

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

PRINTED: 07/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315231	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/06/2025
NAME OF PROVIDER OR SUPPLIER THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP			STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD SEWELL, NJ 08080		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT #: NJ182689, NJ182815, NJ184057 CENSUS: 162 SAMPLE SIZE: 8 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584			4/10/25

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

TITLE

(X6) DATE

Electronically Signed

04/03/2025

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 584	<p>Continued From page 1</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ182815</p> <p>Based on observations, interviews, and review of other facility documentation on 3/5/2025 and 3/6/2025, it was determined that the facility failed to maintain a homelike environment for residents that included access to clean linens. The deficient practice was identified for 1 of 1 nursing units observed.</p> <p>This deficient practice was evidenced by the following:</p> <p>During a tour of the 500 Unit on 3/5/2025 at 10:55 AM, the surveyor asked what the resident census was on the unit, and the US FOIA (b)(6) stated 30 residents. At 11:36 AM, the surveyor toured the 500 High Hallway Linen Room and observed four wash cloths on the shelf. At 11:38 AM, the</p>	F 584	<p>Element 1: The Housekeeping team immediately supplied Unit 500 with fresh linen. The nursing staff were counseled by Administration on calling down to laundry whenever they start to experience a shortage of linen so they can be provided with more.</p> <p>Element 2: All Residents are at risk to be affected by the deficient practice.</p> <p>Element 3: The Housekeeping Director reviewed the facilities PAR and schedule drop off protocol with the Housekeeping staff ensuring we are maintaining proper inventory and delivering linen within the time frames set aside by the facility.</p>		

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F 584	<p>Continued From page 2</p> <p>surveyor toured the linen room for the 500 Low Hallway Linen Room and observed three wash cloths on the shelf.</p> <p>The surveyor reviewed the Resident Council Meeting Minutes dated 12/19/2024, 1/3/2025, and 1/30/2025 which revealed resident complaints on the lack of linens available for resident care.</p> <p>On 3/5/2025 at 1:07 PM, the surveyor interviewed the US FOIA (b)(6) who was working in the laundry room. The US FOIA (b)(6) stated that the linen was delivered to the units twice a day. The US FOIA (b)(6) indicated that PAR levels (the amount of inventory established by the facility) were used to determine the number of linens that go on each linen cart. The US FOIA (b)(6) stated that there were always resident complaints about linens and that there were not enough towels and washcloths in the facility.</p> <p>On 3/5/2025 at 2:41 PM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that there were three washcloths in the linen room this morning. CNA #1 indicated the linens were delivered to the unit late every day, usually after 10:30 AM. CNA #1 indicated there were times, when she had to wait for linen to come to the unit, which resulted in her cutting a bath blanket to be able to provide care to the residents.</p> <p>On 3/5/2025 at 3:17 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the PAR levels for the linen were low and identified there needed to be changes made.</p> <p>On 3/5/2025 at 4:10 PM, the surveyor interviewed the US FOIA (b)(6) who stated she</p>	F 584	<p>Element 4:</p> <p>As a quality measure, on a weekly basis for four weeks, then on a monthly basis for two months, the LNHA or Designee will perform a linen audit to ensure compliance with the facilities protocol. Results will be recorded and shared during the facilities monthly Quality Assurance Committee monthly for (3) three months for review, revisions will be made as necessary.</p>		

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F 584	<p>Continued From page 3</p> <p>was aware of not having enough linens in the facility. The [US FOIA (b)(6)] indicated that the facility investigated and found that the staff were throwing away linens due to improperly labeled bins in the soiled linen room.</p> <p>On 3/6/2025 at 10:20 AM, the surveyor toured the 500 Low Hallway Linen Room and observed no washcloths and three towels. At 12:07 PM, the surveyor conducted a tour of the 500 Unit High hallway Linen Room and observed no washcloths and three towels. At 12:10 PM, the surveyor did a follow-up tour of the 500 Low Hallway Linen Room and observed no washcloths and towels.</p> <p>On 3/6/2024 at 12:11 PM, the surveyor interviewed the [US FOIA (b)(6)] who confirmed there were no washcloths and three towels in the 500 Unit High Hallway Linen Room and no washcloths and towels in the 500 Unit Low Hallway Linen Room. The [US FOIA (b)(6)] indicated that the lack of linens had been an ongoing issue and staff would have to call the laundry to bring more linens to the unit. The [US FOIA (b)(6)] stated there were times when the staff had to cut bath blankets to provide resident care.</p> <p>On 3/6/2025 at 1:58 PM, the surveyor interviewed the [US FOIA (b)(6)] the presence of the [US FOIA (b)(6)] and the survey team who stated that he was aware of the issue with the lack of linen, and it was brought up in the last Resident Council meeting. The [US FOIA (b)(6)] stated that he had ordered more linens to help resolve the issue. The [US FOIA (b)(6)] indicated that linens should always be readily accessible to residents. The [US FOIA (b)(6)] stated that he thought the staff calling laundry for linens was considered readily accessible.</p>	F 584			

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F 657 SS=D	<p>On 3/6/2025 at 2:05 PM, the [US FOIA (b)] in the presence of the [US FOIA (b)] and the surveyor team stated that it was not acceptable for staff to use bath blankets to provide care to the residents in place of towels and washcloths.</p> <p>NJAC 8:39-21.3 (a) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p>	F 657			4/10/25

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F 657	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ184057</p> <p>Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation on 03/05/2025 and 03/05/2025, it was determined that the facility failed to update and revise a resident's care plan, specifically for a newly identified [redacted] for 1 of 1 resident reviewed for comprehensive person-centered care plans, (Resident #4).</p> <p>This deficient practice was evidenced by the following:</p> <p>A review of the Admission Record (an admission summary) reflected that Resident #4 was admitted to the facility with diagnoses that included but were not limited to: [redacted]</p> <p>A review of the admission Minimum Data Set, an assessment tool used to facilitate the management of care dated [redacted], reflected that the resident had a Brief Interview for Mental Status score of [redacted] out of 15, indicating that the resident was [redacted]. Section [redacted] revealed [redacted].</p> <p>A review of Resident #4's Care Plan (CP) initiated on [redacted] included under "Focus" [redacted].</p> <p>A review of Resident #4's Progress Notes (PNs) dated [redacted] revealed the following written</p>	F 657	<p>Element 1: Resident #4 care plan was immediately updated with the proper [redacted] recommendations. Nursing staff involved counseled on immediately by the Director of Nursing on updating a resident's care plan whenever new recommendations are provided.</p> <p>Element 2: All Residents with wounds are at risk to be affected by the deficient practice.</p> <p>Element 3: The Facilities Care Plans, Comprehensive, Person Centered Policy were reviewed by the Director of Nursing with the nursing staff ensuring every resident has a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented while also indicating assessments of residents are ongoing and care plan are to be revised as information about the resident is provided.</p> <p>Element 4: As a quality measure, on a weekly basis for four weeks, then on a monthly basis for two months, the DON or Designee will audit 3 charts to ensure all new wound care recommendations are being updated in the resident's care plan. Results will be recorded and shared during the facilities monthly Quality Assurance Committee</p>		

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F 657	<p>Continued From page 6</p> <p>by LPN #1: Aide [certified nursing assistant] informed me today that patient [Resident #4] has a [redacted] in the [redacted]. Cleaned with [redacted] and [redacted] and applied [redacted] and [redacted]. Risk management note done and [redacted] consult in chart.</p> <p>A review of Resident #4's [redacted] care notes with an effective date of [redacted] revealed the following [redacted] care recommendations:</p> <p>[redacted] Location: [redacted]</p> <p>NJ Exec Order 26.4b1</p> <p>Signs of [redacted] none</p> <p>Size: NJ Exec Order 26.4b1</p> <p>[redacted] type: [redacted]</p> <p>[redacted] [redacted] [redacted]</p> <p>[redacted] none</p> <p>Description: none</p> <p>[redacted] NJ Exec Order 26.4b1</p> <p>A review of Resident #4's CP showed no updates with interventions of the aforementioned.</p> <p>On 03/05/2025 at 4:03 P.M., during an interview with the [redacted] (US FOIA (b)(6)), the surveyor asked what was the importance of the CP and who was responsible to update the CP? In the presence of another surveyor, the [redacted] (US FOIA (b)(6)) said she was unable to answer the question.</p> <p>On 03/05/2025 at 4:05 P.M., during an interview with the [redacted] (US FOIA (b)(6)), she stated the importance of the CP is how the team stays updated on the resident's needs, and what care needs to be provided for the resident. The [redacted] (US FOIA (b)(6)) stated the CP should be updated or revised with any new change in a resident's condition. When</p>	F 657	<p>monthly for (3) three months for review, revisions will be made as necessary.</p>		

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F 657	Continued From page 7 presented Resident #4's CP, the ^{US FOIA (b)} confirmed the CP was not revised or updated to reflect an actual skin breakdown on ^{NJ Exec Order 26.4b1} She said "the CP should have been updated and revised once the resident (Resident #4) developed a ^{NJ Exec Order 26} The observation of the ^{NJ Exec Order 2} and interventions should have been on the CP". She further stated the Interdisciplinary Team (nurses, social worker, therapist,) is responsible to initiate and/or revise the CP A review of the facility's policy with a revised date of 01/2025 titled "Care Plans, Comprehensive, Person-Centered" under "Policy Statement" reveals "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident". Under "Policy Interpretation and Implementation" #13. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents'	F 657			
F 658 SS=D	NJAC 8:39-27.1(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #: NJ184057	F 658	Element 1: Resident #4 did not experience a negative		4/10/25

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F 658	<p>Continued From page 8</p> <p>Based on observation, interview, and review of pertinent facility documents on 03/05/2025 and 03/05/2025, it was determined that the facility failed to: a.) ensure the treatment cart was secured during [NJ Excep Order 26] care observation, b.) initial, date, and time a [NJ Excep Order 26.4b] prior to applying on a resident (R#4) in accordance with professional standards of clinical practice. The facility also failed to follow its policies titled "Storage of Medications and [NJ Excep Order 26] Care" This deficient practice was identified for 1 of 1 resident observed for [NJ Excep Order 26] care.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>On 03/05/25 at 12:00 P.M., the surveyor observed the Registered Nurse (RN#1) parked the treatment cart outside the door of Resident #4's room. RN#1 performed hand hygiene, don clean gloves, and gathered all supplies needed and proceeded to the resident's room to perform [NJ Excep Order 26] care. RN#1 left the treatment cart unlocked and walked to Resident #4's room who was in bed and pulled the resident's privacy curtain. The treatment cart was out of the line of</p>	F 658	<p>outcome related to the deficient practice and Resident #4 [NJ Ex Order 26.4(b)(1)] at the facility.</p> <p>Element 2: All Residents are at risk to be affected by the deficient practice.</p> <p>Element 3: The Director of Nursing counseled the nursing staff on the importance of ensuring the treatment cart is never left unattended while unlocked and properly dating resident treatments. The Director of Nursing reviewed the facilities Storage of Medications policy with the nursing staff stating compartments containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport items shall not be left unattended if open or otherwise potentially available to others. The Facilities Wound Care policy was reviewed with the nursing staff to which reviewed marking tape with initials, time and date and apply dressing.</p> <p>Element 4: As a quality measure, on a weekly basis for four weeks, then on a monthly basis for two months, the Infection Preventionist or Designee will perform 3 observational audits to ensure compliance with locked treatment carts and properly dated resident treatments. Results will be recorded and shared during the facilities monthly Quality Assurance Committee monthly for (3) three months for review, revisions will be made as necessary.</p>		

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F 658	<p>Continued From page 9</p> <p>sight of RN#1 and no residents were observed present in the hallway and by the treatment cart. RN#1 was observed performed [NJ Exec Order 26.4b1] care after which she applied a [NJ Exec Order 26.4b1] to the resident's [NJ Exec Order 26.4b1] without initials, date or time.</p> <p>On 03/05/2025 at 12:45 P.M., during an interview with RN#1, she stated the treatment cart should always be locked. She said its important to keep the treatment and medication carts always locked to avoid residents from getting into the carts. RN#1 acknowledged the treatment cart was unlocked and left unattended while performing [NJ Exec Order 26.4b1] care for Resident #4. RN#1stated "if a treatment cart is left unlocked, a resident could get an ointment to ingest or rub causing harm or injury to the resident. During the same interview, RN#1 confirmed the [NJ Exec Order 26.4b1] for Resident #4 was not initial, dated or time prior to application on the resident's [NJ Exec Order 26.4b1]. She stated the importance of dating, timing and writing the initial on a [NJ Exec Order 26.4b1] is so that other staff caring for the resident knows the last time the [NJ Exec Order 26.4b1] care was performed for the resident. She stated, "I should have initial, timed and dated the dressing prior to applying the [NJ Exec Order 26.4b1] on the resident's [NJ Exec Order 26.4b1]."</p> <p>On 03/05/2025 at 1:00 P.M., during an interview with the [US FOIA (b)(6)], she stated all [NJ Exec Order 26.4b1] should have an initial, date and time written on it prior to applying on a resident's [NJ Exec Order 26.4b1]. She stated it was important so that staff are aware of the last time the [NJ Exec Order 26.4b1] was completed. The [US FOIA (b)(6)] also stated the medication and treatment carts should be locked unless I am standing there, it is important for safety. If a resident got into a medication cart or treatment cart, "there could be a potential for harm or injury to the resident."</p>	F 658			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315231	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/06/2025
NAME OF PROVIDER OR SUPPLIER THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP			STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD SEWELL, NJ 08080		
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F 658	Continued From page 10 On 03/05/2025 at 4:10 P.M. during an interview with the US FOIA (b)(6) , she stated "my expectation is for all NJ Exec Order 26.4b1 to be dated with the nurse's initials and time prior to applying the NJ Exec Order 26.4b1 . The US FOIA (b)(6) also said the medication and treatment carts should be locked by the nurse when not in use. Its is important because of the safety of the residents. A review of the facility's policy titled "Storage of Medications" with a revised date of 6/2024, under "Policy Interpretation and Implementation" 7. Compartments (including drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport items shall not be left unattended if open or otherwise potentially available to others. A review of the facility's policy titled "Wound Care" with a revised date of 04/2024 under "Steps in the Procedure" 13. Dress wound. Pick up sponge with paper and apply directly to area. Mark tape with initials, time and date and apply dressing.	F 658			
F 686 SS=G	NJAC 8:39-29.4(h) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686			4/10/25

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F 686	<p>Continued From page 11</p> <p>professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint #: NJ184057</p> <p>Based on interview, record review, and review of other pertinent facility documents on 03/05/2025 and 03/06/2025, it was determined that the facility failed to: a.) obtain a Physician's Order for a [NJ Exec Order 26.4b1] care recommendation which resulted in worsening of the [NJ Exec Order 26.4b1] b.) implement recommendations from the [NJ Exec Order 26.4b1] care consultant to prevent worsening of [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1].</p> <p>This deficient practice occurred for 1 of 1 resident reviewed for [NJ Exec Order 26.4b1] (Resident #4). This deficient practice was evidenced by the following: Resident #4 was identified as having a [NJ Exec Order 26.4b1] within the [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] failed to transcribe the verbal order obtained for [NJ Exec Order 26.4b1] care. On [NJ Exec Order 26.4b1] during a [NJ Exec Order 26.4b1] consult, Resident #4's [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] progressed to [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b1]. Review of Resident #4's Order Summary Report (OSR) from [NJ Exec Order 26.4b1] showed no evidence for [NJ Exec Order 26.4b1] care order in place for the resident's [NJ Exec Order 26.4b1]. On [NJ Exec Order 26.4b1], Resident #4 was seen by the Physician and transferred out to the Emergency</p>	F 686	<p>Element 1: The facility could not retroactively correct the deficient practice as it relates to Resident #4 since the resident [NJ Exec Order 26.4b1] the facility. No current residents were affected by this practice.</p> <p>Element 2: All Residents with wounds are at risk to be affected by the deficient practice.</p> <p>Element 3: The Director of Nursing reviewed the facilities "Wound Care" policy with the nursing staff stating the purpose of the facilities policy is to promote wound healing. The Director of Nursing reviewed the Facilities "Medication and Treatment Order" policy with the nursing staff stating verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, date and time of the order. The Director of Nursing reviewed the facilities "Charting and Documentation" policy with the nursing staff stating all services provided to the resident,</p>		

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F 686	<p>Continued From page 12</p> <p>Room for NJ Exec Order 26.4b1. According to the hospital records, Resident #4 was admitted to the hospital on NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1</p> <p>This deficient practice was evidenced by the following:</p> <p>A review of the Admission Record (an admission summary) reflected that Resident #4 was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1</p> <p>A review of the admission Minimum Data Set, an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b1, reflected that the resident had a Brief Interview for Mental Status score of NJ Exec Order 26.4b1 out of 15, indicating that the resident was NJ Exec Order 26.4b1. Section NJ Exec Order 26.4b1 revealed NJ Exec Order 26.4b1</p> <p>A review of Resident #4's Progress Notes (PNs) dated NJ Exec Order 26.4b1 revealed the following written by LPN #1: Aide [certified nursing assistant] informed me today that patient [Resident #4] has a NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1. Cleaned with NJ Exec Order 26.4b1, and applied NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Risk management note done and NJ Exec Order 26.4b1 consult in chart.</p> <p>A review of Resident #4's NJ Exec Order 26.4b1 care notes with an effective date of NJ Exec Order 26.4b1 revealed the following:</p> <p>NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1</p>	F 686	<p>progress toward the care plan goals, or any changes in the resident's medical, physical functional or psychological condition, shall be documented in the resident's medical record and the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.</p> <p>Element 4: As a quality measure, on a weekly basis for four weeks, then on a monthly basis for two months, the DON or Designee will perform 3 chart audits to ensure all new wound orders have a treatment order in place in an effective and timely manner. Results will be recorded and shared during the facilities monthly Quality Assurance Committee monthly for (3) three months for review, revisions will be made as necessary.</p>		

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F 686	<p>Continued From page 13</p> <p>Signs of [redacted] none NJ Exec Order 26.4b1</p> <p>[redacted] type: [redacted] NJ Exec Order 26.4b1 NJ Exec Order 26.4b1</p> <p>[redacted] none Description: none NJ Exec Order 26.4b1</p> <p>Review a [redacted] care notes with an effective date of [redacted] revealed the following: NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1</p> <p>[redacted] Signs of [redacted] none NJ Exec Order 26.4b1</p> <p>[redacted] type: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1</p> <p>[redacted] none Description: none NJ Exec Order 26.4b1</p> <p>A review of Resident #4's OSR and TAR revealed no evidence the [redacted] care recommendations were implemented for the resident's [redacted] care from [redacted] NJ Exec Order 26.4b1</p> <p>A review of Resident #4's PNs dated [redacted] revealed: pt [Resident #4] [redacted] [redacted], all medications [redacted] whole with [redacted] C/O [complained of] [redacted] in their [redacted] [redacted] cleaned and changed.</p> <p>Further review of Resident #4's PNs dated [redacted] NJ Exec Order 26.4b1, showed no further evidence [redacted] care was provided.</p> <p>A review of Resident #4's OSR with an order date</p>	F 686			

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F 686	<p>Continued From page 14</p> <p>o [NJ Exec Order 26.4b1], revealed the following order: [NJ Exec Order 26.4b1] care: [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] to base then cover with [NJ Exec Order 26.4b1] then [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] cleanse. One time a day for [NJ Exec Order 26.4b1].</p> <p>A review of Resident #4's TAR dated [NJ Exec Order 26.4b1] revealed the aforementioned order for [NJ Exec Order 26.4b1] care.</p> <p>On 03/05/2025 at 3:49 P.M., during an interview with LPN#1, she confirmed to the surveyor that she received a verbal order from the physician for [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] for Resident #4's [NJ Exec Order 26.4b1] and did not put the order in Point Click Care (PCC) as per facility's policy. LPN #1 stated once a [NJ Exec Order 26.4b1] is observed, the process is to evaluate the [NJ Exec Order 26.4b1] notify the resident's Physician of the [NJ Exec Order 26.4b1] and obtain an order for [NJ Exec Order 26.4b1] care. She said the expectation is for the nurse to put the order in PCC where it's transcribed to the TAR for implementation. She further stated, "all new [NJ Exec Order 26.4b1] and existing [NJ Exec Order 26.4b1] should have a treatment order in place." When asked by the surveyor if the order she received on [NJ Exec Order 26.4b1] Resident #4 should have been put in PCC and transcribed to the TAR, she said, "yes". LPN#1 said the nurse is responsible to notify the physician of recommendations for [NJ Exec Order 26.4b1] care and obtain a Physician's Order for the recommendations. LPN#1 said she was unsure why the physician was not notified for Resident #2's [NJ Ex Order 26.4b1] recommendations. LPN#1 said, if [NJ Exec Order 26.4b1] care is not provided as ordered, the [NJ Exec Order 26.4b1] could get worse</p>	F 686			

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F 686	<p>Continued From page 15</p> <p>On 03/05/2025 at 4:10 P.M., during an interview with the US FOIA (b)(6), she said, if there is a NJ Exec Order 26.4b1, the nurse will evaluate and notify the Physician, get a new treatment order, start the risk management and request a NJ Exec Order 26.4b1 consult. The US FOIA (b)(6) said, "the expectation is if a nurse obtains a new NJ Exec Order 26.4b1 care order from the Physician, the order should be placed in PCC and carried out on the TAR as per physician specifics." The US FOIA (b)(6) said there should be a treatment order in place for all NJ Exec Order 26.4b1 and the resident's NJ Exec Order 26.4b1 could get worse if there is no treatment in place. The US FOIA (b)(6) also said NJ Exec Order 26.4b1 care recommendations should be carried out on the TAR, and NJ Exec Order 26.4b1 care provided as ordered. The US FOIA (b)(6) confirmed there was no treatment order on the TAR from NJ Exec Order 26.4b1.</p> <p>On 03/13/2025 at 10:00 A.M., during an offsite interview with Resident #4's Physician, he said the expectation is, NJ Exec Order 26.4b1 care orders should be followed as ordered. He said once the nurse receives a verbal order for NJ Exec Order 26.4b1 care, the order should be implemented immediately. He said it is unacceptable if NJ Exec Order 26.4b1 care is not done or followed. The Physician said, "if NJ Exec Order 26.4b1 care is not started immediately, the NJ Exec Order 26.4b1 could get worse". During the same interview, the Physician said there should be an order in place for all NJ Exec Order 26.4b1.</p> <p>A review of the facility's policy title "Wound Care" with a revised date of 04/2024 under "Policy" revealed the following: "The purpose of this procedure is to provide guidelines for the care of wounds to promote wound healing.</p> <p>A review if the facility's policy with a revised date of 12/2024 titled "Medication and Treatment Order" under "Policy Interpretation and</p>	F 686			

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F 686	Continued From page 16 Implementation" revealed: "7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, date and time of the order". A review of the facility's policy titled "Charting and Documentation" under "policy Statement" revealed: "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's' medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.	F 686			
F 812 SS=D	NJAC 8:39-27.1 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly 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.	F 812			4/10/25

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F 812	<p>Continued From page 17</p> <p>§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: Complaint#: NJ182815</p> <p>Based on observations, interviews, and review of other facility documentation on 3/5/2025, it was determined that the facility failed to: a.) ensure that food items were dated, b.) ensure outdated food items were discarded, and c.) ensure refrigerator temperatures in the kitchen were completed to prevent foodborne illnesses.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 3/5/2025 from 10:08 AM to 10:40 AM, the surveyor, accompanied by the US FOIA (b)(6) observed the following during a tour of the kitchen:</p> <ol style="list-style-type: none"> 1. On the bread rack, the surveyor observed: <ul style="list-style-type: none"> - an unopened loaf of sliced rye sandwich bread with a use by date of 2/22/25. - an opened gluten free white wide slice bread with a use by date of 2/11/25. -an opened bag of 8 English muffins with no label and no expiration date. 2. The surveyor observed a temperature log sheet outside the walk-in refrigerator that had a blank space for 3/4/2025, for PM temperatures. 3. The surveyor and US FOIA entered the walk-in refrigerator that contained milk and juice. The surveyor observed a cart in the walk-in refrigerator that contained the following: 	F 812	<p>Element 1: The Dietary staff immediately discarded any and all undated food items throughout the kitchen. The staff also ensured all current refrigerator temperature logs were accurate and fully filled out for that shift.</p> <p>Element 2: All Residents who receive meals are at risk to be affected by the deficient practice.</p> <p>Element 3: The Dietary Director reviewed the facilities "Dating/Labeling of Food Items" policy with the dietary staff stating food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The Facilities refrigerator temperature log protocol was also reviewed by the Dietary Director with the dietary staff indicating all temperature logs throughout the kitchen must be filled out daily as per the schedule indicted on the logs.</p> <p>Element 4: As a quality measure, on a weekly basis for four weeks, then on a monthly basis for two months, the LNHA or Designee will perform 2 observational audits to ensure compliance with proper dating of all food items and fully completed temperature logs within the kitchen. Results will be</p>		

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F 812	<p>Continued From page 18</p> <ul style="list-style-type: none"> - a pitcher of orange juice that had no date on it. -an opened 64 oz. cranberry apple juice bottle with no date on it. -an opened 64 oz. cranberry raspberry juice bottle with no date on it. <p>On 3/5/2025 at 10:30 AM, the surveyor interviewed the [US FOR] who stated that all food and juice items should have been dated once opened. The [US FOR] indicated that gluten free items have a longer shelf date, and the gluten free bread had the incorrect use by sticker on it. The [US FOR] agreed that any food items past the "use by" date should have been discarded. The [US FOR] confirmed the blank space on the walk-in refrigerator temperature log sheet and indicated the PM temperature for 3/4/2025 should have been recorded.</p> <p>Review of the facility food service policy titled, "Dating/Labeling of Food Items" with a reviewed/revised date of 01/2025 revealed under "Policy Explanation and Compliance Guidelines for Staffing", "2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a label, the day/date of opening, and the day/date the item must be consumed or discarded."</p> <p>Review of the facility job description titled, "Dietary Director" dated April 2020 revealed under "Essential Duties and Responsibilities", "Monitor food preparation and food storage areas to be sure that health and sanitation regulations are being met."</p>	F 812	recorded and shared during the facilities monthly Quality Assurance Committee monthly for (3) three months for review, revisions will be made as necessary.		

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F 812	Continued From page 19	F 812			
F 880 SS=D	<p>NJAC 8:39-17.2 (g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§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:</p> <p>§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 §483.71 and following accepted national standards;</p> <p>§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;</p>	F 880			4/10/25

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NAME OF PROVIDER OR SUPPLIER THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP			STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD SEWELL, NJ 08080		
(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	<p>Continued From page 20</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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: Complaint #: NJ184057</p> <p>Based on observation, interview, and review of pertinent facility documents on 3/5/2025 and 3/6/2025, it was determined that the facility staff failed to maintain appropriate infection control practices specifically by not properly discarding</p>	F 880	<p>Element 1: The Nurse immediately discarded the unused NJ Exec Order 28.4b1 from the treatment cart.</p> <p>Element 2: All Residents are at risk to be affected by</p>		

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F 880	<p>Continued From page 21</p> <p>an opened pack of unused [NJ Exec Order 26.4b1] after a [NJ Exec Order 26.4b1] care observation to prevent the potential spread of infection in accordance with the Center for Disease and Control prevention guidelines and Standards of Clinical Practice. The facility staff failed to follow their policy titled "Infection Prevention and Control Program."</p> <p>This defiant practice was identified during 1 of 1 [NJ Exec Order 26.4b1] care observation.</p> <p>On 3/5/2025 at 12:00 P.M., the surveyor observed the Registered Nurse (RN#1) complete a [NJ Exec Order 26.4b1] care treatment. Upon completion of the [NJ Exec Order 26.4b1] care, RN#1 was observed gathering and returned an opened pack of unused [NJ Exec Order 26.4b1] and placed it in the treatment cart.</p> <p>On 03/05/2025 at 12:45 P.M., during an interview with RN#1, she stated the opened pack of unused [NJ Exec Order 26.4b1] from the resident's room should have been discarded and not placed in the treatment cart. She further stated it was important not to put the opened pack of unused [NJ Exec Order 26.4b1] back on the treatment cart to avoid cross contamination.</p> <p>On 03/05/2025 at 1:31 P.M., during an interview with the [US FOIA (b)(6)] she stated all unused treatment supplies should be discarded once not used during a [NJ Exec Order 26.4b1] care. The [US FOIA (b)(6)] stated the expectation is to take only items needed during a treatment with the treatment cart outside the door to obtain extra supplies if needed. Opened unused [NJ Exec Order 26.4b1] should not be placed back on the treatment cart once it was previously taken in the resident's room, it is important because of infection prevention.</p>	F 880	<p>the deficient practice.</p> <p>Element 3: The Facilities "Infection Prevention and Control Program" policy was reviewed with the nursing staff; specifically, staff were educated to ensure that an opened dressing is not returned to a treatment cart due to infection control.</p> <p>Element 4: As a quality measure, on a weekly basis (4) four weeks, then on a monthly basis (2) two months, the Infection Preventionist or Designee will observe 2 resident treatments to ensure proper infection control. Results will be recorded and shared during the facilities monthly Quality Assurance Committee monthly for (3) three months for review, revisions will be made as necessary.</p>		

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F 880	Continued From page 22 On 03/05/2025 at 4:10 P.M., during an interview with the [US FOIA (b)(6)] she stated unused [NJ Exec Order 28.4b1] supplies should be discarded after a [NJ Exec Order 28.4b1] dressing. When asked by the surveyor if an opened pack of unused [NJ Exec Order 28.4b1] should be returned to the treatment cart, the [US FOIA (b)(6)] stated, "no, the nurse should not put unused [US FOIA (b)(6)] supplies back on the treatment cart. It's important to prevent cross contamination." A review of the facility policy with a revised date of 01/2025, title "Infection Prevention and Control Program" under "Purpose" revealed: "To ensure the facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and state requirements". NJAC 8:39-19.1	F 880			
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Complaint #: NJ182815 Based on observations and interviews on	F 919	Element 1: The staff immediately rounded all units to ensure to call bells were not left		4/10/25

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F 919	<p>Continued From page 23</p> <p>3/5/2025 and 3/6/2025, it was determined that the facility failed to ensure their wireless call bell system communicated calls directly to the staff. This deficient practice was evidenced by the following:</p> <p>1. According to the Admission Record (AR), Resident #1 was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1</p> <p>A review of resident #1's Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, revealed a Brief Interview of mental Status (BIMS) score of NJ Exec Order 26.4b1 out of 15, which indicated the resident's NJ Exec Order 26.4b1. The MDS further revealed the resident was dependent for NJ Exec Order 26.4b1.</p> <p>On 3/5/2025 at 11:21 AM, the surveyor interviewed Resident # 1 in the presence of the resident's family member. The resident stated he /she was admitted to the facility several weeks ago. Resident #1 indicated that the day before it took staff 50 minutes to answer his/her call light. Resident #1 further stated that this was not the first time this occurred and that he/she had reported it to the nurse. The surveyor had Resident #1 ring his/her call bell. The surveyor returned to the resident's room at 11:35 AM and observed the call bell light still on with no audible sound present. The resident stated no staff had answered his/her call bell yet. Resident #1 further indicated that the staff had come to his/her room about ten minutes prior to the surveyor coming to the room the first time. Resident #1 stated the staff probably were not going to come back since</p>	F 919	<p>unanswered.</p> <p>Element 2: All Residents are at risk to be affected by the deficient practice.</p> <p>Element 3: The ADON reviewed the facilities "Communication-Call System" policy with the nursing staff stating to promptly respond to all call bells within 10 minutes.</p> <p>Element 4: As a quality measure, on a weekly basis for four weeks, then on a monthly basis for two months, the LNHA or Designee will perform 3 observational call bell audits to ensure the staffs promptness. Results will be recorded and shared during the facilities monthly Quality Assurance Committee monthly for three months for review, revisions will be made as necessary.</p>		

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F 919	<p>Continued From page 24</p> <p>[REDACTED] called for them earlier and they had already responded.</p> <p>2. According to the AR, Resident #3 was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [REDACTED].</p> <p>A review of Resident #3's MDS, an assessment tool dated [REDACTED], revealed a BIMS score of [REDACTED] out of 15, which indicated the resident's [REDACTED] was NJ Exec Order 26.4b1. The MDS further revealed the resident needed substantial assistance for NJ Exec Order 26.4b1.</p> <p>3. According to the AR, Resident #7 was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [REDACTED].</p> <p>A review of Resident #7's MDS, an assessment tool dated [REDACTED], revealed a BIMS score of [REDACTED] out of 15, which indicated the resident's NJ Exec Order 26.4b1. The MDS further revealed the resident was dependent for NJ Exec Order 26.4b1.</p> <p>On 3/6/2025 at 10:01 AM, the surveyor interviewed Resident #7 who stated that sometimes it took the staff more than ten minutes to answer his/her call bell. The resident further indicated that there were times his/her call bell was not answered by the staff. The resident further stated this mostly had occurred on the evening shift.</p> <p>On 3/5/2025 at 11:23 AM, the surveyor interviewed Resident # 3 who stated he/she had</p>	F 919			

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F 919	<p>Continued From page 25</p> <p>been a resident of the facility [REDACTED] and recently [REDACTED]. Resident #3 indicated that it took a long time for staff to answer his/her call light and sometimes the staff never came to the room to answer the light. Resident #3 further stated that he/she had made the charge nurse aware.</p> <p>On 3/5/2025 at 2:52 PM, the surveyor interviewed the Certified Nursing Assistant (CNA #2) who stated the call bells on the 500 Unit did not ring to the staff work areas. CNA #2 proceeded inside a resident room and rang the call bell. The surveyor observed a green light illuminate with no audible sound present on the ceiling in front of the resident room. CNA #2 indicated that the green light meant the resident would be calling from their room and if the light was red, it was calling from the resident bathroom. CNA #2 stated the only way she was aware that the call bell was ringing was if she looked up at the ceiling while standing in the hallway when she was not busy providing care to other residents.</p> <p>On 3/5/2025 at 3:00 PM, the surveyor did not observe any staff at the designated staff work areas on the 500 Unit Low and High Hallways.</p> <p>On 3/6/2025 at 9:55 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #2) who stated she was unable to see two rooms (Room 513 and 514) call lights from the staff work area in the 500 High Hallway. The [REDACTED] indicated a staff member would have to sit in the middle of the hallway to see if the call lights would illuminate from those two rooms. The [REDACTED] confirmed that there was no call bell system at the workstation to alert the staff that the residents were ringing their call bells.</p>	F 919			

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F 919	<p>Continued From page 26</p> <p>On 3/6/2025 at 10:12 AM, the surveyor interviewed the Registered Nurse (RN#1) who stated she was unable to see the call lights for two rooms (Room [REDACTED] and [REDACTED] from the staff work area in the [REDACTED] Low Hallway. RN #1 indicated that the staff should be in the hallways to monitor the call bells since they were not audible and do not ring to any main location.</p> <p>On 3/6/2025 at 10:16 AM, the surveyor interviewed the [REDACTED] (US FOIA (b)(6)) who indicated that she was aware that the residents had complained about their call bells not being answered for more than ten minutes especially on the 7pm-7am shift. The [REDACTED] (US FOIA (b)(6)) stated that the staff were supposed to be monitoring the call lights hourly as the call bells were not audible on the unit and were to respond in a timely manner.</p> <p>On 3/6/2025 at 1:58 PM, the surveyor interviewed the [REDACTED] (US FOIA (b)(6)) in the presence of the [REDACTED] (US FOIA (b)(6)). The [REDACTED] (US FOIA (b)(6)) stated she was not aware of any resident complaints regarding the call bells not being answered. The [REDACTED] (US FOIA (b)(6)) further indicated that the staff were expected to respond to the call bells in a timely manner. The [REDACTED] (US FOIA (b)(6)) stated it was everyone's responsibility to answer the call bells and that staff had received training on responding to the resident call bells.</p> <p>On 3/6/2025 at 1:58 PM, the surveyor interviewed the [REDACTED] (US FOIA (b)(6)) that confirmed the call bells in the new building which consisted of the 400 and 500 unit, did not ring to a centralized location and that staff had to visually see if the call bell was ringing.</p>	F 919			

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F 919	Continued From page 27 Review of the facility's policy titled, "Communication-Call System" with a reviewed/revised date of 01/2025 revealed under "Purpose", "To provide a mechanism for residents to promptly communicate with nursing staff." Under "Procedures", "7. Nursing staff will answer call bells promptly..." NJAC 8:39-27.1 (a)	F 919			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/06/2025
NAME OF PROVIDER OR SUPPLIER THE CENTER FOR REHAB & NURSING WASHI		STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD SEWELL, NJ 08080		
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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ182689, NJ182815, NJ184057 Based on review of facility documents on 3/5/25 and 3/6/25, it was determined that the facility failed to ensure staffing ratios were met for 4 of 14-day shifts and 1 of 14 evening shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	1. No residents were affected by not meeting the State of NJ minimum staffing requirements. 2. All residents have the potential to be affected. 3. The staffing coordinator was re-educated regarding the minimum state staffing ratios. Recruitment and retention efforts continue to include: a. Job fairs b. Weekly Regional Labor Management reviews to include LNHA, DON, ADON, staffing coordinator, and HR c. Recruitment bonus and sign-on bonuses offered	4/10/25

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

TITLE

(X6) DATE

Electronically Signed

04/03/25

New Jersey Department of Health

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S 560	<p>Continued From page 1</p> <p>nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>For the 2 weeks of staffing prior to survey from 02/16/2025 to 03/01/2025, the facility was deficient in CNA staffing for residents on 4 of 14-day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows:</p> <p>On 02/16/25, the facility had 18 CNAs for 154 residents on the day shift, required at least 19 CNAs.</p> <p>On 02/17/25, the facility had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs.</p> <p>On 02/24/25, the facility had 17 CNAs for 153 residents on the day shift, required at least 19 CNAs.</p> <p>On 02/25/25, the facility had 18 CNAs for 153 residents on the day shift, required at least 19 CNAs.</p>	S 560	<p>4. To monitor and maintain ongoing compliance the Director of Nursing or designee will monitor staffing daily for 1 week, weekly for 3 weeks and monthly for 3 months. Results will be presented to the Quality Assurance and Performance Improvement team quarterly for continued review and recommendations until substantial compliance is achieved.</p>		

New Jersey Department of Health

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S 560	Continued From page 2 On 02/25/25, the facility had 10 CNAs to 22 total staff on the evening shift, required at least 11 CNAs.	S 560			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315231	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/23/2025
NAME OF FACILITY THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP		STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD SEWELL, NJ 08080

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	04/23/2025	LSC	04/23/2025	LSC	04/23/2025
ID Prefix F0686	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/23/2025	LSC	04/23/2025	LSC	04/23/2025
ID Prefix F0919	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(g)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/23/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/6/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060806	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/23/2025
NAME OF FACILITY THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD SEWELL, NJ 08080	

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/23/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/6/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			