STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING ______ B. WING ______	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

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F 000	INITIAL COMMENTS Complaint: #164113, #164915, #170376, #171027 Survey Date: 5/8/24 to 5/16/24 Census: 184 Sample: 36 + 2 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 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607		6/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 07/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	Continued From page 1 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to implement the facility's abuse policy to ensure reference checks were completed for Ten (10) of Ten (10) newly hired staff reviewed. This deficient practice was evidenced by the following: On 05/14/24, the surveyor reviewed Ten (10) randomly new employee files which revealed the following: Staff #1-a U.S. FOIA (b)(6) with a hire date of Ex Order 26.4B1 did not have a previous employee reference on file. Two (2) undated typed personal reference letters were on file. Staff #2-a U.S. FOIA (b) with a hire date of Ex Order 26.4B1, did not have a previous employee reference on file. An emailed personal reference letter dated NJ Exec Order 26.4b1 and an undated typed personal reference was on file. Staff #3 - a U.S. FOIA (b)(6) with a hire date of Ex Order 26.4B1 did not have a previous employee reference or any personal references on file.	F 607	F607 Develop/Implement Abuse/Neglect Policies 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Staff #1 □ a U.S. FOIA (b)(6)), with a hire date of Ex Order 26.4B1 has had reference checks completed, Staff # 2 □ a U.S. FOIA (b with a hire date of Ex Order 26.4B1 is no longer an employed in the facility, Staff # 3 □ a U.S. FOIA (b)(6) with a hire date of Ex Order 26.4B1 no longer employed in the facility, Staff # 4 □ a U.S. FOIA (b)(6), with a hire date of Ex Order 26.4B1 is no longer employed in the facility, Staff #5 □ a U.S. FOIA (b)(6) , with a hire date of Ex Order 26.4B1 is no longer employed in the facility, Staff #6 □ a U.S. FOIA (b with a hire date of Ex Order 26.4B1 has had reference checks completed, Staff #7- a U.S. FOIA with a hire date of Ex Order 26.4B1 has had reference checks completed, Staff #8 □ a U.S. FOIA (b)(6) with a hire date of Ex Order 26.4B1, has had reference checks completed, Staff #9 □ a U.S. FOIA (b)(6) with a hire date of Ex Order 26.4B1 has had reference checks completed, Staff # 10 □ a U.S. FOIA with a hire date of Ex Order 26.4B1 has had	

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Continued From page 2

Staff #4- a U.S. FOIA (b)(6) with a hire date of Ex Order 26.4B1 did not have a previous employee reference on file. There were two (2) undated typed personal reference letters on file.

Staff #5- a U.S. FOIA (b)(6) , with a hire date of Ex Order 26.4B1, had an undated and unsigned employer verification on file.

Staff #6-a U.S. FOIA (b) with a hire date of Ex Order 26.4B1 had an emailed previous employee reference letter dated Ex Order 26.4B1

Staff #7-a U.S. FO, with a hire date of Ex Order 26.4B1, did not have a previous employee reference on file.

Staff #8- a U.S. FOIA (b)(6), with a hire date of Ex Order 26.4B1, did not have a previous employee reference on file. One (1) undated typed personal reference letter was on file.

Staff #9 -a U.S. FOIA (b)(6)), with a hire date of Ex Order 26.4B1, did not have a previous employee reference on file. One (1) undated typed personal reference letter was on file.

Staff #10-a U.S. FOIA, with a hire date of Ex Order 26.4B1, had a typed previous employee reference on file dated NJ Ex Order 26.4b1. One (1) undated typed personal reference letter was on file.

On 05/14/24 at 12:24 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that he requests 2 reference letters form the employee and they could be from a relative or co-worker. The U.S. FO stated that he does not get the reference letters prior to hiring and that he asked the employees to provide the

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reference checks completed. All reference checks completed on the 10 identified employees did not reveal anything that would identify potential risk of abuse/neglect of any resident, and none of them have been involved in any abuse/neglect allegations. No residents were identified to have been affected by the deficient practice.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?
All residents residing in the facility have the potential to be affected by the deficient practice. A review of the abuse/neglect allegations/investigations against facility staff in the last 12 months was conducted by the Director of Nursing (DON), none were substantiated, and all staff who had allegations of abuse had reference checks conducted prior to starting employment.

3. What measures will the facility put into place or what systemic changes will be made to ensure that the deficient practice will not recur?
The U.S. FOIA (b) (6)) was educated by the Licensed Nursing Home Administrator (LHNA) on the facility□s policy titled Abuse and Neglect Policy and Procedure to ensure that all prospective employees will be carefully screened using Reference checks, Criminal Background and License check process to identify potential risk of abuse/neglect of any resident prior to hiring.
The systemic change will be that the HR

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

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FORM APPROVED
OMB NO. 0938-0391

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F 607	Continued From page 3 reference letters. When asked if references should be done prior to working, the U.S. FOIA (b)(6) stated, "We try to do it, it looks better." On 05/14/24 at 12:50 PM, the surveyor interviewed the U.S. FOIA (b)(6)), the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) regarding the hiring process. The U.S. FOIA (b)(6) stated that prior to hiring, an application, a background check, license verification, a physical and references should be done. The U.S. FOIA (b)(6) stated that contacting previous employers to verify employment should be done prior to hiring. On 05/15/24 at 10:29 AM, during a follow up interview with the U.S. FOIA (b)(6) , the U.S. FOIA (b)(6) stated that the references could be personal or from previous employers. The U.S. FOIA (b)(6) stated that the employee can provide a personal reference, but the facility should call and verify that reference prior to employment. The U.S. FOIA (b)(6) further stated that the facility should attempt to contact previous employers to verify employment prior to hiring. A review of the facility's policy titled "Abuse and Neglect Policy and Procedure," reviewed 11/13/23, revealed that all prospective employees will be carefully screened using the following process to identify potential risk of abuse/neglect of any resident:1. Reference Check, 2. License check and background check. NJAC 8:39-9.3(b)	F 607	Director or designee will utilize an Employee Cover Sheet to document that Job Reference Checks were attempted, the result recorded and kept with the application for employment for the prospective employee to ensure that the facility has carefully screened them to identify potential risk of abuse/neglect of any resident. The HR Director or designee will conduct a comprehensive audit of current employees to ensure that job reference checks are completed and documented in the employee file on the Employee Cover Sheet. All new applicants will be carefully screened using the process of conducting reference checks prior to hiring to identify potential risk of abuse/neglect of any resident. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur, i.e., What Quality Assurance Program will be put into place? The LHNA or designee will conduct weekly audits x 4 weeks of all new employee applications, then monthly audits x 3 months of 5 new employee applications to ensure that reference checks are completed and documented on the Employee Cover Sheet prior to hiring and maintained in the employee file. The results of these audits will be presented by the HR Director and reviewed at the Quarterly Quality Assurance Performance Improvement (QAPI) meeting to ensure compliance x 2	

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F 607	Continued From page 4	F 607	quarters. The QAPI Committee will then determine the need for continuation after.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; 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 a.) provide personal hygiene and provide timely assistance for 2 of 2 residents dependent on staff for NJ Exec Order 26.4b1 care, Resident #21 and #147 and b.) provide NJ Exec Order 26.4b to Resident #280 who required assistance with ADL's care. This deficient practice was evidenced by the following: 1.) On 5/9/24 at 10:20 AM, the surveyor observed Resident #147 in bed, the head of the bed was elevated, and the resident was able to answer questions. Upon inquiry, the resident stated he/she had not been provided with Ex Order 26.4B1 care since last night. Resident #147 further stated that, "I have asked the U.S. FOIA (b)(6) to change me in the morning, but they haven't." At 10:36 AM, the surveyor asked the U.S. FOIA) to make Ex Order 26.4B1 rounds on this resident. Resident #147 was observed to have on Ex Order 26.4B1 with the Ex Order 26.4B1 Ex Order 26.4B1	F 677	F677 SS=D ADL Care Provided for Dependent Residents 1.) What Corrective action will be accomplished for those residents affected by the deficient practice. Residents #21, #147, #280 were identified to be affected by the deficient practice. Resident # 21 and Resident #147 had Ex Order 26.4B1 provided immediately, their NJ Ex Ord was assessed, and were observed. Resident#280 were cleaned and trimmed by the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) assigned. CNA # 1, and CNA # 2 were immediately re-educated by the Assistant Director of Nursing (ADON) to use a single adult brief, and to provide timely care for residents. CNA # 3 was immediately re-educated by the U.S. FOIA (b)(6) to check during care and clean, trim and file them if needed or requested by the resident. 2.) How will the facility identify other residents having the potential to be affected by the same, Deficient practice and what corrective action will be taken?	6/25/24

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F 677	Continued From page 5 Ex Order 26.4B1. The U.S. FOIA closed the Ex Order 26.4B1 and told the resident, "Let me call your U.S. FOIA (b) to provide you Ex Order 26.4B1. At 11:06 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated, Ex Order 26.4B1 are done normally every 2 hours and the residents should not be ." Due to the above observation, the surveyor and the U.S. FOIA continued Ex Order 26.4B1 rounds which revealed the following: At 11:10 a.m., unsampled Resident #89 was Ex Order 26.4B1 At 11:15 a.m., Resident #21 was wearing a Ex Order 26.4B1. At 11:21 a.m., unsampled Resident #65 was Ex Order 26.4B1 At 11:25 a.m., unsampled Resident #123 was Ex Order 26.4B1 At 11:32 a.m., unsampled Resident #116 was Ex Order 26.4B1 A review of the Admission Summary revealed that Resident #147 was admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1 The quarterly Minimum Data Set (MDS), an assessment tool, dated Ex Order 26.4B1, revealed that Resident # 147's Brief Interview for Mental Status (BIMS) was Ex O out of 15 which indicated the resident was Ex Order 26.4B1. Section GG of the MDS which referred to	F 677	All residents with incontinence have the potential to be affected by this deficient practice. All residents have the potential to be affected by the deficient practice of not receiving nail care. An initial audit has been conducted for all current residents to ensure fingernails are clean, trimmed and filed per resident preference. An initial audit has been conducted on 3 consecutive shifts for current residents who are incontinent to ensure they receive incontinent care/checks timely and wearing a single adult brief. No new issues were identified during these audits. 3.) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " The facility educator or designee will in-service CNA staff on the facility policy of timely and appropriate incontinent care, use of single adult briefs, and checking resident fingernails to ensure they are kept clean, filed and trimmed will be responsible for checking and cleaning fingernails during the resident□s scheduled shower day(s). " The DON/designee will conduct a random audit of 5 incontinent residents weekly x 4 weeks and then monthly x 2 quarters to ensure appropriateness and timely care of the incontinent residents and use of one adult brief. " The DON/designee will conduct a random audit of 5 residents weekly x 4 weeks and then monthly x 2 quarters to ensure nail care is provided. 4.) How the facility will monitor its	

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F 677	Continued From page 6 Activities of Daily Living (ADLs) revealed that Resident #147 was NJ Ex Order 26.4(b)(1) on staff for NJ Ex Order 26.4(b)(1). Section H of the MDS which referred to [redacted] revealed that Resident #147 was always Ex Order 26.4B1 [redacted]. Section M of the MDS revealed that the resident had Ex Order 26.4B1 Ex Order 26.4 Review of the Care Plan for Resident #147 initiated on Ex Order 26.4B1 with revision date of Ex Order 26.4B1, revealed a "focus for [name redacted] has impaired functional status r/t (related to) recent hospitalization, Ex Order 26.4B1 [redacted]." The goal was for Resident #147 will show improvement in functional status evidenced by increased self-participation in ADL's. The interventions included: NJ Ex Order 26.4(b)(1): NJ Ex Order 26.4(b)(1) X 1: NJ Ex Order 26. does NJ Ex Ord of the activity; resident does NJ Ex Order of the effort to complete the activity. Further review of the Care Plan, initiated on Ex Order 26.4B1 with a revision date of Ex Order 26.4B1 revealed a "focus for [name redacted] is at risk for Ex Order 26.4B1 [redacted] A review of the form NJ Ex Orde "Task" under NJ Ex Order 26.4(b)([redacted] (GG), NJ Ex Order 26.4(b)(1) (GG), NJ Ex Order 26.4(b) [redacted] and NJ Ex Order 26.4(b)(1), which revealed the last time the resident received care was on NJ Ex Order 26.4 at 19:08 (7:08 PM). There was no	F 677	corrective actions to ensure that the deficient practice is being corrected and will not recur. " The DON or designee will report outcomes of all audits at the Quarterly Quality Assurance Performance Improvement (QAPI) Committee for 2 consecutive quarters to monitor this deficient practice to ensure compliance. The committee will then determine the need for continuation after.	

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F 677	Continued From page 7 other documentation that the resident received care between the time of the above observation. On 5/15/2024 at 12:41 PM, the above concerns were presented to the U.S. FOIA (b)(6) the U.S. FOIA (b)(6), and the U.S. FOIA (b)(6) 2.) On 5/9/23 at 11:15 AM, the U.S. FOIA checked Resident #21 for Ex Order 26.4B1 care. The surveyor and the U.S. FOIA observed resident in bed, who was wearing Ex Order 26.4B1, the resident Ex Order 26.4B1. The U.S. FOIA acknowledged that "the residents should not be Ex Order 26.4B1." A review of the Admission Summary revealed that Resident #21 was admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1 The Annual MDS dated NJ Ex Order 26.4b1, revealed that Resident #21's BIMS was Ex Order out of 15, indicating the resident was Ex Order 26.4B1. Section GG of the MDS which referred to ADLs revealed that Resident #21 was NJ Ex Order 26.4(b)(1) on staff for Ex Order 26.4B1. Section H of the MDS which referred to revealed that Resident #147 was always Ex Order 26.4B1 . At 11:32 AM, the surveyors interviewed CNA #1 and CNA #2. They both acknowledged that they	F 677		

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F 677	Continued From page 8	F 677		

make Ex Order 26.4B1 twice a shift, they check their residents in the morning and if the residents are NJ Ex O then check them after breakfast. They further stated, "if the resident asks them to NJ Ex Order 26.4(them, they will NJ Ex Order 26.4(the resident." CNA #1 and CNA #2 also stated that they put only Ex Order Ex Order 26 on the resident and would tell the nurse if they saw a resident in Ex Order 26.4B1.

On 5/15/2024 at 12:41 PM, the above concerns were presented to the U.S. FOIA (b)(6) the U.S. FOIA (b)(6), and the U.S. FOIA (b)(6)

3. Observation on 05/08/24 at 11:22 AM, revealed Resident #280 in bed, Ex Order 26.4B1 Ex Order 26.4B1

Observation on 05/09/24 at 08:41 AM, revealed the resident eating breakfast, the Ex Order 26.4B1

Observation on 05/10/24 at 10:10 AM, after AM care had been provided, revealed the resident in bed, The Ex Order 26.4B1 When inquired regarding Ex Order 26.4B1 Resident #280 stated that she was Ex Order 26.4B1 Ex Order 26.4B1. Resident #280 stated that he/she was assisted with morning care but Ex Order 2 care was not done. She stated that she would like the Ex Order 26.4B1

On 05/10/24 at 10:13 AM, during an interview with CNA #3 who cared for Resident #280, she confirmed that Resident #280 was a NJ Ex Order 26.4b1. she further stated, " I have to for

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F 677	Continued From page 9 the resident". When inquired about Ex Order 26.4B1, CNA#3 stated that Ex Order 26.4B1 was part of AM care. On 05/10/24 at 10:22 AM, the surveyor escorted the U.S. FOIA (b) (6)) to the room and we both observed the Ex Order 26.4B1 The nurse stated, " Oh yes the NJ Exec Order 26.4b1 needed to be cleaned". The resident stated, "Ex Order 26.4B1". In the presence of CNA #3, Resident #280 stated, "Ex Order 26.4B1". On 5/10/24 at 11:30 AM, during a second interview with the U.S. FO assigned to the resident's care, she stated that Resident #280 refused the Ex Order 26.4B1. However, the surveyor returned to the room with CNA #3 and the resident stated in the presence of the CNA #3, "Ex". The U.S. FO could not provide a care plan or documentation of Resident #280's Ex Order 26.4B1. On 5/10/24 at 12:15 PM, the surveyor reviewed the Electronic Medical Record (EMR) which revealed that Resident #280 had diagnosis which included Ex Order 26.4B1. Review of the Admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of Ex Order 26.4B1 revealed a "Brief Interview for Mental Status (BIMS)" score of Ex Ord out of 15 indicating R# 280 had Ex Order 26.4B1 Further review of the "MDS" revealed R# 280 required substantial maximum for hygiene.	F 677		

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F 677	Continued From page 10	F 677		

Review of the care plan had a focus for impaired functional status related to Ex Order 26.4B1 and Ex Order 26.4B1. The goal was for Resident #280 to show improvement by increased self-participation in Activities of Daily Living (ADL's). Interventions included: Assist as needed. Encourage self participation in ADL's as tolerated.

Review of the facility policy titled, "Activities of Daily Living Supporting," with revised date of 03/24, indicated, "Residents will be provided with care and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's) The policy further stated that Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Under Policy Interpretation and Implementations: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:
c. elimination (toileting).

A review of the facility document titled, "Job Description with Position: Certified Nursing Assistant," revealed Basic Function: To provide services that support the care delivered to patients/residents requiring long term or rehabilitative care. Under Duties and Responsibilities: 1.e.) Assistance is given with patient care, such as, bathing, dressing, positioning, monitoring temperature, feeding, making up beds, and toileting. k.) Familiar and able to perform all of the basic CNA skills.

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F 677	Continued From page 11 NJAC 8:39-27.1 (a), 27.2(d, g, h, j)	F 677		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to consistently assess a resident's NJ Exec Order 26 access site when returning from the [redacted] clinic. The deficient practice was identified for 1 of 2 residents, Resident #4, reviewed for NJ Exec Order 26 care and services and is evidenced by the following. On 5/9/24 at 10:15 AM, the surveyor observed the resident seated in a wheelchair in their room eating breakfast. The resident was NJ Ex Orde but refused an interview. The resident told the surveyor that they had Ex Order 26.4B1 the previous day. The surveyor reviewed the medical record for Resident #4. The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1 [redacted]	F 698	F698 Dialysis 1. How will corrective action be accomplished for those individual residents found to be affected by the deficient practice? Resident # 4 had their Ex Order 26.4B1 access site checked immediately and a positive Ex Order 26.4B1, site was intact without signs or symptoms of infection or malfunction. Resident # 4 physician□s orders were updated to check the Ex Order 26.4B1 access site every shift and the [redacted] communication form was updated to include checking the [redacted] access site upon return from [redacted] 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents in the facility who receive hemodialysis have the potential to be affected by the deficient practice. A comprehensive review of residents residing in the facility who receive	6/25/24

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F 698	Continued From page 12 Ex Order 26.4B1 . A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26.4B1, reflected that the resident had a brief interview for mental status (BIMS) score of Ex out of 15, indicating that the resident was Ex Order 26.4B1 A review of the NJ Exec Order 26.4 Communication Sheets from Ex Order 26.4B1 revealed that the resident's Ex Order 26.4B1) was located on the resident's Ex Order 26.4B1 and that the facility was checking the Ex Order 26.4B1 Ex Order 26.4B1 . The Ex Order 26.4B1 Communication Sheets had no information showing that the Ex Order 26.4B1 were being checked Ex Order 26.4B1 by the facility. The surveyor reviewed the facility progress notes from NJ Exec Order 26.4b1 which revealed no Ex Order 26.4B1 documentation. A review of the comprehensive care plan revealed a focus area of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 , potential for complications. A review of the interventions revealed the following interventions "Monitor NJ Exec Order 26. NJ Ex Order 2 for NJ Exec Order 26.4b1 every shift. Monitor site for s/s (sign and symptoms of) NJ Ex Order 26.4(b)(1 If	F 698	hemodialysis was conducted and no other residents were found to be without physician orders to check the dialysis access site every shift. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur? The facility□s Dialysis Communication form was updated to include pre and post monitoring of dialysis access site on dialysis days. The facility educator will in-service licensed nursing staff on the facility policy to ensure all residents who receive hemodialysis have a physician□s order to check the dialysis access site every shift and pre and post dialysis treatment. The DON or designee will conduct weekly random audits x 4 weeks, then monthly x 2 quarters of 3 residents who receive hemodialysis to ensure their dialysis access site is being checked every shift and pre and post dialysis. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON will present the results of these audits at the Quarterly Quality Assurance Performance Improvement (QAPI) Committee for 2 consecutive quarters to monitor this deficient practice to ensure compliance. The committee will then determine the need for continuation after.	

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F 698	Continued From page 13 NJ Exec Ord or NJ Exec O not present or s/s infection are observed, notify U.S. FOIA (b) (6)) for prompt intervention. Monitor bleeding at site, if present, apply direct pressure with sterile gauze and notified U.S. FOIA (A review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) revealed the following physician's order (PO) dated NJ Exec Order 26.4 to check blood pressure and pulse prior to leaving for and on return from No NJ Exec Order 26.4b1) on NJ Exec Order 26.4 every shift Monday, Wednesday and Friday Pre and Pos . A further review of the May 2024 OSR revealed no PO to check the NJ Exec Order 26.4b1 access site NJ Exec Order 26.4b1). A review of the NJ Exec Order 26.4b1 electronic medication administration record (EMAR) revealed no documentation showing that the NJ Exec NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1) was being checked every shift. On 5/13/24 at 11:40 AM, the surveyor interviewed the NJ Exec Order 26.4 U.S. FOIA (b)(6)) who stated that a resident who had an NJ Ex Order 26.4(b)(1) ,that it NJ Exec Order 26.4b1) should be checked every shift including . In the presence of the surveyor, the U.S. FOIA (b)(6) reviewed Resident #4's medical record. The U.S. FOIA (b)(6) reviewed the Communication Sheets and acknowledge that the resident had an NJ Exec Order 26.4b1 on their NJ Exec Order 26.4 and that the NJ Exec Order 26.4b1 should be checked on every shift. The U.S. FOIA (b)(6) acknowledge that they were no post-dialysis notes written on the Dialysis Communication Sheets and this documentation would have included the resident's vitals and that the resident's NJ Exec Order 26.4b1 access site NJ Exec Order 26.4b1 NJ Exec Ord was checked. The U.S. FOIA (b)(6) also reviewed	F 698		

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F 698	Continued From page 14 the resident's progress notes, PO and EMAR and acknowledge that there was no documentation that showed that the resident's NJ Exec Order 26.4b1 site NJ Exec Order 26.4b1) was checked . The U.S. FOIA (b)(6) then reviewed the resident's care plan and acknowledged that the resident's NJ Exec Order 26.4b1 access site NJ Exec Order 26.4b1 should be checked every shift. The U.S. FOIA (b)(6) told the surveyor that he will try to find any additional information to show that the facility was checking the NJ Ex Order 26.4(b)(1) . On 5/14/24 at 11:30 AM, the surveyor interviewed the U.S. FOIA (b)(6), who had no additional information. The NJ Exec Order 26 stated that the resident should have had an order to check the U.S. FOIA (b)(6) access site (NJ Exec Order 26.4b1) every shift and he further stated that there was no documentation that he could provide which showed that the facility was checking the resident's NJ Exec Order 26.4b1 . On 5/14/24 at 12:35 PM, the surveyor presented the above concern to the administration team which included the U.S. FOIA (b)(6) U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)). The U.S. FOIA (b) acknowledge that it was important to check the NJ Exec Order 26.4b1 to assure the wasn't any clotting. There was no additional information provided. A review of the facility's policy for "Care of a Resident Receiving Dialysis" revised on 1/5/2024, and was provided by the U.S. FOIA (b) revealed the following: "If a resident has an AV fistula (access site), nursing will access and palpate for thrill and auscultate for bruit every shift by a license nurse. This will be documented in the EHR (electronic	F 698		

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F 698	Continued From page 15 health record)." NJAC 8:39-27.1(a); 2.9	F 698		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on obervations, interviews, record review, and pertinent facility documents it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents a.) conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission and b.) were seen by the attending physician or NJ Exec Order [redacted] every thirty days with a physician visit at least every sixty days. This	F 712	F712 Physician visits-Frequency/Timeliness/Alt NPP 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The attending physicians for residents #4, #11, #23, #33, #77, #130, #135 and #147 were immediately notified of the facility policy of the attending physician	6/25/24

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F 712	Continued From page 16 deficient practice was observed for 8 of 8 residents (Resident #4, #11, #23, #33, #77, #130, #135 and #147) reviewed for physician visits. This deficient practice was evidenced by the following: 1. On 5/9/24 at 12:25 PM, the surveyor observed Resident #77 sitting in Ex Order 2 chair who stated, Ex Order 26 " A review of Resident #77 Admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included but not limited to: Ex Order 26.4B1 A review of the progress notes in the Electronic Medical Records (EMR) revealed the attending physician saw the resident on Ex Order 26.4B1 Ex Order 26.4B1. Further review of the EMR revealed the U.S. FO saw the resident on Ex Order 26.4B1, and Ex Order 26.4B1 A review of the progress notes revealed that the resident was admitted to the facility in Ex Order 26.4B1. Resident #77 was discharged and returned to the facility in Ex Order 26.4B1 and Ex Order 26.4B1 Ex Order 26. Further review of the progress notes, did not reveal that the physician saw the resident	F 712	responsible for supervising the care of residents must conduct face-to-face visits and write progress notes every thirty days for the first ninety days of admission and are seen by the attending physician or Nurse Practitioner every thirty days with a physician visit at least every 60 days. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. A comprehensive audit of current resident attending physician visits has been conducted by the LNHA and DON or designee to determine which current attending physicians are in compliance with the policy of the attending physician responsible for supervising the care of residents and must conduct face-to-face visits and write progress notes every thirty days for the first ninety days of admission and are seen by the attending physician or Nurse Practitioner (NP) every thirty days with a physician visit at least every 60 days. All attending physicians that are not in compliance have been notified. Attending physicians who fail to comply with this policy will have their residents assigned to another provider. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	

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F 712	Continued From page 17 upon readmission in Ex Order 26.4B1 or upon return in Ex Order 26.4B1 or Ex Order 26.4B1 A review of the EMR did not reveal a Progress Note (PN) from the attending physician or the attending U.S. FO in Ex Order 26.4B1 or that the physician and U.S. FO were consistently alternating monthly visits. 2. A review of Resident #23s AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26.4B1 Ex Order 26.4B1 A review of the PN in the EMR revealed the attending physician saw the resident on Ex Order 26.4B1 Further review of the EMR revealed the U.S. FO saw the resident on Ex Order 26.4B1 A review of the PN revealed the resident was out of the facility in Ex Order 26.4B1 and Ex Order 26.4B1. Further review of the progress notes, did not reveal that the physician saw the resident upon	F 712	All current attending physicians and Nurse Practitioners will be in-serviced by the LHNA or DON and provided with a copy of the Physicians Visit policy to conduct face-to -face visits at least every 30 days for the first 90 days after admission and seen by the attending physician or NP every 30 days with a physician visit at least every 60 days. The LNHA or designee will conduct weekly random audits x 4 weeks, then monthly x 2 quarters of 10 resident charts to ensure attending physicians and Nurse Practitioner documentation meets the requirement in the Physician Visits Policy. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place? The LHNA will present the results of these audits at the Quarterly Quality Assurance Performance Improvement (QAPI) Committee for 2 consecutive quarters to monitor this deficient practice to ensure compliance. The committee will then determine the need for continuation after.	

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F 712	Continued From page 18 readmission in NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), or NJ Ex Order 26.4(b)(1) A review of the EMR did not reveal a PN from the attending physician or the attending U.S. FO for Ex Order 26.4B1 or that the physician and were consistently alternating monthly visits. 3. A review of Resident #33's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26.4B1 A review of the PN in the EMR revealed the attending physician saw the resident on Ex Order 26.4B1 Further review of the EMR revealed the U.S. FO saw the resident on Ex Order 26.4B1 Ex Order 26.4B1. A review of the PN revealed the resident was at the facility from Ex Order 26.4B1. The resident was discharged and returned to the facility in Ex Order 26.4B1. Further review of the progress notes, did not reveal that the physician saw the resident upon readmission in Ex Order 26.4B1 and Ex Order 26.4B1. A review of the EMR did not reveal a PN from the attending physician or the attending U.S. FO in Ex Order 26.4B1 r that the physician and U.S. FO	F 712		

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F 712	Continued From page 19 were consistently alternating monthly visits. 4. A review of Resident #11's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26.4B1 A review of the PN in the EMR revealed the attending physician saw the resident on Ex Order 26.4B1 . Further review of the EMR revealed the NP saw the resident on Ex Order 26.4B1 A review of the PN revealed the resident was discharged and returned to the facility in Ex Order 26.4B1 Ex Order 26 . Further review of the progress notes, did not reveal that the physician saw the resident upon readmission in Ex Order 26.4B1 A review of the EMR did not reveal a PN from the attending physician or the attending U.S. FO for Ex Order 26.4B1 or that the physician and U.S. FO were consistently alternating monthly visits. 5. A review of Resident #147's AR revealed the	F 712		

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F 712	Continued From page 20	F 712		

resident was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26.4B1 .

A review of the PN in the EMR revealed the resident was admitted to the facility in Ex Order 26.4B1

A review of the PN in the EMR revealed the attending physician saw the resident on Ex Order 26.4B1 Further review of the EMR revealed the NP saw the resident on Ex Order 26.4B1 Ex Order 26.4B1

A review of the EMR did not reveal a PN from the attending or the attending U.S. FO in Ex Order 26.4B1.

6. A review of Resident #130's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26.4B1

A review of the progress notes in the EMR revealed the attending physician saw the resident on Ex Order 26.4B1, and Ex Order 26.4B1 Further review of the EMR revealed the US FOIA (b)(6) saw the resident on Ex Order 26.4B1.

A review of the progress notes revealed the resident was readmitted to the facility in Ex Order 26.4B of Ex Order 26.4B Further review of the progress notes, did

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F 712	Continued From page 21 not reveal that the physician saw the resident upon readmission in Ex Order 26.4B1 . A review of the EMR did not reveal a progress note from the attending physician or the attending nurse practitioner in Ex Order 26.4B1 or that the physician and were consistently alternating monthly visits. 7. A review of Resident #135's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26.4B1 . A review of the progress notes in the EMR revealed the attending physician saw the resident on Ex Order 26.4B1 and Ex Order 26.4B1 Further review of the EMR revealed the Nurse Practitioner saw the resident on Ex Order 26.4B1 A review of the EMR did not reveal a progress note from the attending physician or the attending nurse practitioner in Ex Order 26.4B1 8. A review of Resident #4's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26.4B1	F 712		

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F 712	Continued From page 22 Ex Order 26.4B1 A review of the progress notes in the EMR revealed the attending physician saw the resident on Ex Order 26.4B1 Further review of the EMR revealed the Nurse Practitioner saw the resident on Ex Order 26.4B1, and Ex Order 26.4B1 Further review of the EMR did not reveal that the physician and ___ were consistently alternating monthly visits. On 05/14/24 at 11:30 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated, "we inform the U.S. FOIA (b)(6) if we notice the attending has not seen the resident." He was unable to speak to the frequency of physician visits. On 05/14/24 at 12:45 PM, during a meeting with the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) stated the attending physican for long term care alternated every 60 days. They should do the initial on admission then monthly for first 90 days,	F 712		

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F 712		F 712		

Continued From page 23
then can be seen by MD every 60 days, U.S. FOIA can see in between. The surveyor verified attending physician and/or the U.S. FOIA must see resident at least every 30 days. The U.S. FOIA (b)(6), and the U.S. FOIA (b) were all in agreement.

On 5/14/24 at 1:16 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding physician visits, who stated, "They document in the EMR every time they see a resident. The attendings are supposed to see the resident every 30 days. They have their schedule. Whenever we call them to see the resident or if the resident requests, they (the physician) come see them."

A review of the facility policy "Physician Visits" reviewed December 2023 revealed: "Policy Statement: The Attending Physician must make visits in accordance with applicable state and federal regulations. Policy Interpretation and Implementation:
1.The Attending Physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone.
2.The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and the at least every sixty (60) days thereafter.
4.After the first ninety (90) days, if the attending Physician determines that a resident need not be seen by him/her every thirty (30) days, and alternate schedule may be established, but not to exceed every sixty (60) days. A Physician

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F 712	Continued From page 24 Assistant or Nurse Practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted law or regulation." NJAC 8:39-23.2 (b)(d)	F 712		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed 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	F 755		6/25/24

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F 755	Continued From page 25 §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: Complaint #: NJ00170376 Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that a resident received as needed (prn) NJ Ex Order 26.4(b)(1)) medication in accordance with the prescriber's orders and accepted professional standards. The deficient practice was identified for 1 of 6 residents (Resident #227) reviewed for medication management. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records 1. How will corrective action be accomplished for those individual residents found to be affected by the deficient practice? Resident # 227 no longer resides in the facility. The resident had NJ Ex Order 26.4(b)(1) related to the deficient practice. The US FOIA (b)(6) was given appropriate disciplinary action as soon as the medication error was discovered, and the nurse is no longer employed at the facility. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who have physicians□ orders for more than one narcotic medication as needed for pain have the potential to be affected by the deficient practice. A comprehensive review of residents who have physician orders for more than one narcotic medication as needed for pain in the last 3 months did not reveal any medication errors related to the deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?	

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F 755	Continued From page 26 nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A review of a closed medical record revealed a Progress Note (PN) dated Ex Order 26.4B1 identified that Resident #227 complained of getting both Ex Order 26.4B1 10 minutes apart. The note revealed that both the U.S. FOIA (b)(6) was made aware of the complaint. The surveyor reviewed the closed medical record for Resident #227. The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; Ex Order 26.4B1). A review of the admission Minimum Data Set (MDS), an assessment tool, used to facilitate the management of care, dated Ex Order 26.4B1, reflected that the resident had a brief interview for mental	F 755	The facility educator or designee will provide in-servicing to the current licensed nursing staff on safe narcotic medication administration with emphasis on the importance of ensuring that they are administered at safe intervals to prevent an adverse reaction. The DON or designee will conduct weekly audits x 4 weeks, then monthly audits x 2 quarters of residents with physician□s orders of more than one as needed narcotic pain medication to ensure they have been administered at safe intervals. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON will present the results of these audits at the Quarterly Quality Assurance Performance Improvement (QAPI) Committee for 2 consecutive quarters to monitor this deficient practice to ensure compliance. The committee will then determine the need for continuation after.	

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F 755	Continued From page 27 status (BIMS) score of Ex Order out of 15, indicating that the resident was Ex Order 26.4B1. A review of the Order Summary Report (OSR) revealed the following physician's order (PO) dated Ex Order 26.4B for Ex Order 26.4B1) tablet Ex O Ex Order 26.4B1) give Ex O tablets Ex Order 26.4B1 every Ex O hours as needed for Ex Order 26.4B1. Ex O tablets Ex Order 26.4B1. May cause Ex Order 26.4B1 Ex Order 26.4B1 A further review revealed a PO dated Ex Order 26.4B1 A review of the Ex Order 26.4B1 electronic medication administration record (EMAR) revealed that on Ex Order 26.4B1 tablets of Ex Order 26.4B1 Ex Order 26. was documented as being administered to Resident #227 with a pain scale of Ex Order 26.4B1). The Ex Order 26.4B1 EMAR also revealed that on Ex Order 26.4B1 that Ex O tablet of Ex Order 26.4B1 Ex Order 26.4B was documented as being administered with a documented scale of Ex Order 26.4B1 A review of a facility Medication Error Report form dated Ex Order 26.4B1 revealed the following: Under description of error the facility wrote that the resident was assess having a level of Ex O and that the nurse should have administered per the physician's order Ex O tablets of Ex Order 26.4B1 tablets. The nurse should have waited a hour to assess the resident. Under reason for error the facility wrote the following: "Failure to read order before administering medication. Ex Order 26 therapy should have been evaluated before considering a different medication."	F 755		

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F 755	Continued From page 28 On 5/13/24 at 1:00PM, the surveyor attempted to interview the U.S. FOIA (b)(6)) but was informed by the U.S. FOIA (b)(6) that the nurse no longer worked at the facility. On 5/14/24 at 12:35 PM, the surveyor presented the above concern to the administration team which included the U.S. FOIA (b) (6) , U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) There was no additional information provided. A review of the facility's policy for "Medication Preparation for Dispensing" revised on 1/31/2024, and was provided by the U.S. FOIA (b) revealed the following: "G. Prior to Medication Administration: 1. Verify each medication preparation that the medication is the RIGHT DRUG, at the RIGHT DOSE, the RIGHT ROUTE, at the RIGHT RATE, at the RIGHT TIME, for the RIGHT CUSTOMER. 2. Verify that the MAR reflects the most recent medication order. 3. Check expiration date on medication label." "J. Medication Administration: 3. Medications are administered in a timely fashion as specified by policy. 4. As specified by federal and state regulations, controlled substances are documented as given at the time of administration." "K. After Medication Administration: 1. Document necessary medication administration/treatment information (e.g., when medications are administered, medication injection site, refused medications and reason, prn medications, etc.) on appropriate forms."	F 755		

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F 755	Continued From page 29 NJAC 8:39-11.2(b), 29.2 (a)(d) ,	F 755		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to serve hot and cold food items at appropriate and appetizing temperature for 3 of 5 resident units (1 NJ Exec Order 2 NJ Exec Order 2and 2 NJ Exec Order), for 1 of 1 resident reviewed for food (Resident #165) and for 3 of 5 residents who attended a resident council meeting. The deficient practice was evidenced by the following: On 05/08/24, at 11:12 AM, the surveyor interviewed Resident #165 who stated the main concern was that the hot food was cold, along with the coffee for all three meals. On 05/09/24 at 9:46 AM, during a follow up interview with Resident #165, the resident stated the temperatures were "off" and the hot food was not hot, and the cold food was not cold.	F 804	F804 Nutritive Value /Appear, Palatable/Prefer Temp 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? -Resident #165 has had NJ Ex Order 26.4(b)(1) from receiving food that was too warm or too cold. Resident #165 has been provided with hot and cold food items at appropriate and appetizing temperature without further complaint. The three residents who were interviewed at resident council have had no negative effects from receiving food that was too warm or too cold. The three residents at resident council have been provided with hot and cold food items at appropriate and appetizing temperature without further complaints. Resident #280 and resident #60 whose trays were tested with	6/25/24

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On 05/10/24 at 10:39 AM, a surveyor conducted a resident council meeting and 3/5 residents stated the food was not hot enough and the coffee could be cold at times. Two of the five residents stated that they requested cold cereal for breakfast because they knew the hot food would be cold. Two of five residents stated the lunch and dinner were also not hot enough. A resident stated, "when the food comes up, the food stays there for a few minutes and it's not going to get to you", and "it will be cold when I get it."

On 05/10/24 at 8:10 AM, surveyor #1 conducted a meal observation on U.S. FOIA (b)(6) and observed the following:

-8:13 AM the meal cart was brought to the unit.

-8:18 AM, 5 minutes after the cart was brought to the unit, one staff removed a tray and brought it to a resident room.

-8:22 AM, the 2nd meal tray was removed from the cart.

-8:36 AM, the U.S. FOIA (b)(6) joined Surveyor #1 for the the observation.

-8:37 AM, (25 minutes after the meal truck was delivered) the surveyor and the U.S. FOIA (b)(6) both checked meal temperatures of the last meal tray (Resident #280) and using separate thermometers.

-Vegetable Frittata
surveyor
93 degrees Farenheight (F) 94 F

F 804

unacceptable food temperatures prior to receiving them were immediately provided with new breakfast food items at appropriate hot and cold temperatures.

2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

-All residents have the potential to be affected by this deficient practice. US FOIA (b)(6) delivering the food carts was educated on the need to notify a nurse as soon as the cart is delivered to the assigned unit. Nurse will sign the meal truck delivery sheet given by dietary aide. Sign in sheet contains the time of cart leaving the kitchen and the time when the cart was delivered to the unit. Nurses on the units were educated on the need for them to notify all aides on the unit as soon as the food carts gets there, and they are to immediately begin passing trays to ensure proper food temps are met and maintained.

3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?

-Nursing staff was in-serviced by the Assistant Director of Nursing (ADON) or designee on the policy for Food Temperatures with emphasis on serving resident meal trays as quickly as possible upon delivery to the unit to maintain safe and palatable food.

- Sign in Sheet was created for dietary aide delivering food carts to the unit to document what time the cart leaves the kitchen and what time it gets to the unit.

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Hot Farina
surveyor U.S. FOIA (b)(6)
128 130 F

Whole Milk
surveyor U.S. FOIA (b)(6)
50 F 47.7 F

Orange juice
surveyor U.S. FOIA (b)(6)
52 F 51.6 F

Coffee
surveyor U.S. FOIA (b)(6)
123 F 122 F

On 05/10/24 at 8:47 AM, Surveyor #1, reviewed temperature logs in the kitchen with the US FOIA (b)(6) and US FOIA (b)(6)) which revealed:

Vegetable Fritatta 191 F
Juice 38 F
Farina 200 F

At that time, the surveyor interviewed the US FOIA (b)(6) regarding what the hot food temperatures should be when they reach the resident and the US FOIA (b)(6) stated, "ideally hot should be 140 F or above", and cold food should be 41 F or below which revealed the food temperatures in the kitchen were acceptable.

On 05/09/24 at 8:05 AM, Surveyor #2 observed the meal cart arrive on the NJ Ex Order 26.4(b) Unit (low side) and observed the first tray was passed at 8:09 AM. At 8:27 AM, an open meal cart arrived with the meal trays for the high side of the unit. At 8:31 AM, the staff initiated passing the trays. At 8:44

F 804

Once the carts are delivered to the unit the nurse will then sign off that the cart was received, and that nurse is then responsible for getting all aides on the unit to start passing the trays in a timely manner to ensure food safety.

4) How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place?
-FSD or designee will perform Test tray temperature checks on 3 trays /per week x 4 weeks and then one tray per week x 3 months.
-FSD will be present at resident council meetings to discuss the actual meal service temperatures and use the results for the quarterly QA meetings.
-The results of the test tray temperature checks will be presented by the FSD at the quarterly Assessment and Assurance (QAA) committee meeting for review to ensure that the deficient practice will not recur.

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F 804	Continued From page 32 AM, the last meal tray was passed and the surveyor tested Resident #60's tray in the presence of the U.S. FOIA (b)(6) , which revealed: Puree Fruit: 115.3 F Milk: 56.8 F Cheese Sauce for Farina: 109.6 F On 05/10/24 at 8:30 AM, Surveyor #3 observed the 2 South Sub-Acute, meal delivery and the meal truck arrived on the unit at 8:40 AM. The last tray was passed at 8:54 AM and the meal temperatures of an unsampled resident's meal tray were checked by the surveyor in the presence of aU.S. FOIA (b)(6) which revealed: Eggs: 111.0 F Farina: 120.3 F Hot water for Tea: 115.9 F A Test Tray form provided by the U.S. FOIA (b)(6) on 05/10/24 at 9:00 AM revealed "Acceptable Temperatures": Soup/Hot Cereal- 140 F or above; Milk/ Juice- 40- 50 F; Coffee 135-180 F; Breakfast Entree- 120 F, or above; Entree- 130 F or above. NJAC 8:39-17.4 (a)2	F 804		
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,	F 812		6/25/24

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F 812	Continued From page 33 state or local authorities. (i) This may include food items obtained directly 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 pertinent documents it was determined that the facility failed to ensure: a) a consistent system for labeling and dating was implemented to ensure all potentially hazardous foods were labeled with a use by date, b) the kitchen environment, all equipment and dishware was maintained in a clean and sanitary manner and transported appropriately, and c) staff performed appropriate hand hygiene, to limit the potential for contamination, and the risk of potential foodborne illness. The deficient practice was evidenced by the following: On 05/08/24 at 9:26 AM through 10:40 AM, the surveyor conducted a tour of the kitchen with the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) and observed the following: 1. The step garbage can next to hand washing sink did not open when the foot pedal was	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. 1. 1,4 The step garbage can that did not open properly as well as the door gasket, that was ripped and the curtain that was ripped both located in the walk-in freezer were all replaced. 2. 2,3,4, all food items in walk in refrigerator, walk in freezer, and dry storage room that were not properly labeled and dated with a use by or open date were immediately discarded. 3. 2,4 Areas that were noted to have splatter type stains and debris were immediately cleaned and sanitized by the dietary staff. 4. The can opener and slicer that were	

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stepped on and this was confirmed by the [U.S. FOIA]

2. The walk-in refrigeration unit contained the following:

- A metal pan on the bottom shelf contained six cabbage heads with visible darkened areas/spots. The cabbage was not labeled and did not contain a use by date. The surveyor asked the [U.S. FOIA] if the cabbage was dated and she stated, "I don't see one".

- A plastic type bin of uncovered celery stalks, located on a bottom shelf, had a sticker affixed to the bin with "2/27/24". When asked about the date, the [U.S. FOIA] stated, they forgot to take the label off the bin and confirmed there was no use by date on the celery when she lifted the packages and was unable to locate a use by date.

- A blue colored box that contained bags of red grapes had "4-26-24" written on the box. There was no use by date.

- Two boxes of mushrooms, both uncovered, were also located on the shelf, one box was labeled "Medium 10 lbs" with a white sticker "4/18", and the second box was labeled "4/30". Neither box contained a use by date.

-The grate covering the fan located in the refrigeration unit contained black spots and soiled areas and there was black splatter type debris on the ceiling, corner, and portions of the wall areas.

3. The walk-in refrigerator contained the following:

- One ten-pound box of "Fully Cooked Boneless,

F 812

both noted to be soiled and had food debris were immediately cleaned and sanitized by the dietary department.

5. The [US FOIA (b)] noted to have been observed Transporting dishes in an unsanitary manor, as well as not following proper hand hygiene was in serviced on proper food handling and hand hygiene policy and procedure.

2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All residents have the potential to be affected by this deficient practice.

1.Food Service Director and Corporate food service director audited all remaining items in the walk-in refrigerator, walk in freezer and dry storage room to ensure they had proper open and use by dates. Any food that was found to be past the use by date or that was not properly labeled was discarded.

2.The food service director inspected all kitchen equipment to ensure they were properly cleaned and sanitized and free of debris and splatter.

3. The Food service Director Inspected all areas of the kitchen to ensure all areas were cleaned and free of debris and splatter.

3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?

1. Food service director has in serviced all Dietary staff that if any kitchen equipment in need of replacement or repair should be promptly reported to FSD, FSD will

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F 812	Continued From page 35 Skinless Chicken Meat, Diced Chicken" was labeled in red handwriting, "4/30". The box was labeled, "Keep Frozen", there was no indication when the product was defrosted or a use by date. - Three white boxes labeled ten pounds of "Fully Cooked ½ Inch White Meat Chicken", two of the boxes had a date on the box "02/08/24" and there was no use by date, the third box had a handwritten date, "4/18/24" and did not contain a use by date. - A box that contained rolls of Turkey Bologna, that were not dated and the box was labeled "Sell/Freeze by 11/24/23, Keep Refrigerated", another box of 19.76 pounds of Turkey Bologna rolls had a handwritten date of "11/29/23" with the same "Sell/Freeze by 11/24/23" label. There was no use by dates on the items. Another Turkey Bologna roll had a printed label "Date Received 1/23/24", partially over another label "Sell/Freeze by 02/15/24, Keep Refrigerated". The surveyor asked the U.S. FOIA what the product use by date should be. The U.S. FOIA stated, seven days from the open date. The surveyor asked where the date was located on the boxes. The U.S. FOIA stated, "I don't see it". The surveyor asked if there should be a use by date on the products and the U.S. FOIA stated, "yes" and he was unable to provide a use by date. -A package of opened parmesan cheese was wrapped and had a piece of paper with a handwritten date 11/28/24. There was no use by date, and the package was discarded by the U.S. FOIA (b) -A five-pound opened container of Cottage Cheese had a sticker on it, "Received 04/02/24",	F 812	then inform maintenance in a timely manor. 2. 2,3,4 All dietary employees has been serviced on labeling and dating policy. 3. 2,4 All dietary staff has been in-serviced to follow the cleaning schedule and keep the kitchen clean in all areas. 4. All dietary staff has been in-in serviced on how to properly sanitize and clean all kitchen equipment. 5. All dietary staff has been in-serviced on proper food handling and hand hygiene policy and procedure and to cover and safely and transport dishware and other items in a sanitory manor. 4) How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? 1. The Food service director will complete daily routine inspections times 8 weeks to ensure all kitchen equipment is in proper working condition. Any equipment in need of repair will be communicated to maintenance. Results will be reviewed quarterly at QA meeting. 2.The FSD//Supervisor will complete daily routine inspections times 8 weeks to ensure proper label and dating protocol is performed. All unlabeled and undated items will be discarded. Results will be reviewed Quarterly at QA meeting for two consecutive Quarters. 3. FSD//Supervisor will complete daily routine kitchen inspections times 8 weeks to ensure the entire kitchen is free of any spillage or debris. Results will be reviewed	

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there was no use by date. The sell by sticker on the package indicated, "04/26/24". The surveyor asked about the use by date, the [U.S. FO] stated, "I don't see a use by date."

-Three cases of 4-ounce skim milk dated, "May 7, 2024", and the surveyor asked the [U.S. FO] if the milk could be used and the [U.S. FO] stated, "no."

-14 cased of defrosted juices, "STORE AT 0F" printed on box in bold. The boxes did not contain use by dates

4. The walk-in freezer contained the folllowing:

-The door gasket was ripped and pulling off door and the door curtain was ripped.

-A box contained a plastic bag of breaded chicken patties which was not sealed and was open to air. The box was dated 04/16/24 and there was no use by date.

-Three logs of frozen ground beef were stored on top of packages of various frozen meats. There were no use by dates.

-There was a three pack of frozen turkey burgers and there was no use by date.

4. The dry storage room contained the following: a large, unsealed bin with stains on top of the bin. The bin had dark splatter type stains on the outside and in the inside of the bin. The top of the bin had "Coconut Shredded, Open 05/01/24" written on the top of the lid. There was a white shredded product in the bin. The [U.S. FOIA] confirmed that there was no use by date.

F 812

quarterly at QA meeting for two consecutive quarters.
4. FSD//Supervisor will inspect all kitchen equipment daily time 8 weeks to ensure it is properly cleaned in accordance with cleaning schedule and free of debris. Results will be reviewed Quarterly at QA meeting for two consecutive quarters
5. FSD/Supervisor Will conduct daily routine dining room inspections times 8 weeks to ensure staff is following proper food handling and hand hygiene procedures. Results will be reviewed at QA meeting for two consecutive quarters.
6. FSD /Supervisor will conduct daily inspections times 8 weeks to ensure staff is following proper procedure of transporting dishware and other items to the dining rooms in a safe manor. Results will be reviewed quarterly at QA meeting for two consecutive quarters.

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-The floor in the dry storage room had debris in the corners of the room. The surveyor asked the U.S. FOIA about a cleaning schedule for the kitchen and the U.S. FOIA stated there was no schedule yet, as he was new to the facility and was working on it.

-17 individual four-ounce containers of thickened cranberry juice cocktail were located on a shelf in the dry storage room. The juice had a best if used by date of 4/4/24.

-Splatters of various colored debris were observed on the ceiling in the dry storage room.

-A large fan inside the kitchen to the outside had a grate covered with dust like debris.

-The can opener that was affixed to the metal table was very soiled with dark debris on the base and blade. The U.S. FOIA confirmed as he observed that the base of the can opener was difficult to remove due to debris.

On 05/10/24 at 8:52 AM, during a second kitchen observation conducted with the U.S. FOIA (b) the surveyor observed the large slicer covered with plastic, which was identified as clean, and when the U.S. FOIA removed the plastic there were several areas of food debris on the base and blade area.

On 05/08/24 at 12:10 PM, during a lunch meal observation on the second floor, the surveyor observed the Cook transporting dishware and other supplies from the hallway into the dining room on a three tiered black cart. The bottom tier of the cart contained eight dishes, face up, that were uncovered during transit.

05/08/24 at 12:21 PM, during the same meal

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F 812	Continued From page 38 observation on the second floor, the U.S. FOIA (b) was observed using paper towels to wipe perspiration off of his head, then proceeded to place gloves on his hands without first performing hand hygiene, and proceeded to plate food on the uncovered dishes from the cart. The Handwashing/Hand Hygiene Policy, revised December 2023, revealed "This facility considers hand hygiene the primary means to prevent the spread of infection". 6. Waterless alcohol products are preferred method for hand hygiene except for the following situations: a. When hands re visibly soiled ... 8. Use an alcohol-based hand rub containing at least 62 % alcohol; or alternatively, soap and water for the following: ... f. Before donning sterile gloves. The Storage Areas Policy, undated, revealed ...Food is stored in an area that is clean, dry and free from contaminants. Food is stored, prepared, and transported at appropriate methods designed to prevent contamination or cross contamination. 4. ... All containers must be legible and accurately labeled and dated. 6. Schoops must be provided for bulk foods. Scoops are not to be stored in food or ice containers, but are kept covered in a protected area near the containers. 8. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods. a. Old stock is always used first (first in-first out method). c. Food should be dated as it is placed on the shelves. Date marking top indicate the date or day by which a ready to eat, potentially hazardous food should be consumed, sold or discarded will be visible on all high risk food. 14. Refrigeratged Food Storage. a. All refrigerator units are kept clean and in good working	F 812		

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F 812	Continued From page 39 condition at all times. f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable) or discarded. 15. Frozen Foods: d. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. NJAC 8:39-17.2 (g)	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		6/25/24

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§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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F 867	Continued From page 42 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility Quality Assessment and Performance Improvement (QAPI) committee, that identified quality concerns, failed to utilize the Facility Performance Improvement Plan to follow the facility process to measure and utilize data acquired for frequency of physician visits. This deficient practice was evidenced by the following: On 05/16/24 at 9:40 AM, the surveyor reviewed the facility provided "QAPI Plan Primary physicians' documentations compliance Effective Date: February 26, 2024 " which revealed "Design and Scope: Statements and Guiding Principles: PMD's (primary medical doctor)/NP's (Nurse Practitioner) Federal documentations compliance." ... "Other Services Provided: Nursing and medical record staff will monitor physician visits compliance and informing the upper management." ... "Feedback, Data Systems and Monitoring: Monitoring Process: Audit physicians and their NP's progress notes every other month for compliance x 6 months. Conduct meetings with the physician and and their NP's every time there's issues to address. Goal is 100% compliance 3 months."	F 867	F867 QAPI/QAA Improvement Activities 1. How will corrective action be accomplished for those individual residents found to be affected by the deficient practice? No residents were identified as being affected by the deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who reside in the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur? The Regional Nurse Consultant (RNC) re-educate the U.S. FOIA (b) (and the U.S. FOIA (b on the policy and procedure of QAPI/QAA Improvement Process. The LHNA will conduct a monthly audit x 2 months, then quarterly x 2 quarters of QAPI/QAA Improvement activities the facility is working on to ensure that the monitoring process that was put into place is being followed as stated in the QAPI	

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F 867	Continued From page 43 At 10:32 AM, during a meeting with the surveyor, the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6)) regarding the results of the above mentioned QAPI Plan, the U.S. FOIA (b) stated she presented the QAPI Plan at the April QAPI meeting. She stated audits were done but she was unable to provide the surveyor with an audit tool or evidence that the audits were being done according to the "Monitoring Process" of auditing physician and U.S. FOIA (progress notes every other month for compliance since being self-identified on 2/26/24 or that the audit results were presented at the QAPI meeting. She was also unable to show the surveyor that the facility was progressing toward the "Goal of 100% compliance in 3 months." The [redacted] stated she sent an email or a text to the physicians that were identified. The U.S. FOIA (b)(6) stated, "the purpose (of a QAPI plan) was to show improvement, identify issues, how we are going to work on them and if they are working." Regarding the purpose of audits, the U.S. FOIA (b) stated, "so we can identify if it is working. We continue with what is working if not we come up with a plan to change it." The U.S. FOIA (b)(6) and the U.S. FOIA (b) both confirmed that they were unable to quantify the audits that were completed. Therefore, they were unable to show a monitoring system to show that their QAPI Plan was working. A review of the facility policy "Performance Improvement-QA Committee" last revised 1-2024, revealed: "Policy: ...The committee will implement quality assurance and performance improvement programs (PIP) for the facility ..." "The committee ...Any ongoing concerns will be discussed, and PIP will be started to rule out route cause. PIP will be revised and updated as schedule. Staff will be educated as needed."	F 867	plan and that the data acquired is utilized to measure the progress of the QAPI/QAA Improvement Plan and discussed with the QAA Committee members in the Quarterly QAPI meeting. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place? The LHNA or designee will present the results of these audits at the Quarterly Quality Assurance Performance Improvement (QAPI) Committee for 2 consecutive quarters to monitor this deficient practice to ensure compliance. The committee will then determine the need for continuation after.	

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F 867	Continued From page 44 NJAC 8:39-33.1(a)(b)(c)(e)	F 867		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality	F 868		6/25/24

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F 868	Continued From page 45 assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, the facility failed to ensure the required committee members, the U.S. FOIA (b)(6) , was present for four of six Quality Assurance and Performance Improvement (QAPI) meetings and was evidenced by the following: On 05/16/24 at 9:53 AM, the surveyor reviewed the facility provided QAPI book, that included the quarterly sign in sheets for the QAPI meetings, which revealed: - "Employee In-Service Education; Date: Jan (January) 2023; Subject: QAPI" the U.S. F did not sign in as being in attendance. - "Daily Department Head Meeting; Date: 7/26/23; Subject: QAPI 2nd Quarter April-June 2023" the U.S. F did not sign in as being in attendance. - "Employee In-Service Education; Date: 10/17/23; Subject: QAPI" the U.S. F did not sign in as being in attendance. - "Daily Department Head Meeting; Date: 1/31/24; Subject: QAPI 4th Quarter 2023" the U.S. F did not sign in as being in attendance. On 05/16/24 at 10:08 AM, during a meeting with the surveyor, the U.S. FOIA (b)(6) , the U.S. FOIA (b)(6) that the required members that should attend the QAPI meeting	F 868	F868 QAA Committee 1. How will corrective action be accomplished for those individual residents found to be affected by the deficient practice? No residents were identified as being affected by the deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who reside in the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur? The Regional Nurse Consultant re-educated the US FOIA (b)(6) on the facility policy of Performance Improvement QA Committee that the Infection Preventionist (IP) is required to attend and participate in the Quarterly QAPI Committee meeting, and if unable to attend another member of the committee will be appointed to present and discuss the IP report in their absence. The LHNA or designee will conduct an audit quarterly x 3 quarters to ensure that the IP attends the Quarterly QAPI meeting, or another member is appointed	

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F 868	Continued From page 46 included but were not limited to; the U.S. FOIA (b) (6) the U.S. FOIA (b), the U.S. FOIA (b) (6), department heads, and the U.S. FOIA (b)(6) [redacted]. At 10:17 AM, in the presence of the surveyor, the U.S. FOIA (b)(6), and the U.S. FOIA (b) reviewed the signatures on the January 2023 sign in sheet and were unable to determine who the U.S. F was at that time or that the U.S. F had attended the meeting. The U.S. FOIA (b)(6) reviewed the sign in sheets for July 2023, October 2023, and January 2024 and was unable to verify that the U.S. F was in attendance. The U.S. FOIA (b)(6) stated, "the purpose of the sign in sheets was to keep a record of who was there at that time." The U.S. FOIA (b) stated, "the purpose of the U.S. F attending was to review infection control, identify any trends or outbreaks we are having." A review of the facility policy "Performance Improvement-QA Committee" last revised 1-2024, revealed: "Procedure: The Performance Improvement Committee shall be composed of, but not necessarily limited to the following personnel: -Administrator -Medical Director -Director of Nursing -Infection Preventionist NJAC 8:39-33.1(a)(b)	F 868	to present and discuss the IP report to the committee if the IP is unable to attend. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place? The LHNA will present the results of these audits at the Quarterly Quality Assurance Performance Improvement (QAPI) Committee for 3 consecutive quarters to monitor this deficient practice to ensure compliance. The committee will then determine the need for continuation after.	
F 880 SS=E	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	F 880		6/25/24

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F 880		F 880		

Continued From page 47
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;

§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

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F 880	Continued From page 48 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. 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, interviews and review of pertinent documentation, it was determined that the facility failed to a.) adhere to accepted standards of infection control practices for donning (put on) the required Personal Protective Equipment (PPE) prior to providing care to residents on NJ Ex Order 26.4b1 (Resident #23 and #279) and b.) perform appropriate hand hygiene according to the Center for Disease Control (CDC) and the facility's policy. The deficient practice was evidenced by the following: 1. On 5/8/23 at 10:30 AM, during initial tour on unit NJ Exec Order 26, the surveyor observed a white signage posted at Resident #23's door. The door	F 880	F880 Infection Prevention and Control 1. How will corrective action be accomplished for those individual residents found to be affected by the deficient practice? Resident # 23 had NJ Ex Order 26.4b1 as a result of the deficient practice, and the contact precautions were discontinued per physician□s order on NJ Ex Order 26.4b without further signs or symptoms NJ Ex Order 26.4b1. CNA #1 was immediately re-educated by the Infection Preventionist (IP) nurse on the policy for following isolation for residents on contact precautions. Resident # 279 remains on enhanced	

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F 880	Continued From page 49 was closed and there was a PPE bin with yellow disposable gowns, outside the room. The surveyor observed the Contact Precautions signage which included but were not limited to; Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. On 5/9/23 at 12:34 PM, the surveyor observed a Certified Nursing Assistant (CNA) #1 take a lunch tray into Resident #23's room. CNA#1 did not don a yellow gown as the sign on the resident's door indicated before entering the room. Upon exiting Resident #23's room, The surveyor conducted an interview with the [redacted] The [redacted] acknowledged that she did not have a gown on when entering the resident's room and she stated, "I had gloves on and they didn't tell us to put a gown on before entering into this room when we are passing out trays." At 12:40 PM, the surveyor brought the U.S. FOIA (b)(6) [redacted] to the door of Resident #23 and asked what the "Stop Contact Precautions" signage meant. The U.S. FOIA (b)(6) stated that everything on the sign should be done before you enter the room. The U.S. FOIA (b)(6) stated that the resident was on contact isolation	F 880	barrier precautions and has had no s/s of NJ Ex Order 26.4b1 CNA # 2 and staff # 1 (US FOIA (b)(6) [redacted] were both immediately re-educated by the IP nurse on the facility policy and procedure for following isolation for residents on enhanced barrier precautions. CNA # 1 and CNA # 3 were both immediately re-educated on the facility policy and procedure Handwashing/Hand Hygiene and return demonstration was completed correctly. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who require contact and enhanced barrier isolation precautions have the potential to be affected by the deficient practice. A review of current residents on contact and enhanced barrier precautions was completed on the 7-3, 3-11 and 11-7 shifts and CNA and NA staff were observed donning and doffing the correct personal protective equipment (PPE) when entering and exiting resident rooms. All residents who reside in the facility have the potential to be affected by the deficient hand hygiene practice. Observations of CNA and NA staff were conducted on 7-3, 3-11 and 11-7 shifts and hand washing was completed per policy. No other residents were found to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur? The IP nurse or designee will in-service	

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F 880	Continued From page 50 for) in the She confirmed that CNA #1 should have donned a gown before entering the room. The U.S. FOIA (b)(6) stated that "We need to gown up and put gloves on every time we go in this room because the staff is going to have contact with the patient" the purpose of PPE was to "prevent the spread of infection." The U.S. FOIA (b)(6) further explained to CNA #1, "for contact isolation rooms, you need to put PPE for everything." The surveyor reviewed the medical records for Resident #23 which revealed the following: The Admission Record (AR) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1 A review of the Order Summary Report indicated a physician order, dated from Ex Order 26.4B1 and from Ex Order 26.4B1 for "Maintain Contact Precautions for NJ Ex Order 26.4B every shift unti Ex Order 26.4B1 Ex Order 26.4B1 A review of the May 2024 Treatment Administration Record (TAR) under "Maintain contact precautions for MRSA every shift" revealed that nursing had signed the TAR as completed for the "Day", "Eveni" (evening) and "Night" shifts. A review of Nursing Progress Notes (PN) dated	F 880	CNA and NA staff on the facility policy and procedure for contact and enhanced barrier isolation precautions and according to the CDC and facility policy and procedure for Handwashing/Hand Hygiene. The IP nurse will conduct competencies/observations of CNA and NA staff donning and doffing the correct PPE for residents on contact and enhanced barrier precautions. The IP nurse will conduct competencies/observations of CNA and NA staff completing handwashing/hand hygiene to ensure it is being completed per the CDC and facility policy. The IP nurse or designee will conduct random weekly audits x 4 weeks, then monthly x 2 quarters of 5 CNA and/or NA staff to ensure they are wearing the correct PPE for residents who require contact or enhanced barrier isolation precautions per facility policy. The IP nurse or designee will conduct random weekly audits x4 weeks, then monthly x 2 quarters of 10 CNA and/or NA staff to ensure they are completing handwashing/hand hygiene according to CDC and facility policy. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place? The IP nurse or designee will present the results of these audits at the Quarterly Quality Assurance Performance Improvement (QAPI) Committee for 2 consecutive quarters to monitor this	

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F 880	Continued From page 51 5/8/24 at 00:22 (12:22 AM) revealed, "on isolation precautions for NJ Ex Order 26.4b1." On 5/15/24 at 12:10 PM, during an interview with the U.S. FOIA (b)(6) the U.S. FOIA stated, "Anyone going into contact isolation room, must have PPE" and expectations from the staff are "to do what the posted sign says." On 05/15/24 at 12:41 PM, the U.S. FOIA (b)(6)) and the Regional Nurse were informed of the above concerns. 2. On 05/08/24 at 10:25 AM, the surveyor toured the Unit (and observed signage posted at the door for enhanced barrier precautions which included but were not limited to; Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy Wound Care: any skin opening requiring a dressing. The surveyor observed an isolation bin containing gowns, gloves and surgical mask in the hallway at the door entrance.	F 880	deficient practice to ensure compliance. The committee will then determine the need for continuation after.	

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F 880	Continued From page 52 On 05/08/24 at 10:30 AM, the surveyor entered the room and observed Resident #279 in bed. The head of the bed was elevated and the resident was resting with the eyes closed. The resident had a Ex Order 26.4B1 (Ex Order 26.4B1 On 05/08/24 at 11:37 AM, the surveyor observed 2 staff members in the room assisting Resident #279 with care. One staff was changing the bed linen and the other staff was assisting the resident with NJ Ex Order 26.4(b)(1) Both staff were observed with mask and no gown on. During an interview with staff #1 at 10:45 AM, she identified herself as a CNA (#2) and informed the surveyor that staff #2 was an orientee U.S. FOIA (b)(6) The CNA stated that Resident #279 had a Ex Order 26.4 Ex Order 26.4B1 during the day. On 05/10/24 at 10:30 AM, the surveyor knocked at the door, and the staff prompted the surveyor to enter the room. The curtain was drawn and the surveyor observed the U.S. FOIA at the beside assisting Resident #279 with care. The U.S. FOIA had a mask and gloves on. The U.S. FO did not have a gown on as required by the signage posted at the door. On 05/10/24 at 10:45 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the above observation. The U.S. FOIA (b)(6) revealed that the U.S. FOIA (b should not be working alone. They just came in, they should be working with another U.S. FOIA (b. The U.S. FOIA further stated that all staff should have on the required PPE while providing care. On 05/10/24 at 11:30 AM, review of the electronic medical record (EMR) reflected that Resident	F 880		

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F 880	Continued From page 53 #279 was admitted to the facility with diagnoses which included, but were not limited to Ex Order 26.4B1 A review of the Order Summary Report for May 2024, revealed the following orders for Resident #279:Ex Order 26.4B1 Care every shift. Maintain Enhanced Barrier Precautions related to: NJ Exec Orde Use every shift for Disrupt potential spread of NJ Ex Order 26.4b1 On 05/15/24 at 08:53 AM, the surveyor interviewed CNA #2 who was observed in the room with the Orientee and not wearing the required PPE. The U.S. FOIA stated that she was not aware that she had to have a gown on while changing the linen and could not provide the rationale for not wearing the required PPE while at the bedside providing care. On 05/15/24 at 1:15 PM, the facility was informed of the above concerns and requested the policy for NJ Ex Order 26.4(b)(1)). 4. On 05/09/24 at 11:32 AM, the surveyors entered an unsampled resident's room with CNA# 1 and CNA #3 for an care check. In the presence of the surveyors, CNA#1 performed hand washing as follows: she turned on the water, wet her hands, applied soap, lathered, and rubbed hands together for a total of 12 seconds outside of the running water, she rinsed her hands under the water, obtained a paper towel and dried her hands. CNA #3 walked over to the sink with the running water and	F 880		

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F 880	Continued From page 54	F 880		

performed hand washing as follows: she wet her hands, applied soap, lathered and rubbed hands together for a total of 11 seconds outside of the running water, she rinsed her hands under the water, obtained a paper towel, dried her hands and used a clean paper towel to turn off the water. Both CNA's donned gloves and proceeded with the [redacted] check.

05/09/24 at 11:35 AM, after CNA# 1 and CNA# 3 exited the resident's, the surveyors interviewed them regarding hand washing. CNA#3 stated she sings the "Happy Birthday" song once while lathering her hands and then sings it again while rinsing her hands. She stated, "It (lathering hands with soap) should be done for at least 20 seconds." CNA #1 agreed. CNA #3 stated, "she counted in her head for 20 seconds while lathering."

On 05/09/24 at 11:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated hand hygiene should be done before and after care, before and after medication administration and in between residents. She stated you turn on the water, wet hands, lather hands with soap for 30 seconds before rinsing. LPN#1 further stated "you sing happy birthday 2 times while rubbing hands with soap, then rinse them, dry hands with a paper towel and take another paper towel to turn off the water."

On 05/14/24 at 11:07 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] regarding hand washing. She stated, "hand hygiene should be done before any care, after eating, and after touching soiled things." The U.S. FOIA [redacted] stated hand washing was done with soap and water as follows: turn on the water, rub hands for

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F 880	Continued From page 55	F 880		

20 seconds with the soap, rinse hands, dry and use a clean paper towel to turn off the water. She stated staff could sing happy birthday "a couple of times and sing it again while rinsing your hands."

On 05/14/24 at 12:42 PM, during a meeting with the U.S. FOIA (b), the U.S. FOIA (b) and the U.S. FOIA (b)(6), the surveyor presented the above concerns. The U.S. FOIA (b) stated, "you handwash every time you touch the patient, during care, in between patients and when hands are soiled." She stated, "you turn on the water, wet hands, apply soap, lather and rub hands for 20 seconds, rinse hands, use a paper towel to dry and get another one to turn off the faucet."

A review of the facility provided "Employee In-Service Education" dated 4/18/24, "Objective: Infection Control-Isolation Precautions + Hand Washing ..." revealed that CNA #1, CNA #2 and CNA #3 attended.

A review of the facility provided annual "Hand Hygiene Competency" revealed a "Yes" under "Competent" for "Hand Hygiene with Soap & Water ...4. Vigorously rubs hands for at least 20 seconds including palms, back sides of hands between fingers, thumbs, and wrists" for CNA #1, dated 6/6/23 and CNA #2, dated 6/5/23.

On 05/16/24 at 8:15 AM, the U.S. FOIA (b)(6) provided the policy for "Enhanced Barrier Precautions". The following were noted:
Purpose
To outline the implementation of Enhanced Barrier Precautions to disrupt the potential spread of multidrug-resistant organisms.
Procedure:
EBP is used in conjunction with standards precautions and expand the use of PPE to don a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING ______ B. WING ______	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

(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 880	Continued From page 56	F 880		

gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.
Examples of high- contact resident care activities requiring gown and gloves use for Enhanced Barrier Precautions include:
Dressing
Providing hygiene
Changing Linens...
Indwelling medical devices examples include central lines, urinary catheters, feeding tubes and tracheostomies.
EBP should be used for any residents who met the above criteria, wherever they reside in the facility.. .
The policy was not being followed.

A review of the facility's policy "Handwashing/Hand Hygiene" dated December 2023 revealed:
"Policy Interpretation and Implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors."
"Procedure: Washing hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) ..."
"Applying and removing Gloves 1. Perform hand hygiene before applying non-sterile gloves."

A review of the facility's provided policy "un-titled" with revised date April 2024 revealed: Contact Precautions- are a type of Transmission-Based Precaution that is intended to prevent transmission of infectious agents, that are spread by direct or indirect contact with the resident or the resident's environment. Contact Precautions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING ______ B. WING ______	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 57 require the use of a gown and gloves on every entry into a resident's room. The resident is given dedicated equipment and is placed into a private room as available, cohorted, or grouped together. The facility will post clear signage on the door or wall outside of the resident room indicating the type of precautions and required person protective equipment (PPE), e.g., gown and gloves, along with the high-contact resident care activities requiring PPE. NJAC 8:39-19.4 (a) (1) (2) (5)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062023	A. BUILDING: ______ B. WING ______	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	**2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088**

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency 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: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, on 4 of 14 day shifts as follows: This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	S560- 1) There were no residents identified to have been affected by the deficient practice of not meeting the NJ staffing requirements during the 7:00Am-3:00PM shifts on the dates of 4/21/24, 4/24/24, 4/25/24, 5/04/24. A review of the care proved on the day shift of those dates identified, revealed no complaints or grievances related to care that were reported on these dates on the day shift. 2)All residents have the potential to be affected by this deficient practice. All residents 3) the following measures have been	6/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/05/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062023	A. BUILDING: ___ B. WING ___	C 05/16/2024

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S 560	Continued From page 1	S 560		

established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:

One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift.

One (1) 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 (1) 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.

The facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:

-04/21/24 had 21 CNAs for 176 residents on the day shift, required at least 22 CNAs.
-04/24/24 had 21 CNAs for 173 residents on the day shift, required at least 22 CNAs.
-04/25/24 had 21 CNAs for 173 residents on the day shift, required at least 22 CNAs.
-05/04/24 had 20 CNAs for 176 residents on the day shift, required at least 22 CNAs.

On 05/15/24 at 11:54 AM, the surveyor interviewed the staffing coordinator, who acknowledged she was aware of the state minimum staffing ratios and that the facility usually met the ratios.

put into place to prevent the deficient practice from recurring.

1. Advertising / job postings for CNAS have been posted on multiple hiring platforms.
2. Incentives such as bonuses are offered to CNAS to pick up vacant shifts.
3. If unable to fill a shift with its in-house employees, agencies will be utilized to fill those open shifts.
4) The administrator will review the staffing schedule weekly to monitor the staffing ratio weekly times 90 days. The findings will be presented and reviewed at facility QA meeting for two consecutive quarters.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315283	A. Building B. Wing	6/27/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

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) ID Prefix	Reg. #	LSC	DATE (Y5) Correction Completed
F0607	483.12(b)(1)-(5)(ii)(iii)		06/25/2024
F0677	483.24(a)(2)		06/25/2024
F0698	483.25(l)		06/25/2024
F0712	483.30(c)(1)-(4)		06/25/2024
F0755	483.45(a)(b)(1)-(3)		06/25/2024
F0804	483.60(d)(1)(2)		06/25/2024
F0812	483.60(i)(1)(2)		06/25/2024
F0867	483.75(c)(d)(e)(g)(2)(i)(ii)		06/25/2024
F0868	483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)		06/25/2024
F0880	483.80(a)(1)(2)(4)(e)(f)		06/25/2024

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/16/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062023 (Y1)	A. Building B. Wing (Y2)	6/27/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

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 06/25/2024	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/16/2024	☐ 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
	315283	A. BUILDING **01** B. WING ____________	**05/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	**2385 SPRINGFIELD AVENUE** **VAUXHALL, NJ 07088**

(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 05/15/24. 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 05/15/24 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. South Mountain HC is a two-story building with a basement that was built in 1987. It is composed of Type II protected construction. The facility is divided into 14 - smoke zones. The generator does approximately 45% of the building per the Maintenance Director. The current occupied beds are 173 of 195.	K 000		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit	K 293		6/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/31/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING **01** B. WING ______	**05/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	**2385 SPRINGFIELD AVENUE** **VAUXHALL, NJ 07088**

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K 293	Continued From page 1 travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the exit door in the kitchen had an exit sign above the door in accordance with NFPA 101 Life Safety Code (2012 edition) 7.10.1.2.2. This deficient practice had the potential to affect 173 residents who resided at the facility. Findings include: An observation on 05/15/24 at 12:25 PM revealed the exit door near the US FOIA (b)(6) office was not equipped with an illuminated exit sign. During an interview at the time of the observation, the US FOIA (b)(6) confirmed there was no exit sign at the exit door. NJAC 8:39-31.1(c), 31.2(e)	K 293	K293- 1) Regarding the exit door near the dietary managers office not being equipped with an illuminated exit sign. No residents were affected by the deficient practice. The maintenance director was immediately made aware of the lack of signage. A new illuminated exit sign was ordered. 2) All residents have the potential to be affected by this deficient practice. Maintenance Director audited all other exits throughout the building to ensure they all had required illuminated exit signs. All other exits were found to have the required exit sign. A new illuminated sign has since been installed above the identified exit door. 3) The US FOIA (b)(6) was in serviced on the requirement for every exit door in the facility to have an illuminated exit sign displayed above the exit door. 4) The Maintenance Director will audit all facility exit doors monthly to ensure that they all have the proper illuminated exit signs. Findings will be reviewed at QA meeting for two consecutive quarters.	
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.	K 311		6/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING **01** B. WING ___	**05/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 311	Continued From page 2 An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 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 fire rated door assemblies were equipped with approved fire exit hardware for one out of thirteen stairway exit doors; and failed to ensure the stairway door on the second floor latched when closed 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 173 residents who resided at the facility. Findings include: An observation on 05/15/24 at 1:25 PM revealed the main center stairway exit door on the first floor next to the elevators was equipped with panic hardware and not the required fire exit hardware which violated the listing of the fire rated door assemblies. An observation on 05/15/24 at 12:33 PM revealed the main center stairway door on the second floor would not latch because the latching mechanism was removed. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the stairway door was equipped with panic hardware. The US FOIA (b)(6) also confirmed the latching mechanism was removed because the inside handle was a pull handle and	K 311	K311- 1) Regarding the Fire exit doors that did not have the required fire exit hardware. No residents were affected by the deficient practice. The maintenance director immediately placed an order for the required fire exit hardware for the main center stairway door located on the first floor and ordered a new latching mechanism for the main center stairway door on the second floor. 2) All residents have the ability to be affected by the deficient practice. The maintenance director audited all other fire exits throughout the building to ensure that they had the proper fire exit hardware and were latching properly. All other doors were found to be in compliance. 3) The US FOIA (b)(6) was in serviced on the requirements needed to be met for fire exit doors, including the requirements for them to have the specific fire exit hardware and the need for the fire doors to latch properly when closed. 4) Maintenance director will audit all fire exit doors in the facility monthly to ensure they have all have the required parts necessary for fire exit doors and that all doors are in required operational conditions. Results will be presented at facility QA meeting for two consecutive quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING **01** B. WING ___	**05/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 311	Continued From page 3 if the latching mechanism was on the frame, the door could not be opened from inside the stairway. NJAC 8:39-31.2(e) NFPA 80	K 311		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity testing of the smoke detectors were completed every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 173 residents who resided at the facility. Findings include: A review of the facility's "Inspection and Testing Reports," dated 12/26/23, provided by the US FOIA (b)(6), revealed the report had no reference to a smoke detection sensitivity test. An observation on 05/15/24 from 12:05 PM to	K 345	K345- 1) regarding the facilities failure to conduct Smoke detection sensitivity testing. No residents were affected by this deficient practice. The maintenance director immediately reached out to the fire alarm company to schedule the smoke detection sensitivity test. 2) All residents have the ability to be affected by this deficient practice. The Fire alarm company is scheduled to perform the required smoke detection sensitivity testing at the facility on 6/05/2024. 3) US FOIA (b)(6) was in serviced on required testing requirements and frequencies for the smoke detection sensitivity testing to be done every	6/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 4 1:50 PM revealed smoke detectors were located in the corridors, the resident rooms, and other concealed areas throughout the building. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the smoke sensitivity testing was not completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	alternate year. 4)Maintenance Director will review documentation of the smoke sensitivity detection testing to ensure that they are being done at the frequency in which they are required. Findings will be reviewed at QA meeting for two consecutive quarters.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential	K 761	K76- 1) Regarding the fire doors that were found to not be in compliance with the required annual inspection and testing. No residents were affected by this deficient practice. The maintenance director immediately began to inspect and	6/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING 01 B. WING ______	05/16/2024

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SOUTH MOUNTAIN HC	**2385 SPRINGFIELD AVENUE** **VAUXHALL, NJ 07088**

(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 761	Continued From page 5 to affect all 173 residents who resided at the facility. Findings include: A review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence the fire doors were inspected annually. Observations of the facility's fire doors on 05/15/24 from 12:05 PM to 1:50 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview on 05/15/24 at 2:55 PM the US FOIA (b)(6) confirmed the fire doors had not been inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	test all fire doors in the facility. 2) All residents have the ability to be affected by this deficient practice. A facility wide audit was completed for all fire doors in the facility found to not have been inspected and tested annually. The required inspection and testing have since been completed for all fires doors in the facility. 3) US FOIA (b)(6) was in serviced on requirements to have all fire doors inspected and tested annually, and to retain the records of these inspections and tests after they are completed. 4)Maintenance director will audit all fire doors in facility monthly to ensure they have been inspected and tested annually in accordance with regulation. Findings will be presented at QA meeting for two consecutive quarters.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315283	A. Building 01 - MAIN BUILDING 01 B. Wing	7/5/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

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 K0293	Correction Completed 06/25/2024	ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 06/25/2024	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 06/25/2024
ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 06/25/2024	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
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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	
5/16/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO