify the appropriate department to bring an NJ Ex [redacted] for the resident's bed.

At 10:56 AM, the resident informed the surveyor that they think they should have NJ Exec Order 26 [redacted] and that NJ Exec Order 26.4b1 the use of one.
At 10:58 AM, RN #1 informed the surveyor the resident should have an NJ Exec Order 26.4b1 because it was ordered, and she was not sure why the resident did not have one.

On 3/25/24 at 11:02 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the resident NJ ex order 26 [redacted] and it was not really being checked by the nursing staff as ordered.

On 3/25/24 at 11:08 AM, the US FOIA (b)(6) [redacted] notified the surveyor that an NJ Exec [redacted] was being brought to the resident's room by the housekeeping/maintenance department.

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F 658	Continued From page 24 Review of the facility's undated "Administering Medications" policy included but was not limited to: "medications must be administered in accordance with the orders, including any required time frame." NJAC 8:39-11.2 (a) (b)	F 658		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 5 of 51 days reviewed under the Sufficient and Competent Nurse Staffing Task. The deficient practice was evidenced by the following:	F 727	I. Element 1 Corrective Action There was a recruitment meeting held immediately and the recruitment process was revamped an restructured. The facility is in the process of hiring RNs in order to maintain RN coverage for at least eight hours daily. II. Element 2 Identification of Others	4/30/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 25 A review of the Nurse Staffing Reports completed by the facility for the weeks of 07/10/2022 through 07/16/2022, 01/08/2023 through 01/14/2023, 03/10/2024 through 03/16/2024 revealed the facility had no RN coverage for all shifts on 07/16/2022, 01/08/2023, 01/14/2023, 03/10/2024, and 03/16/2024. A review of the facility provided schedules for those dates did not reveal any RN coverage. Additionally, facility provided schedules for 07/17/2022 and 03/17/2024. 07/17/2022 did not reveal any RN coverage. The schedule for 03/17/2024 revealed the Director of Nursing was present in the facility however the resident census on that day was 136. On 03/26/2024 at 1:40 PM during an interview with the surveyor, the[US FOIA (b)(6)] said they have Registered Nurses at times but sometimes they leave for various reasons. A review of the undated facility policy titled, "Staffing" revealed under 'Policy Interpretation and Implementation" that, "1. This facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the deliver of resident care services." NJAC 8:39-25.2(h)	F 727	All residents residing in the facility had the potential to be affected. III. Element 3 Systemic Changes Education was provided for [US FOIA (b)(6)] on the importance of meeting federal and state guidelines on staffing. Discussing new rates and sign on bonuses for RNs. Recruiting internationally for RNs. Recruiting RNs through other agencies and Nursing schools. IV. Element 4 Quality Assurance The Director of Nursing, or designee, will review schedules weekly for 12 weeks to ensure the facility has an RN working for at least 8 consecutive hours each day. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations determined by the QAPI Committee.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		4/30/24

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F 755	Continued From page 26 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the accountability of the narcotic shift count logs were completed in accordance with facility policy. The deficient practice was identified on 2 of 4 medication carts reviewed (1 [redacted] side cart and 2 [redacted] side cart) during the Medication Storage Task.	F 755	I. Element 1 Corrective Action Narcotic shift count log were reviewed and audited. All Licensed nurses were in-serviced on reconciling narcotics count logs II. Element 2 Identification of Others	

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F 755	Continued From page 27 The deficient practice was evidenced by the following: On 03/19/2024 at 10:05 AM during an interview with the surveyor, Licensed Practical Nurse (LPN) # 4 said that narcotic shift count logs are to be completed by two nurses (the incoming and outgoing nurses) at the same time once they confirm an accurate count of the narcotics (opium, opium derivatives, and their semi-synthetic substitutes) in the medication cart. She also confirmed that shift count logs should not be missing any documentation or signatures. Further, she said that the inventory sheet should be filled out when she prepares to administer a narcotic. At that time, the surveyor, in the presence of LPN 4, reviewed the 1 East low side medication cart "Narcotic Bingo Card Log" which revealed the following: On 3/10/24 the 3-11 shift section revealed that positive, negative, and "End Shift total" sections were blank. On 3/13/24 the 11-7 shift section revealed that positive and negative sections were blank. On 03/19/2024 at 10:33 AM during an interview with the surveyor, LPN # 2 stated that the narcotics shift log should be counted and signed by the incoming and outgoing nurses together. At that time, LPN # 2 stated, "I forgot to sign it in this morning." At that time, the surveyor in the presence of the LPN # 2, reviewed the 2 West High side medication cart's "CONTROLLED DRUGS CARD COUNT" document which revealed the following: On 03/04/2024, in the "7A-3P Shift" section, the positive and negative count section was blank. On 03/05/2024, in the "7A-3P Shift" section, the positive and negative count section was blank.	F 755	All residents residing in the facility who receive controlled medications have the potential to be affected. III. Element 3 Systemic Changes In-service was provided for Licensed Nurses on documenting on the narcotic shift count log IV. Element 4 Quality Assurance The Director of Nursing, or designee, will review 3 logs blank spaces 5 days a week for 4 weeks then weekly for 8 weeks. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations determined by the QAPI Committee.	

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F 755	Continued From page 28	F 755		

On 03/06/2024, in the "3P-11P SHIFT" section, the "Nurse on (11-7) [3-11]" section was blank.
On 03/07/2024, in the "7A-3P SHIFT" section, the "Nurse off (11-7)" section was blank.
On 03/11/2024, in the "7A-3P Shift" section, the positive and negative count section was blank.
On 03/19/2024, in the "7A-3P SHIFT" section, the "Nurse On (7-3)" section was blank.

On 03/19/2024 at 11:14 AM during an interview with the surveyor, LPN # 6 said all nurses assigned to carts are responsible for the organization and maintenance of the medication cart. She further stated that narcotic shift to shift count logs are to be completed by two nurses (the incoming and outgoing nurses) at the same time once they confirm an accurate count of the narcotics in the cart. She also confirmed that logs should not be missing any documentation, signatures.

On 03/19/2024 at 1:33 PM during an interview with the surveyor, the US FOIA (b)(6) said controlled substance shift to shift logs are to be completed with two nurses at the change of shift. The US FOIA (b) said this occurs after they both complete a count of the controlled substance in the medication cart to show they [narcotics] are accounted for. She confirmed that the purpose is for accountability of the controlled medications.

A review of the facility's undated policy titled; "Controlled Substances" revealed that "nursing staff will count controlled drugs at the end of each shift. The nurse coming on duty and nurse going off duty will make the count together. They will document and report any discrepancies to the Director of Nursing services."

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F 755	Continued From page 29 NJAC 8:39-29.3(a)	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		4/30/24

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F 756	Continued From page 30 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure required monthly visits by the US FOIA (b)(6)) for the months of NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. This irregularity was identified for 3 of 3 residents reviewed for US FOI review, Residents #63, #83, and #27. This deficient practice was evidenced by the following: 1.) On 03/21/24 at 11:37 AM, the surveyor reviewed the US FO progress notes. During review it was identified that the US FO reviewed Resident #63 medications NJ ex order 26.4b1 NJ ex order 26.4b1. There was no available documentation for NJ ex order 26.4b1 A review of the Admission Record for Resident #63 indicated the resident had medical diagnoses which included but were not limited to NJ ex order 26.4b1 . On 03/26/24 at 10:05 AM, the surveyor interviewed the US FOIA (b)(6) regarding the US FOIA. The US FOIA (b) told the surveyor, "The US FOIA (b)(6) stopped coming". The surveyor asked what process was put in	F 756	I. Element 1 Corrective Action Hired new pharmacy consultant II. Element 2 Identification of Others All residents residing in the facility who receives medication had the potential to be affected. III. Element 3 Systemic Changes New pharmacy consultant started and reviewed NJ Ex Order 26.4b1 and continues to review. IV. Element 4 Quality Assurance The Director of Nursing, or designee, will complete 2 random audits of Pharmacy Consultant Notes for 4 weeks then once a week for 8 weeks to ensure medication review is complete. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations	

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F 756	Continued From page 31	F 756		

place for the three months the facility did not have a [US FOIA] The [US FOIA (b)] replied, "We did medication pass with nurses and looked at the new admissions medications". The [US FOIA (b)] told the surveyor the facility at that time was in the process of getting a new US FOIA (b)(6)

On 03/26/24 at 12:30 PM, the surveyor requested documentation supporting the facility securing a new [US FO] following the [NJ Exec Order 26] [US FO] reviews. No information was provided.

On 03/28/24 at 12:31 PM, the surveyor reviewed the policy titled, "Pharmacy Consultant Policy and Procedure", an undated policy. Under number five of the policy, it indicated that the Consultant Pharmacist is responsible to provide drug regimen review reports to the Administrator, DON, and to the Nurse Managers monthly.

2.) On 03/21/2024 at 09:49 AM the surveyor reviewed the [US FO] progress notes. During review it was identified that the [US FO] reviewed Resident #83's medication from NJ ex order 26.4b1 NJ ex order 26.4b1 There was no available documentation for NJ ex order 26.4b1

On 03/21/2024 at 09:49 AM the surveyor reviewed the progress notes for Resident #83 which indicated the resident had [NJ ex order 26.4b1] NJ ex order 26.4b1), and NJ ex order 26.4b1). Review of quarterly MDS dated [NJ ex order 26.4b1] revealed a Brief Interview of Mental Status of [NJ ex o] indicating NJ ex order 26.4b1 .

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F 756	Continued From page 32	F 756		

On 03/26/24 at 10:05 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the US FOIA The US FOIA (b) told the surveyor, "The US FOIA (b)(6) stopped coming". The surveyor asked what process was put in place for the three months the facility did not have a US FOIA The US FOIA (b) replied, "We did medication pass with nurses and looked at the new admissions medications".

Review of facility provided, undated policy titled, "Pharmacy Consultant Policy and Procedure", number five of the policy indicatd, "the Consultant Pharmacist is responsible to provide drug regimen review reports to the Administrator, DON, and to the Nurse Managers monthly."

N.J.A.C. 8:39-29.3(a)1

3.) A review of the US FO progress notes revealed Resident #27's medications were reviewed NJ ex order 26.4b1 . There was no available documentation for NJ ex order 26.4b1

A review of the Admission Record for Resident #27 indicated that, the resident had medical diagnoses which included but were not limited to NJ ex order 26.4b1 NJ ex order 26.4b1

A review of the annual Minimum Data Set (MDS),

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F 756	Continued From page 33 an assessment tool dated [NJ ex order 26.4b1] revealed the resident had a Brief Interview of Mental Status score of [NJ ex.4] 15, meaning the resident had [NJ ex] [redacted] On 03/26/24 at 10:05 AM, during an interview with the surveyor, the [US FOIA (b)] stated, "The US FOIA (b)(6) stopped coming". The surveyor asked what process was put in place for the three months when the facility did not have a [US FOIA] The [US FOIA (b)] replied, "We did medication pass with nurses and looked at the new admissions medications." The [US FOIA (b)] said the facility at that time, was in the process of getting a new US FOIA (b)(6). A review of the undated facility-provided policy titled, "Pharmacy Consultant Policy and Procedure", number five of the policy indicated, "the Consultant Pharmacist is responsible to provide drug regimen review reports to the Administrator, DON, and to the Nurse Managers monthly." N.J.A.C. 8:39-29.3(a)1	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/30/24

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F 761	Continued From page 34 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to accurately label multidose medications to facilitate the consideration of precautions and safe administration. The deficient practice was observed for 1 of 4 medication carts (2 NJ Exec Order 26.4b1) reviewed under the Medication and Storage Task. The deficient practice was evidenced by the following: On 03/19/2024 at 10:33 AM, the surveyor in the presence of Licensed Practical Nurse (LPN) # 2 observed the 2 NJ Exec Order 26.4b1 medication cart. At that time, the surveyor observed the following: 1 opened Artificial Tear bottle. The bottle was not dated when it was opened. 1 opened Spiriva (treats asthma and chronic obstructive pulmonary disease) handheld inhaler. The inhaler was not dated when it was opened. 3 opened Lantaprost 0.005% ophthalmic solution	F 761	I. Element 1 Corrective Action All medications with that require a date when opened and without a date were immediately thrown away and replaced. An in-service was immediately conducted with the US FOIA to not leave medication unattended on the cart. II. Element 2 Identification of Others An assessment of the risk this could present to the residents was completed, and all residents could have been affected by this practice. III. Element 3 Systemic Changes In-service was provided for Licensed Nurses on dating of medications when opened when applicable. In-service was also conducted for	

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F 761	Continued From page 35 eye drops. The bottles were not dated when they were opened. 1 opened Dorzolamide hydrochloride and Timolol maleate ophthalmic solution eye drops. The bottle was not dated when they were opened. At this time, during an interview with the surveyor, LPN # 2 stated, "The eye drops, and inhaler should have been dated and initialed once opened." On 03/19/2024 at 1:34 PM, during an interview with the surveyor, the US FOIA (b)(6) stated, " ...Inhalers when open should be dated on the packaging and the medication itself, this includes insulin and eye drops." The US FOIA (b) confirmed that opened medications should be dated. A review of the facility's undated policy titled, "Labeling of Medication Containers" revealed that, "labels for each single unit dose package shall include all necessary information, such as: The name and strength of the drug, the lot or control number, the dated drug dispensed, the expiration date, when applicable dating of medications should be dated with the open date." 2. On 3/21/24 at 12:16 PM, the surveyor observed LPN2 during medication administration for Resident #381. LPN2 gathered the prescribed medication for Resident #38 NJ ex order 26.4b1 [redacted] She then placed the NJ Exec Orde vial on top of the medication cart, which was situated in the hallway, outside of the resident's room, and proceeded to enter the room to NJ ex order 26.4b1 [redacted]	F 761	Licensed nurses on not leaving medication unattended on the carts IV. Element 4 Quality Assurance The Director of Nursing, or designee, will complete 2 random audits of medication carts and medication rooms weekly for 4 weeks then once a week for 8 weeks to ensure all medications are properly dated once opened. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations determined by the QAPI Committee.	

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F 761	Continued From page 36 cart. At 12:20 PM, LPN2 returned to the medication cart, at which point the surveyor interviewed the [redacted]. The [redacted] stated she "should have put the [redacted] in the drawer so no one can grab it." On 3/25/24 at 9:16 AM, the surveyor interviewed the [redacted] who confirmed that nurses administering medication should not leave medication on top of the cart unsecured. The [redacted] confirmed that LPN2 should not have left the [redacted] vial on top of the medication cart. Review of the facility's undated "Administering Medications" policy included but was not limited to, "during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. N.J.A.C. 8:39-29.4	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		4/30/24

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F 812	Continued From page 37 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 03/18/2024 from 9:18 AM to 9:45 AM, the surveyor, accompanied by the US FOIA (b)(6) [redacted], toured the kitchen and observed the following: In the walk-in freezer, the surveyor observed a spinach quiche, two packages identified by the US FOIA (b) [redacted] as pulled pork, and a pie with no labels or dates. The US FOIA (b) [redacted] stated that there should be a use by label if out of the package. He further stated that the above referenced items were not correct. A review of facility provided policy titled "Labeling and Dating System Protocol" rev 5/23/23, revealed "All fresh and frozen foods must be dated with the date it was received into the	F 812	I. Element 1 Corrective Action The spinach quiche, pulled pork, and a pie were immediately thrown out II. Element 2 Identification of Others All residents residing at the facility who eat quiche, pork or pie from the kitchen have the potential to be affected. III. Element 3 Systemic Changes Dietary staff were educated on proper labeling and dating protocol. IV. Element 4 Quality Assurance 4. The Director of Dietary, or designee, will complete inventory of food items in the kitchen weekly for 12 weeks to ensure items are dated and labeled. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any	

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	315309	A. BUILDING _____ B. WING _____	C 03/27/2024

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F 812	Continued From page 38 kitchen, unless it has a Purveyor shipping label on it." Also included was "All food in freezer storage - 6 months." N.J.A.C. 18:39-17.2(g)	F 812	additional recommendations determined by the QAPI Committee.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following: On 03/18/2024 during initial kitchen tour with the US FOIA (b)(6)), the surveyor observed debris and trash around the dumpster area. The US FOIA stated that housekeeping was responsible for this area. He also stated that it was Monday and he guessed nobody had gotten out there as of that time. On 03/21/2024 at 12:28 PM the surveyor noted debris and trash in the area behind the dumpster area. On 03/25/2024 at 12:44 PM the surveyor interviewed the US FOIA (b)(6) who stated that housekeeping, maintenance and the kitchen are all in charge of the parking lot. He was shown a photo of the dumpster area and stated that they should go further than just the	F 814	I. Element 1 Corrective Action All debris and garbage was immediately removed from the area II. Element 2 Identification of Others An assessment of the risk this could present to the residents was completed, and all residents could have been affected by this practice. III. Element 3 Systemic Changes An in-serviced was held with maintenance, housekeeping and dietary departments on keeping facility property free of garbage and debris at all times. A thirty yard dumpster was placed on facility property for the disposal of garbage and debris IV. Element 4 Quality Assurance Administrator / designee will monitor the facility grounds five days weekly for four	4/30/24

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F 814	Continued From page 39 parking lot. A review of facility provided policy "Sanitation: Dumpster/Garbage Disposal", dated November 15, 2022, included: o Keep dumpster and dumpster site areas clean and free of debris o If any trash is on the ground or around the dumpster, you are responsible to pick it up and put it in the dumpster N.J.A.C. 8:39-19.3(c)	F 814	weeks and then weekly times three months. All findings will be discussed in the next QA	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		4/30/24

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F 880	Continued From page 40 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 41 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to 1.) implement appropriate NJ Exec Order 26.4b1 specifically by applying precautions to a room that contained a resident with a p NJ Exec Order 26.4b1 for 1 of 1 resident (Resident #6) and 2.) failed to perform effective hand hygiene for a minimum of twenty seconds. The deficient practices were identified for 1 of 1 resident (Resident # 6) reviewed for NJ Exec Order 26.4b1 under the NJ Exec Order 26.4b1 task and 2 of 3 nurses observed during the Medication Administration task . The deficient practices were evidenced by the following: 1.) A review of Resident # 6's "Admission Record" located in the Electronic Medical Record (EMR) revealed that on NJ ex order 26.4b1, he/she NJ ex ord A review of Resident # 6's "Order Summary Report" located in the EMR revealed that on NJ ex order 26.4b1 a, NJ ex order 26.4b1 On 03/19/2024 at 10:47 AM, the surveyor observed that Resident # 6's room did not have a NJ Exec Order 26.4b1 sign near the doorway nor was there any personal protective equipment (gowns, gloves, and masks worn to	F 880	I. Element 1 Corrective Action Resident #6 was NJ Exec Order 26.4 RN#1 and LPN #1 immediate hand hygiene competency was performed. CNA #1, CNA #2, LPN #3 were immediately in-serviced on proper PPE and NJ Exec Order 26.4 II. Element 2 Identification of Others All residents residing awaiting a stool culture and/or received medications from RN#1 or LPN#1 on this date have the potential to be affected. III. Element 3 Systemic Changes IP held an in-service on proper hand hygiene and isolation of a resident awaiting a stool culture for the facility IV. Element 4 Quality Assurance The Infection Preventionist, or designee, will complete weekly rounds to ensure infection control protocols are in place for those awaiting a stool culture. The Infection Preventionist, or designee, will observe 2 hand hygiene observations weekly for 4 weeks then monthly for 2 months to ensure proper technique. The results of these reviews will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for	

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F 880	Continued From page 42 limit the potential of spreading pathogens) outside of the room. On the same date at 10:53 AM, the surveyor knocked on Resident # 6's door which was answered by Certified Nurses Aide (CNA) # 2. CNA # 2 NJ ex order 26.4b1 . The surveyor observed another unidentified CNA also located within the room. The unidentified CNA did not have a gown on. At that time, CNA # 2 confirmed they were providing care to Resident # 6. On the same date at 11:04 AM, the surveyor observed Licensed Practical Nurse (LPN) # 3 enter Resident # 6's NJ ex order 26.4b1 . At approximately six minutes later, LPN # 3 exited the resident room and used alcohol-based hand rub (ABHR) for hand hygiene. On the same date at 11:30 AM during an interview with the surveyor CNA # 1 said Resident # 6 NJ ex order 26.4b1 CNA # 1 confirmed that Resident # 6 NJ ex order 26.4b1 . CNA # 1 said that there was NJ ex order 26.4b because Resident # 6 NJ ex order 26.4b1 . On the same date at 11:40 AM during an interview with the surveyor, LPN # 3 said Resident # 6 NJ ex order 26.4b1 She said that it may take forty-eight to seventy-two hours to get the test results. At that time, she confirmed results were not found. On the same date at 11:48 AM during an interview with the surveyor, The Licensed Practical Nurse/Unit Manager (LPN/UM) # 3 confirmed that if the physician orders a	F 880	any additional recommendations determined by the QAPI Committee.	

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F 880	Continued From page 43	F 880		

NJ Exec Order 26.4b1, there should be a NJ Exec Order 26.4b1 sign on the resident's door. At that time, the LPN/UM # 3 denied knowing if any residents were on NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1

On the same date at 12:24 PM during an interview with the surveyor, the US FOIA (b)(6)) confirmed she would "stress" NJ Exec Order 26.4b1 such as gowns, gloves, and to clean with a product that would kill NJ Exec Order 26.4b1 . She clarified that " NJ Exec Order 26 is a form of a contac NJ Exec Order 26.4b1 Further, she confirmed soap and water used for hand hygiene is most effective against NJ Exec Order 26.4b1 instead of ABHR.

On the same date at 12:41 PM during an interview with the surveyor, the US FOIA (b)(6) confirmed that if a resident is suspected of having NJ Exec Order 26.4b1 , they should place NJ Exec Order 26.4b1 on the resident's room at the time it was suspected.

On 03/26/2024 at 1:40 PM during an interview with the surveyor, the US FOIA (b)(6) confirmed Resident # 6 NJ ex order 26.4b1

NJAC 8:39 - 19.4(a)

2.) On 3/21/24 at 8:56 AM, during medication administration observations, the surveyor observed Registered Nurse (RN) #1 wash her hands after administering medication to a resident. RN #1 doffed (removed) and disposed

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F 880	Continued From page 44	F 880		

of her gloves, as she approached the sink in the resident's room. She turned on the water and proceeded to dispense soap from the wall mounted dispenser into her hand rubbed her hands together briefly and began to rinse the soap off under the running water. During this time, the surveyor was able to time her hand washing using a digital stopwatch timer to be approximately three (3) seconds. The nurse did not perform any other form of hand hygiene in addition to this instance during this time.

On the same date at 9:28 AM during an interview with the surveyor, RN #1 said hand washing should be sixty seconds with soap.

On 3/21/24 at 9:50 AM, during medication administration observations, the surveyor observed Licensed Practical Nurse (LPN) #1 wash her hands. After administering medication to a resident, LPN #1 went to the sink in the resident's room, turned on the water, dispensed soap into her hands and began to lather her hands with soap. She then rinsed her hands under the running water. The surveyor, using a digital stopwatch timer, timed LPN #1's hand washing technique to be 14 seconds. The nurse did not perform any other form of hand hygiene in addition to this instance during this time.

At 9:51 AM, the surveyor interviewed LPN #1, who said hand washing should be 30 seconds. LPN #1 concluded by stating, "I sang happy birthday (to time herself), NJ Exec Order 26.4b1 [redacted]."

On 3/25/24 at 1:15 PM, the surveyor interviewed the US FOIA (b)(6) [redacted], who stated nurses should wash their hands or use hand sanitizer in

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F 880	Continued From page 45 between residents when administering medication. Hand washing should be between 20-30 seconds. She further acknowledged that 14 seconds is not sufficient time for hand washing. Review of the facility's undated "Handwashing/Hand Hygiene" policy included but was not limited to: "for the purposes of infection control, handwashing/ hand hygiene must meet the following requirements: be a multidisciplinary hand-hygiene program, handwashing must be done using antimicrobial soap, all surfaces of the hands must be vigorously rubbed together, handwashing must occur for at least twenty seconds, include the use of alcohol-based hand rubs." NJAC 8:39 - 19.4(a)(n); 27.1 (a)	F 880		

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S 000	Initial Comments NJ00152412, NJ00153397, NJ00154875, NJ 00156118, NJ00161274, The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C/O # NJ160418, NJ152412, NJ156118, NJ161274 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	I. Element 1 Corrective Action Current schedules were reviewed with no concerns. II. Element 2 Identification of Others An assessment of the risk this could present to the residents was completed, and all residents could have been affected by this practice. III. Element 3 Systemic Changes	4/30/24

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

Electronically Signed | 04/16/24

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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. 1.) For the week of Complaint staffing from 02/13/2022 to 02/19/2022, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts, deficient in total staff for residents on 2 of 7 evening shifts, deficient in CNAs to total staff on 1 of 7 evening shifts, and deficient in total staff for residents on 3 of 7 overnight shifts as follows: -02/13/22 had 8 CNAs for 145 residents on the day shift, required at least 18 CNAs. -02/13/22 had 13 total staff for 145 residents on the evening shift, required at least 14 total staff. -02/13/22 had 7 total staff for 145 residents on the overnight shift, required at least 10 total staff. -02/14/22 had 12 CNAs for 145 residents on the day shift, required at least 18 CNAs. -02/15/22 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs. -02/16/22 had 15 CNAs for 143 residents on the day shift, required at least 18 CNAs.	S 560	Staffing Coordinator was educated on meeting the state requirement for CNA to resident ratio. Job posting has been updated for CNA□s. IV. Element 4 Quality Assurance The Director of Nursing, or designee, will review schedule daily to ensure ratios are met according to the state guidelines. The results of these reviews will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations as determined by the QAPI Committee	

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S 560	Continued From page 2 -02/16/22 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -02/17/22 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -02/18/22 had 9 total staff for 140 residents on the overnight shift, required at least 10 total staff. -02/19/22 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs. -02/19/22 had 13 total staff for 140 residents on the evening shift, required at least 14 total staff. -02/19/22 had 8 total staff for 140 residents on the overnight shift, required at least 10 total staff. 2.) For the week of Complaint staffing from 02/27/2022 to 03/05/2022, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -02/27/22 had 11 CNAs for 145 residents on the day shift, required at least 18 CNAs. -02/28/22 had 11 CNAs for 144 residents on the day shift, required at least 18 CNAs. -02/28/22 had 13 total staff for 144 residents on the evening shift, required at least 14 total staff. -02/28/22 had 9 total staff for 144 residents on the overnight shift, required at least 10 total staff. -03/02/22 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -03/03/22 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs. -03/05/22 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. 3.) For the week of Complaint staffing from 07/10/2022 to 07/16/2022, the facility was deficient in CNA staffing for residents on 3 of 7 day shift, deficient in total staff for residents on 1	S 560		

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S 560	Continued From page 3 of 7 evening shifts, and deficient in total staff for residents on 4 of 7 overnight shifts as follows: -07/10/22 had 9 CNAs for 147 residents on the day shift, required at least 18 CNAs. -07/11/22 had 9 total staff for 147 residents on the overnight shift, required at least 10 total staff. -07/12/22 had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. -07/12/22 had 14 total staff for 147 residents on the evening shift, required at least 15 total staff. -07/14/22 had 9 total staff for 150 residents on the overnight shift, required at least 11 total staff. -07/15/22 had 9 total staff for 150 residents on the overnight shift, required at least 11 total staff. -07/16/22 had 11 CNAs for 149 residents on the day shift, required at least 19 CNAs. -07/16/22 had 10 total staff for 149 residents on the overnight shift, required at least 11 total staff. 4.) For the week of Complaint staffing from 12/25/2022 to 12/31/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 1 of 7 evening shifts, deficient in CNAs to total staff on 1 of 7 evening shifts, and deficient in total staff for residents on 4 of 7 overnight shifts as follows: -12/25/22 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -12/25/22 had 12 total staff for 136 residents on the evening shift, required at least 14 total staff. -12/25/22 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. -12/26/22 had 9 CNAs for 136 residents on the day shift, required at least 17 CNAs. -12/26/22 had 9 total staff for 136 residents on the overnight shift, required at least 10 total staff. -12/27/22 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061523	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

(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 4 -12/28/22 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -12/29/22 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs. -12/29/22 had 8 total staff for 136 residents on the overnight shift, required at least 10 total staff. -12/30/22 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. -12/30/22 had 8 total staff for 136 residents on the overnight shift, required at least 10 total staff. -12/31/22 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/31/22 had 8 total staff for 139 residents on the overnight shift, required at least 10 total staff. 5.) For the week of Complaint staffing from 01/08/2023 to 01/14/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -01/08/23 had 10 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/10/23 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/13/23 had 9 total staff for 140 residents on the overnight shift, required at least 10 total staff. -01/14/23 had 14 CNAs for 140 residents on the day shift, required at least 17 CNAs. 6.) For the 2 weeks of staffing prior to survey from 03/03/2024 to 03/16/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -03/03/24 had 8 CNAs for 140 residents on the day shift, required at least 17 CNAs. -03/04/24 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061523	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

(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 5 -03/05/24 had 12 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/06/24 had 12 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/07/24 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -03/08/24 had 10 CNAs for 136 residents on the day shift, required at least 17 CNAs. -03/09/24 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs. -03/10/24 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs. -03/10/24 had 8 total staff for 136 residents on the overnight shift, required at least 10 total staff. -03/11/24 had 8 CNAs for 135 residents on the day shift, required at least 17 CNAs. -03/11/24 had 8 total staff for 135 residents on the overnight shift, required at least 10 total staff. -03/12/24 had 12 CNAs for 134 residents on the day shift, required at least 17 CNAs. -03/13/24 had 15 CNAs for 133 residents on the day shift, required at least 17 CNAs. -03/14/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/15/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/16/24 had 7 CNAs for 131 residents on the day shift, required at least 16 CNAs. On 03/19/2024 at 11:30 AM during an interview with the surveyor, CNA # 1 stated nobody wants to work on the weekends. She further said that she is not able to get her work done ... On 03/16/2024 at 1:40 PM during an interview with the surveyor the Chief Clinical Officer said the facility was aware of the CNA staffing requirements.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061523	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

(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 6 A review of the undated facility policy titled, "Staffing" revealed under "Policy Interpretation and Implementation" that, "1. This facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met ..." The policy further revealed, "2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan."	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation it was determined that the facility failed to provide two evening activity programs per week. This deficient practice was identified in 3 of 3 months reviewed, NJ Exec Order 26.4b1 [redacted] and was evidenced by the following: On 03/21/24 at 10:30 AM, the surveyor held a Resident Council meeting with five residents in attendance. During the meeting 5 of the 5 residents told the surveyor the facility did not offer activities after 5:00 PM. On 03/25/24 at 09:40 AM, the surveyor reviewed the activities calendars for the three months. The surveyor noted that the facility had one activity in	S 720	I. Element 1 Corrective Action Current schedules were changed during survey to have evening activities for all residents twice weekly at Six p.m. The activity calendar was updated. II. Element 2 Identification of Others An assessment of the risk this could present to the residents was completed, and all residents could have been affected by this practice. III. Element 3 Systemic Changes Director of Recreation was educated on	4/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061523	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

(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 720	Continued From page 7 the evening at 6:00 PM on Thursdays only, a movie and it was the only evening with activities offered on the calendar. On 03/26/24 at 10:08 AM, the surveyor interviewed the Activities Director (AD) regarding evening activities. The AD told the surveyor the facility had evening activities on Monday nights on the "sensory side" and on Thursdays the facility showed a movie in the evening for the rest of the residents. The surveyor asked if the sensory side activity was open for all residents and the AD stated it was just for the dementia unit. The surveyor asked if the facility had evening activity employees and the AD stated only on the sensory side on Mondays. The surveyor then asked if he was aware of the NJ regulations and he stated, "Yes, activities two evenings each week. On 03/28/24 at 11:20 AM, the surveyor reviewed the policy titled, "Activities and Social Event", an undated policy. The policy stated that residents have the right to choose the types of activities and social events in which they wish to participate. Number six, under Policy Interpretation stated that the facility will provide activities on most days, including weekends and holidays, as well as scheduled religious and social activities.	S 720	meeting the state requirement for evening activities IV. Element 4 Quality Assurance The Director of Recreation, or designee, will review schedule weekly to ensure there are two evening activities per week at Six p.m. The results of these reviews will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations as determined by the QAPI Committee.	

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
315309 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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 F0584	Correction	ID Prefix F0623	Correction	ID Prefix F0640	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(f)(1)-(4)	Completed
LSC	04/30/2024	LSC	04/30/2024	LSC	04/30/2024
ID Prefix F0644	Correction	ID Prefix F0658	Correction	ID Prefix F0727	Correction
Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(b)(1)-(3)	Completed
LSC	04/30/2024	LSC	04/30/2024	LSC	04/30/2024
ID Prefix F0755	Correction	ID Prefix F0756	Correction	ID Prefix F0761	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	04/30/2024	LSC	04/30/2024	LSC	04/30/2024
ID Prefix F0812	Correction	ID Prefix F0814	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/30/2024	LSC	04/30/2024	LSC	04/30/2024
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	
3/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315309 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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 F0584	Correction	ID Prefix F0623	Correction	ID Prefix F0644	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(e)(1)(2)	Completed
LSC	04/30/2024	LSC	04/30/2024	LSC	04/30/2024
ID Prefix F0727	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.35(b)(1)-(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/30/2024	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	
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?
3/27/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061523 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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 04/30/2024	ID Prefix S0720 Reg. # 8:39-7.3(d) LSC	Correction Completed 04/30/2024	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

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		
3/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061523		5/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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 04/30/2024	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	
3/27/2024	☐ 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
	315309	A. BUILDING **01** B. WING _____	**03/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	**23 SCHOOLHOUSE ROAD** **WHITING, NJ 08759**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 03/21/24. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/21/24 and 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. Aristacare at Whiting is a two-story building that was built in 1985. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 30 % of the building per the Maintenance Director. The current occupied beds are 127 of 180.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6	K 311		4/30/24

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

Electronically Signed | 04/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315309	A. BUILDING **01** B. WING _____	**03/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	**23 SCHOOLHOUSE ROAD** **WHITING, NJ 08759**

(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 311	Continued From page 1 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure seven out of 14 fire rated door assemblies of stairway exit doors were equipped with approved fire exit hardware. The facility also failed to ensure the sprinkler piping in the stairway was sealed with fire rated material in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. and Section 8.6.5. This deficient practice had the potential to affect all 127 residents who resided at the facility. Findings include: An observation on 03/21/24 from 12:00 PM to 1:50 PM revealed the stairway exit doors on the first floor were equipped with panic hardware and not the required fire exit hardware which violated the listing of the rated fire door assemblies. An observation on 03/21/24 at 12:03 PM revealed the one-inch sprinkler piping that penetrated stairway number two on the first floor near the laundry was not sealed with fire rated material. During interviews at the time of observations, the US FOIA (b)(6) confirmed the stairway doors were equipped with panic hardware and stated he bought the hardware from an on-line provider. The US FOIA (b)(6) also confirmed the sprinkler pipe was not sealed in the first floor stairway. NJAC 8:39-31.1(c), 31.2(e)	K 311	I. Element 1 Corrective Action A purchase order was approved and placed for fire rated panic hardware immediately for the 7 out of 14 stairwell doors, it was switched out when they arrived on April 12th. An audit was done for all other doors with panic bars. the sprinkler piping was sealed with a fire rated material immediately too. An audit was done on all of the sprinkler piping. II. Element 2 Identification of Others An assessment of the risk this could present to the residents was completed, and all residents could have been affected by this practice. III. Element 3 Systemic Changes An education was given to the maintenance dept. on all doors locks and bars must be fire rated for 1 hour. An in-service was given to the maintenance dept. that no penetrations' is allowed and must be sealed with the appropriate fire rated materials. IV. Element 4 Quality Assurance The administrator or designee will ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315309	A. BUILDING **01** B. WING _____	**03/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	**23 SCHOOLHOUSE ROAD** **WHITING, NJ 08759**

(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 311	Continued From page 2 NFPA 80	K 311	and monitor the facility weekly for 3 months that all stairwells, elevator shafts, light and ventilation shafts, chutes and vertical openings between floors will be enclosed with construction having fire resistance of at least 1 hour. All findings will be discussed and evaluated in QAPI monthly and re-evaluated as needed.	

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
315309 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	5/1/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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 Reg. # NFPA 101 LSC K0311	Correction Completed 04/30/2024	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
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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	
3/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO