

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

PRINTED: 08/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER ROLLING HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16 CRATETOWN ROAD LEBANON, NJ 08833		
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint #'s: NJ 174181 and 174259</p> <p>STANDARD SURVEY: 1/29/25 to 2/7/25</p> <p>CENSUS: 59</p> <p>SAMPLE SIZE: 15 + 2 closed records</p> <p>A Recertification/LSC survey was conducted from 1/29/25 through 2/6/25, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.</p> <p>During the survey, a finding which constituted Immediate Jeopardy (IJ) was identified under 42 CFR 483.25 (d) F689 as the facility failed to ensure 5 of 5 NJ Exec Order 26.4b1 residents (Residents #3, #13, #29, #37, and #42) at risk for NJ Ex Order 26.4(b)(1) and who had a physician's order (PO) for a NJ Exec Order 26.4b1 received an entrée consistent with the prescribed NJ Exec O</p> <p>During a lunch meal tray preparation in the kitchen on 1/30/25 at 12:13 PM, the surveyor observed small, white, round, pearl-like consistency pasta with red sauce on top and a NJ Exec Order 26.4b1 ticket on the tray line which reflected NJ Exec Order 26.4b1 spaghetti four (4) ounces (oz). At that time, the surveyor interviewed the US FOIA (b)(6) regarding the NJ Exec Order 26.4b1 of the pasta. The US FOIA (b)(6) who was also present confirmed that the small, white, round, pearl-like NJ Exec Order 26.4b1 pasta was NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

03/03/2025

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 000	<p>Continued From page 1</p> <p>the pasta was "pastina" which was small pasta that did not have to be modified.</p> <p>On 1/30/25 between 12:44 PM to 1:09 PM, the survey team observed that the lunch meal trays were delivered to the five (5) residents that were on a NJ Exec Order 26.4b1 and included the small, white, round, pearl-like consistency pasta.</p> <p>Interview with the US FOIA (b)(6) on 1/30/25, confirmed that a NJ Exec Order 26.4b1 consisted of a NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that pasta should be placed in a blender to get the NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that it was important for residents to receive the NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 which could lead to NJ Exec Order 26.4b1.</p> <p>Interview with the US FOIA (b)(6) on 1/30/25, confirmed for a NJ Exec Order 26.4b1, everything needed to be NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and not too dry. The US FOIA (b)(6) confirmed pastina was not NJ Exec Order 26.4b1, even though it was small, round, with a pearl-like texture, it needed to be NJ Exec Order 26.4b1. The US FOIA (b)(6) stated if the resident received the incorrect NJ Exec Order 26.4b1 that placed them at risk for NJ Exec Order 26.4b1.</p> <p>The facility Administration was informed of the F 689 IJ, and was provided the IJ template on 1/30/25 at 4:02 PM.</p> <p>An acceptable removal plan was received on 1/31/25 at 8:54 AM, which indicated the action the facility would take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including Residents #3, #13, #29, #37,</p>	F 000			

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F 000	Continued From page 2 and #47 were assessed for signs and symptoms of [NJ Exec Order 26.4b1] the [NJ Exec Order 26.4b1] Manual was updated to remove pastina (small pasta) and couscous (small-round type of pasta) as approved selections for [NJ Exec Order 26.4b1]; staff were educated on acceptable options for residents on [NJ Exec Order 26.4b1] and the importance of checking the [NJ Exec Order 26.4b1] to ensure they received the [NJ Exec Order 26.4b1] [redacted]	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			3/18/25

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F 584	<p>Continued From page 3</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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a safe and home like environment.</p> <p>This deficient practice was identified on 1 of 3 nursing units [NJ Exec Order 26.4b1] reviewed for environmental concerns, and was evidenced by the following:</p> <p>On 1/29/2025 at 9:38 AM, the surveyor toured the South Unit and observed the following:</p> <p>1.) Inside resident room # [NJ Exec Ord] on the wall adjacent to the door was a large area of unfinished plaster surrounding two sides of an electrical outlet, peeling wallpaper behind the resident's bed, and brown stains on the floor tiles between the resident's bed and the wall adjacent to the door.</p> <p>2.) Outside room # [NJ Exec Ord] the wallpaper was</p>	F 584	<p>The maintenance department immediately addressed the deficiencies cited for the residents residing in rooms [NJ Exec Order 26.4b1]. Additionally, repairs in the South Unit hallway and "Spa" room door and handrail were addressed as follows</p> <p>Repaired the unfinished plaster and peeling wallpaper in room # [NJ Exec Ord]</p> <p>Removed brown stains from floor tiles.</p> <p>Repaired peeling wallpaper outside room # [NJ Exec Ord]</p> <p>Reattached the kick plate on the "Spa" Room door.</p> <p>Repaired peeling paint in room # [NJ Exec Ord]</p> <p>Refinished the missing veneer on the bedside chest in room # [NJ Exec Ord]</p> <p>Installed a new handrail end cap in the hallway outside room # [NJ Exec Ord] to eliminate sharp edges.</p>		

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F 584	<p>Continued From page 4 peeling.</p> <p>3.) Across the hall from room # [REDACTED] the kick plate on the lower half of the door to the room labeled "Spa," was detached and warped.</p> <p>4.) Inside resident room # [REDACTED] on the wall adjacent to bed #2, paint was peeling with small areas of plaster exposed.</p> <p>5.) Inside resident room # [REDACTED] adjacent to bed #2, one third of the veneer was missing, exposing raw wood on the drawer front of the bottom drawer of a three-drawer bedside chest of drawers.</p> <p>On 1/30/2025 at 12:46 PM, during a tour of the [REDACTED] Unit, in the hallway outside room # [REDACTED] the handrail was missing one of the curved end caps, exposing the sharp edges of the handrail.</p> <p>On 1/31/2025 at 10:03 AM, during a tour of the [REDACTED] Unit, in the presence of [REDACTED] (US FOIA (b)(6)) of [REDACTED] (NJ Exec Order 26.49), broken floor tiles were observed in the hallway outside resident room # [REDACTED] and near the door frame of room # [REDACTED].</p> <p>Upon interview with surveyor, the [REDACTED] (US FOIA) stated that environmental rounds were done each day upon arrival, each room was checked, and the staff were asked if there were any issues. Occasionally, administration would accompany the [REDACTED] on rounds. The [REDACTED] (US FOIA) further stated that maintenance was on site Monday through Friday 9:00 AM - 5:00 PM and was on call "24/7." If maintenance was not on site, the staff would text or use a messaging app to communicate issues. Upon request, the [REDACTED] (US FOIA) was unable to provide any</p>	F 584	<p>Replaced broken floor tiles in the hallway outside rooms # [REDACTED] and # [REDACTED].</p> <p>All residents who reside in the facility have the potential to be affected by the deficient practice of not maintaining a safe, clean, homelike environment.</p> <p>A full facility environmental audit was conducted by the Director of Maintenance (DM) and Licensed Nursing Home Administrator (LHNA) to identify any additional areas in need of repair. All additional items identified as a result of the environmental audit have been repaired.</p> <p>A formal written policy for environmental maintenance was developed, including: Weekly documented audits of resident rooms and common areas. Monthly administrative walk-throughs to assess compliance. Process for staff to report maintenance concerns in the maintenance logbook that will be located on the North Unit and checked by the maintenance staff daily and signed off by the DM when completed. Response time expectations for repairs (e.g., high-priority safety issues fixed within 24 hours).</p> <p>The [REDACTED] (US FOIA (b)(6)) and all staff have been provided with education by the LHNA covering: Importance of a homelike environment. How to report environmental concerns. Facility's new maintenance policy and procedures. The LHNA or designee will conduct random environmental audits weekly x 4,</p>		

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F 584	<p>Continued From page 5</p> <p>documentation of repairs or polices relating to the care of the environment, maintenance, or maintenance logs. The [US FOIA] further stated that the facility did not have any policies for maintenance. The [US FOIA] added that maintenance was aware of the peeling wallpaper outside resident room # [US FOIA] but not of the other observations in the hallway and resident's rooms. The [US FOIA] stated that the missing end cap on the handrail could cause "cuts" if not replaced, and that it was important to maintain the integrity of wall coverings to prevent infections.</p> <p>On 2/3/2025 at 10:59AM the surveyor interviewed the [US FOIA (b)(6)], who stated that the [US FOIA] was constantly doing rounds, was always on the lookout and moving around, looking for "safety issues or anything dangerous to the residents." If repairs were needed, the [US FOIA] fixed it or the repair was outsourced. The [US FOIA (b)(6)] stated that the facility had no "official" policy for environment or maintenance. The [US FOIA (b)(6)] continued that the building should be kept "in a homelike environment."</p> <p>On 2/4/2025 at 10:16 AM the [US FOIA (b)(6)] and the survey team, acknowledged the above findings.</p> <p>The faciltiy was unable to provide a policy on environment or maintenance.</p> <p>NJAC 8:39-4.1(a)(11) NJAC 8:39-31.4(a)</p>	F 584	<p>then monthly x 3 months of 10 resident rooms and all resident hallways and common areas to ensure compliance. The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring.</p>		
F 623 SS=D	<p>Notice Requirements Before Transfer/Discharge</p> <p>CFR(s): 483.15(c)(3)-(6)(8)</p>	F 623			3/18/25

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F 623	Continued From page 6 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623			

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F 623	<p>Continued From page 7</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <ul style="list-style-type: none"> (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. <p>§483.15(c)(6) Changes to the notice.</p>	F 623			

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F 623	<p>Continued From page 8</p> <p>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of a resident hospitalization.</p> <p>This deficient practice was identified for 1 of 2 residents (Resident #4) reviewed for hospitalization and was evidenced by the following:</p> <p>On 1/29/25 at 10:10 AM, the surveyor observed the resident [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] sitting in a wheelchair with a visitor at their bedside. Resident #4 stated they were in the hospital back in [NJ Exec Order 26.4b1].</p> <p>On 1/29/25 at 11:00 AM, the surveyor reviewed the medical record for Resident #4.</p> <p>A review of the Admission Record, an admission</p>	F 623	<p>Resident #4 had [NJ Exec Order 26.4b1] from this deficient practice and remains in the facility for long-term care. The Office of the State Long-Term Care Ombudsman has been notified of Resident #4's transfer to [NJ Ex Order 26.4(b)(1)] on [NJ Exec Order 26.4b1].</p> <p>All residents who are over the age of 60 and are transferred to the hospital have the potential to be affected by the deficient practice.</p> <p>A comprehensive review of all residents over the age of 60 who were transferred to the hospital in the last 30 days has been identified and The Office of the State Long-Term Care Ombudsman has been notified via email.</p> <p>The [US FOIA (b)(6)] was educated by the Regional Nurse Consultant on the requirement of notifying The Office of the Long-Term Care Ombudsman of residents over the age 60</p>		

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F 623	<p>Continued From page 9</p> <p>summary, revealed the resident had diagnoses which included NJ Exec Order 26.4b1 (b)(6)).</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1 (b)(6), included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 (b)(6) out of 15, which indicated the resident's NJ Exec Order 26.4b1 (b)(6) was NJ Exec Order 26.4b1 (b)(6). Further review of the MDS revealed the resident had an admission reentry from the acute hospital.</p> <p>A review of the Progress Note (PN), dated NJ Exec Order 26.4b1 (b)(6) at 8:46 PM, reflected the resident was admitted to the hospital for NJ Exec Order 26.4b1 (b)(6).</p> <p>On 1/30/25 at 12:35 PM, the surveyor interviewed the US FOIA (b)(6) who stated that he was unable to locate the notification to the State Long-Term Care Ombudsman (Ombudsman's office) for Resident #4. He then stated that the previous US FOIA (b)(6) completed them up until NJ Exec Order 26.4b1 (b)(6). The US FOIA (b)(6) stated that it was important for the ombudsman's office to be notified of the emergency transfer because they were the resident's advocate, and they should be aware of the resident's care. The US FOIA (b)(6) acknowledged it should have been completed prior to surveyor inquiry.</p> <p>On 1/30/25 at 12:40 PM, the surveyor interviewed the US FOIA (b)(6) who stated she started in NJ Exec Order 26.4b1 (b)(6) and overlapped with the previous US FOIA (b)(6). The US FOIA (b)(6) stated that she was unaware of when the last time the notification to the ombudsman's office was sent. She stated that it was important for the ombudsman's office to be notified, so they were aware of the resident's emergency transfer. At</p>	F 623	<p>who are transferred to the hospital on a monthly basis along with a copy of the notice to the resident or resident representative.</p> <p>The DSS or designee will send the required notifications for residents over 60 years of age who are transferred to the hospital to The Office of the State Long-Term Care Ombudsman on a monthly basis and include a copy of the notice to the resident or resident representative.</p> <p>The policy on Transfers, Discharges, Bed Holds was reviewed and determined that no updates were required at this time.</p> <p>The Administrator or designee will conduct weekly audits x 4 weeks then monthly x 3 months to ensure that the Office of the State Long-Term Care Ombudsman is notified of all residents over the age of 60 who are transferred to the hospital and that the resident or resident representative receives a copy of the notification.</p> <p>The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

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F 623	Continued From page 10 that time, the [US FOIA ID] confirmed it had not been done since she started. She then stated with the transition it was lost. On 1/31/25 at 11:06 AM, the [US FOIA ID] stated that the notification to the ombudsman's office was last completed in [NJ Exec Order 28,451]. A review of the facility's "Transfer/Discharge/Bed Hold Policy and Procedure" dated October 2024, included, "2. Notification: the facility will B. for residents over age 60, send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman."	F 623			
F 625 SS=D	NJAC 8:39-4.1(a)3 Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625			3/18/25

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F 625	<p>Continued From page 11</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy for 1 of 2 residents (Resident #4) reviewed for hospitalizations.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 1/29/25 at 10:10 AM, the surveyor observed the resident [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] sitting in a wheelchair with a visitor at their bedside. Resident #4 stated they were in the hospital back in [NJ Exec Order 26.4b1]</p> <p>On 1/29/25 at 11:00 AM, the surveyor reviewed the medical record for Resident #4.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included [NJ Exec Order 26.4b1]</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated [NJ Exec Order 26.4b1]</p>	F 625	<p>Resident #4 had [NJ Exec Order 26.4b1] from this deficient practice and remains in the facility for long-term care. Resident #4 and their responsible representative have been provided the written bed hold policy for the hospitalization on [NJ Exec Order 26.4b1].</p> <p>All residents who are sent to the hospital have the potential to be affected by the deficient practice of not receiving a written bed hold policy.</p> <p>A comprehensive review of residents sent to the hospital in the past 30 days has been completed and the written bed hold policy has been sent to the residents and/or their responsible representative.</p> <p>The [US FOIA (b)(6)] was educated by the Regional Nurse Consultant on the requirement of providing the residents and/or their responsible representative with a written copy of the bed hold policy.</p> <p>The SSD or designee will review the residents that have been transferred to the hospital and send the written bed hold policy to the resident and/or responsible representative.</p> <p>The policy on Transfers, Discharges, Bed</p>		

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F 625	<p>Continued From page 12</p> <p>included the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of 15, which indicated the resident's [REDACTED] was [REDACTED]. Further review of the MDS revealed the resident had an admission reentry from the [REDACTED] hospital.</p> <p>A review of the Progress Note (PN), dated [REDACTED] at 8:46 PM, reflected the resident was admitted to the hospital for [REDACTED].</p> <p>On 1/30/25 at 12:40 PM, the surveyor interviewed the [REDACTED] (US FOIA (b)(6)) who stated she started in [REDACTED] and overlapped with the previous [REDACTED]. The [REDACTED] stated that she was unaware of when the last time the Transfer/Bed Hold Notice Prior to Hospitalization or Therapeutic Leave form was completed. At that time, the [REDACTED] confirmed the forms had not been done since she started and with the transition it was lost.</p> <p>On 1/31/25 at 11:06 AM, the [REDACTED] stated that the Transfer/Bed Hold Notice Prior to Hospitalization or Therapeutic Leave forms were last completed in [REDACTED].</p> <p>On 2/4/25 at 10:38 AM, the [REDACTED] in the presence of the [REDACTED] (US FOIA (b)(6)) and survey team stated that completing the Transfer/Bed Hold Notice Prior to Hospitalization or Therapeutic Leave form was an oversight. He stated that it was important for the resident or the resident's representative to receive the form so they are aware of the bed hold policy.</p> <p>A review of the facility's "Transfer/Discharge/Bed Hold Policy and Procedure" dated October 2024, included, "1. Notice Before Transfer: When a resident is temporarily transferred on an</p>	F 625	<p>Holds was reviewed and determined that no updates were required at this time.</p> <p>The Administrator or designee will conduct weekly random audits of 3 residents who were transferred to the hospital x 4 weeks, then monthly x 3 months to ensure that the resident and/or responsible representative have received a written bed hold notice.</p> <p>The results of these audits will be reviewed in the Quarterly Quality Assurance Meeting x 2 quarters for suggestions and improvements and to evaluate the need for further monitoring.</p>		

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F 625	Continued From page 13 emergency basis to an acute care facility ...Before a nursing facility transfers a resident to the emergency room (ER) The nursing facility will provide written information to the resident and resident representative that specifies..A. The duration of the state bed-hold policy for hospital transfersB. The reserve bed payment policy."	F 625			
F 658 SS=E	N.J.A.C. 8:39-5.1 (a); 5.2 (a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a) accurately monitor and document a NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 and b) ensure that a resident (Resident #4) received care and treatment in accordance with professional standards of clinical practice, the physician's order, and the facility's policy. This deficient practice was identified for 1 of 1 resident (Resident #159) reviewed for infection and 1 of 1 resident (Resident #4) reviewed for hospitalization and was evidenced by the following:	F 658	Resident #159 no longer resides in the facility. Resident #159 had their NJ Exec Order 26.4b1 immediately and the physician orders were updated to include NJ Exec Order 26.4b1 changes every 7 days as per facility policy. The NJ Exec Order 26.4b1 was assessed by a registered nurse and NJ Exec Order 26.4b1 were observed. Resident #4 remains in the facility and a NJ Exec Order 26.4b1 was scheduled for resident #4 on NJ Exec Order 26.4b1 . The consultation indicated resident #4 is not a candidate for a NJ Exec Order 26.4b1 at this time. No new recommendations were made. All residents with midline IV catheters and physician orders for consultations have the potential to be affected by the		3/18/25

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F 658	<p>Continued From page 14</p> <p>1.) On 1/29/25 at 10:14 AM, during the initial tour of the facility, the surveyor observed signage outside of Resident #159's room which indicated that the resident was on NJ Exec Order 26.4b1 and personal protective equipment (specialized clothing or equipment worn to protect the wearer from infection or injury) was required to be worn in order to enter the resident's room. The surveyor observed Resident #159 lying in bed with an NJ Exec Order 26.4b1 in his/her NJ Exec D. The resident's family member was present and stated that the resident's NJ Exec Order 26.4b1 administration and the NJ Exec Order 26.4b1 was last changed at the hospital. The surveyor observed that there were NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 beside the resident's bed.</p> <p>On 1/29/25 at 12:48 PM, the surveyor reviewed the medical record for Resident #159.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, NJ Exec Order 26.4b1.</p> <p>The resident's comprehensive Minimum Data Set</p>	F 658	<p>deficient practice.</p> <p>A comprehensive review of current residents with physician orders for midline IV catheters has been conducted by the Director of Nursing (DON) to ensure that the midline IV dressing changes have been completed per facility policy and physician orders have been entered correctly. No other residents were found to be affected.</p> <p>All current residents with physician orders for consultations for the last 30 days has been conducted by the DON and no other issues were identified.</p> <p>All current licensed Nursing staff have been educated by the Staff Educator on the facility policy and procedure for changing midline IV dressings 24 hours after insertion and weekly for the duration of IV therapy. This education also includes how to correctly enter physician orders in the electronic medication administration record (eMAR) to ensure the dressing changes are completed per facility policy. All current licensed nursing staff have been educated by the Staff Educator to communicate all physician orders for consultations to the Unit Clerk for scheduling. The Unit Clerk or designee will then schedule the appointment and will communicate this information to the licensed nurse who will then record the appointment information in the electronic health record. The Unit Clerk or designee will also record the consultation appointment on a log that will be reviewed by the DON to ensure that consultations are scheduled appropriately. The policy for IV dressing changes has been</p>		

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F 658	<p>Continued From page 15</p> <p>(MDS), an assessment tool, was in progress and was not completed for review at the time of the observation.</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [REDACTED] NJ Exec Order 26.4b1, that the resident had a potential for complications related to [REDACTED] NJ Exec Order 26.4b1 due to [REDACTED] NJ Exec Order 26.4b1. Interventions included: Monitor [REDACTED] NJ Exec Order 26.4b1 [REDACTED] for signs and symptoms of [REDACTED] NJ Exec Order 26.4b1 and [REDACTED] NJ Exec Order 26.4b1 as ordered.</p> <p>A review of the Order Summary Report (OSR), dated as of [REDACTED] NJ Exec Order 26.4b1, indicated to change the [REDACTED] NJ Exec Order 26.4b1, and cap 24 hours [REDACTED] NJ Exec Order 26.4b1, then every week and as needed for [REDACTED] NJ Exec Order 26.4b1 use, and to [REDACTED] NJ Exec Order 26.4b1, [REDACTED] NJ Exec Order 26.4b1, and [REDACTED] NJ Exec Order 26.4b1 as needed.</p> <p>A review of the Medication Administration Record (MAR) revealed an entry with a start date of [REDACTED] NJ Exec Order 26.4b1 which included: [REDACTED] NJ Exec Order 26.4b1 [REDACTED] then every week and as needed every shift every seven days [REDACTED] NJ Exec Order 26.4b1 use, and to change the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] every week. Further review of the MAR revealed that the order was signed out as completed by nursing on [REDACTED] NJ Exec Order 26.4b1 on both the evening and night shifts.</p> <p>A review of the Progress Notes (PN) failed to include documentation related to the resident's [REDACTED] NJ Exec Order 26.4b1.</p>	F 658	<p>reviewed and determined that no updates were required</p> <p>The DON or designee will conduct weekly audits x 4 weeks, then monthly x 2 months for all residents with physician orders for midline IV catheters to ensure the IV dressing changes are being completed 24 hours post insertion and weekly for the duration of IV therapy. The DON or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to ensure that residents with physician orders for consultations have appointments scheduled in a timely manner.</p> <p>The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring.</p>		

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F 658	<p>Continued From page 16</p> <p>On 1/30/25 at 11:38 AM, the surveyor observed the resident lying in bed accompanied by his/her family member. The resident's [REDACTED] NJ Exec Order 26.4b1 [REDACTED] was dated [REDACTED] NJ Exec Order 26.4b1 [REDACTED]. The resident's family member stated that the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] had not been changed. He/She further stated that the [REDACTED] NJ Exec Order 26.4b1 [REDACTED], but the nurse stated that it was okay since it was such a small amount of medication.</p> <p>On 1/30/25 at 12:07 PM, the surveyor interviewed Registered Nurse (RN) #1 who stated that the resident's [REDACTED] NJ Exec Order 26.4b1 [REDACTED] was supposed to be [REDACTED] NJ Exec Order 26.4b1 [REDACTED] every seven days and she had not seen the resident's [REDACTED] NJ Exec Order 26.4b1 [REDACTED] yet.</p> <p>On 1/30/25 at 12:15 PM, RN #1 accompanied the surveyor into the resident's room to observe the [REDACTED] NJ Exec Order 26.4b1 [REDACTED]. RN #1 stated that the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] was dated [REDACTED] NJ Exec Order 26.4b1 [REDACTED] from the hospital and that the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] should have been changed on [REDACTED] NJ Exec Order 26.4b1 [REDACTED]. RN #1 further stated that it was important to change the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] every seven days to prevent [REDACTED] NJ Exec Order 26.4b1 [REDACTED].</p> <p>On 1/30/25 at 12:26 PM, the surveyor interviewed the [REDACTED] US FOIA (b)(6) [REDACTED] who stated that the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] from the hospital was supposed to be [REDACTED] NJ Exec Order 26.4b1 [REDACTED] within 24 hours, and that was in the facility's order set. The [REDACTED] US FOIA (b)(6) [REDACTED] then proceeded to review the electronic Medication Administration Record (EMAR) in the presence of the surveyor and confirmed that the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] was signed out as completed on [REDACTED] NJ Exec Order 26.4b1 [REDACTED], on both the evening and night shifts. The [REDACTED] US FOIA (b)(6) [REDACTED] stated that it was an infection control concern if the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] was not [REDACTED] NJ Exec Order 26.4b1 [REDACTED] as ordered. The</p>	F 658			

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F 658	<p>Continued From page 17</p> <p>US FOIA (b) further stated that she would have expected to see a progress note to indicate why the NJ Exec Order 26.4b1 was not done as indicated.</p> <p>On 1/31/25 at 9:58 AM, the surveyor interviewed the US FOIA (b)(6) who stated that if a NJ Exec Order 26.4b1 that was dated NJ Exec Order 26.4b1 from the hospital was intact, then it could be NJ Exec Order 26.4b1 seven days later on NJ Exec Order 26.4b1. The US FOIA (b) stated if nursing signed the EMAR to reflect that they changed the resident's NJ Exec Order 26.4b1 then they should have written a progress note to indicate the reason that they did not do it.</p> <p>The US FOIA (b) further stated that it was important to change the NJ Exec Order 26.4b1 as scheduled to ensure that the there was no infection.</p> <p>On 1/31/25 at 10:34 AM, the US FOIA (b) stated, "I have to see this for myself" and proceeded to go into the resident's room. The US FOIA (b) observed the resident's NJ Exec Order 26.4b1 and stated that the dressing NJ Exec Order 26.4b1 yesterday by RN #1. The surveyor informed the US FOIA (b) that RN #1 NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1 after surveyor inquiry.</p> <p>On 1/31/25 at 12:08 PM, the US FOIA (b) provided the surveyor with untitled documentation from the hospital which indicated that the resident's NJ Exec Order 26.4b1</p> <p>On 2/3/25 at 10:25 AM, in the presence of the US FOIA (b)(6) and the survey team, the US FOIA (b) stated that the facility would have NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1 the day after NJ Exec Order 26.4b1 but the resident was not here the day after NJ Exec Order 26.4b1. When the surveyor asked the US FOIA (b) why nursing signed the EMAR to indicate that they had NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 but did not complete the NJ Exec Order 26.4b1</p>	F 658			

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F 658	<p>Continued From page 18 as indicated, the [US FOIA (b)] stated, "I do not know."</p> <p>A review of the facility's "Catheter Insertion and Care" policy revised 1/17/19, included: Midline Dressing Changes Midline catheter dressing will be changed at specified intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines: Change midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way...</p> <p>2.) On 1/29/2025 at 10:10 AM, Resident #4 was observed [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] sitting in a wheelchair next to their bed. The resident stated that they were in the hospital in [NJ Exec Order 26.4b1].</p> <p>A review of the Admission Record, an admission summary revealed the resident had diagnoses that included, a personal history of [NJ Exec Order 26.4b1] [REDACTED]</p> <p>A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated [NJ Exec Order 26.4b1], included the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Exec Order 26.4b1] out of 15, which indicated the resident's [NJ Exec Order 26.4b1].</p> <p>A review of the resident's individual comprehensive care plan (ICCP), dated [NJ Exec Order 26.4b1], included a focus area that the resident was at risk for a [NJ Exec Order 26.4b1] related to [NJ Exec Order 26.4b1]. Interventions included remain free from complications related to [NJ Exec Order 26.4b1].</p>	F 658			

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F 658	<p>Continued From page 19</p> <p>A review of the Order Summary Report (OSR), dated as [NJ Exec Order 26.4b1], included a physician's order (PO) dated [NJ Exec Order 26.4b1], to schedule the resident a [NJ Exec Order 26.4b1] follow up for [NJ Exec Order 26.4b1] placement due to [NJ Exec Order 26.4b1].</p> <p>A review of the Physician Progress Note (PPN) reflected the following: [NJ Exec Order 26.4b1] at 1:36 PM, the resident was admitted for [NJ Exec Order 26.4b1]. [NJ Exec Order 26.4b1] at 12:45 PM, Assessment and plan: obtain [NJ Exec Order 26.4b1].</p> <p>On 1/31/2024 at 11:02 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the unit clerk scheduled and arranged transportation for outside medical appointments. She further stated that the PO should be followed, and if the resident was unable to attend the appointment, the physician should be notified as to why their order was not carried out.</p> <p>On 1/31/2025 at 11:20 AM, the surveyor interviewed the [US FOIA (b)(6)], who stated that she was responsible for scheduling the resident appointments. The [US FOIA (b)(6)] was unable to provide evidence that the appointment was scheduled for Resident #4.</p> <p>On 2/3/2025 at 11:48 AM, the surveyor interviewed the [US FOIA (b)(6)], who stated that a [NJ Exec Order 26.4b1] consult was ordered to determine whether Resident #4 met the criteria for a [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] also stated a [NJ Exec Order 26.4b1] can lead to a resident becomin [NJ Exec Order 26.4b1], which would lead to</p>	F 658			

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F 658	Continued From page 20 NJ Exec Order 26.4b1 She further stated that the nursing staff should have reviewed the order, scheduled the appointment, made transportation arrangements, and notified the team that the appointment had been made. On 2/4/2025 at 10:59 AM, the surveyor conducted a follow-up interview with the US FOIA (b)(6) in the presence of the US FOIA (b)(6) and the survey team. The US FOIA (b)(6) acknowledged that the NJ Exec Order 26 appointment should have been scheduled as ordered. She further stated that a NJ Exec Order 26 appointment was scheduled for tomorrow NJ Exec Order 26.4b1. The facility was unable to provide a policy pertaining to scheduling resident appointments.	F 658			
F 689 SS=L	NJAC 8:39-19.4, 27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent documents on 1/30/25, it was determined that the facility failed to ensure 5 of 5 NJ Exec Order 26.4b1 residents (Residents #3, #13, #29, #37, and #42) at risk of	F 689	Residents #3, #37, #13, and #42 remain in the facility for long term care and resident #29 no longer resides in the facility. On NJ Exec Order 26.4b1 at approximately 12:00 PM Meal trays for residents #3,		3/18/25

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F 689	<p>Continued From page 21</p> <p>NJ Exec Order 26.4b1) and who had physician's order (PO) for a NJ Exec Order 26.4b1 received an entrée NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1</p> <p>This deficient practice was identified for 5 of 5 residents reviewed for NJ Exec Order 26.4b1</p> <p>On 1/30/25 at 12:13 PM, the surveyor observed the lunch meal tray preparation in the kitchen. At that time, the surveyor observed small, white, round, pearl-like consistency pasta with red sauce on top and a NJ Exec Order 26.4b1 on the tray line which reflected NJ Exec Order 26.4b1 spaghetti four (4) ounces (oz).</p> <p>At 12:14, the surveyor interviewed the US FOIA (b)(6) regarding the consistency of the pasta. The US FOIA (b)(6)) who was also present confirmed that the small, white, round, pearl-like consistency pasta was NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that the pasta was "pastina" which was small pasta that did not have to be NJ Exec Order 26.4b1</p> <p>On 1/30/25 between 12:44 PM to 1:09 PM, the survey team observed that the lunch meal trays were delivered to the five (5) residents that were on a NJ Exec Order 26.4b1 and included the small, white, round, pearl-like NJ Exec Order 26.4b1 pasta.</p> <p>Interview with the US FOIA (b)(6) on 1/30/25, confirmed that a NJ Exec Order 26.4b1 consisted of a NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that pasta should</p>	F 689	<p>#13, #29, #37, and #42 with NJ Exec Order 26.4b1 orders that were served pastina had mashed potatoes and gravy substituted for their starch.</p> <p>On NJ Exec Order 26.4b1 at approximately 4:30 PM Residents #3, # 13, #29, #37 and #42 were assessed NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 were noted for these identified residents. Residents #3, # 13, #29, #37 and #42 were monitored for every shift x 3 days for signs/symptoms of NJ Exec Order 26.4b1 per physician orders and none were noted.</p> <p>All residents who receive a pureed diet texture have the potential to be affected by the deficient practice. A review of all residents in the facility was conducted by the Director of Nursing (DON) and no other residents were identified with pureed diet textures.</p> <p>Education was provided to the dietary and nursing staff by the Facility Staff Educator, DON, and Regional Food Service Director that pastina has been removed as an acceptable option for residents on puree diets. Staff were reminded of the importance of checking trays prior to giving them to residents to ensure that the appropriate diet texture is provided to avoid untoward results. The facility grid for acceptable foods for pureed diet textures has been reviewed and updated by the Regional Speech Therapist and Regional Dietitian to ensure all puree food textures are blended, mixed, or processed into a smooth and uniform texture. Pastina has been removed from the facility policy for Pureed diet texture and replaced with Pureed</p>		

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F 689	<p>Continued From page 22</p> <p>be placed in a [REDACTED] to get the [REDACTED]. The [REDACTED] stated that it was important for residents to receive the correct [REDACTED] to [REDACTED] which could lead to [REDACTED].</p> <p>Interview with the [REDACTED] US FOIA (b)(6) on 1/30/25, confirmed for a [REDACTED] and not too dry. The [REDACTED] confirmed pastina was not considered [REDACTED] even though it was small, round, with a pearl-like texture, it needed to be [REDACTED]. The [REDACTED] stated if the resident received the incorrect [REDACTED] that placed them at risk for [REDACTED].</p> <p>The facility's failure to ensure that the 5 of 5 [REDACTED] residents who were at risk of [REDACTED] and who had PO for a [REDACTED] received an entrée [REDACTED] with the [REDACTED], or [REDACTED] could occur to all residents. This resulted in an Immediate Jeopardy (IJ) situation.</p> <p>The IJ began on [REDACTED], and the facility Administration was notified of the IJ on [REDACTED] at 4:02 PM. The facility submitted an acceptable Removal Plan (RP) on 1/31/25 at 8:54 AM. The survey team verified the implementation of the RP during the continuation of the on-site on 1/31/25.</p> <p>The evidence was as follows:</p> <p>A review of the undated facility's "Dysphagia Diets" policy included, the food service department will be responsible for preparing and serving the diet as ordered.</p>	F 689	<p>Pasta.</p> <p>The Food Service Director, or designee will conduct weekly audits x 4 weeks, then monthly x 3 months of all residents who receive Pureed Diets to ensure that they receive the correct consistency and that Pastina is not substituted for Pureed Pasta. The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring.</p>		

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F 689	<p>Continued From page 23</p> <p>On 1/30/25 at 12:13 PM, the surveyor observed the lunch meal tray preparation in the kitchen. At that time, the surveyor observed small, white, round, pearl-like consistency pasta with red sauce on top and a NJ Exec Order 26.4b1 ticket on the tray line which reflected the following:</p> <p>NJ Exec Order 26.4b1 Spaghetti 4 ounces (oz) NJ Exec Order 26.4b1 Italian Medley NJ Exec Order 26.4b1 White Bread NJ Exec Order 26.4b1 Chocolate Frosty Thick.</p> <p>On 1/30/25 at 12:44 PM, the surveyor observed Resident #37's lunch meal tray on the overbed table. The lunch meal ticket on the tray reflected NJ Exec Order 26.4b1 spaghetti. The surveyor observed the small, white, round pieces of pasta covered in a red sauce.</p> <p>On 1/30/25 at 12:56 PM, the surveyor observed Resident #29 in their room with the lunch meal tray on the overbed table. At that time, the surveyor observed the small, white, round, pearl-like NJ Exec Order 26.4b1 pasta and the lunch meal ticket NJ Exec Order 26.4b1. At that time, the Certified Nursing Assistant (CNA #5) confirmed the pasta texture was not the NJ Exec Order 26.4b1 and that it should not have chunks in it. He then stated the NJ Exec Order 26.4b1 should be NJ Exec Order 26.4b1. CNA #5 stated he had seen incorrect NJ Exec Order 26.4b1 before but could not recall when it occurred. CNA #5 stated that he would request an NJ Exec Order 26.4b1 for the resident.</p> <p>On 1/30/25 at 1:00 PM, the surveyor observed Resident #13's lunch meal tray on the meal cart to be delivered. At that time, the surveyor observed the small, white, round, pearl-like NJ Exec Order 26.4b1 pasta with red sauce on top.</p>	F 689			

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F 689	<p>Continued From page 24</p> <p>On 1/30/25 at 1:06 PM, the surveyor observed Resident #37 in bed with the [NJ Exec Order 26.4b1] lunch meal tray in front of them. At that time, CNA #1 stated the resident only ate the ice cream from the lunch tray and did not eat the pasta.</p> <p>On 1/30/25 at 1:09 PM, the surveyor observed Resident #42 [NJ Exec Order 26.4b1] themselves and eating the small, white, round, pearl-like [NJ Exec Order 26.4b1] pasta in their room. Resident #42 stated the food tasted good.</p> <p>On 1/30/25 at 1:18 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that Resident #3 was on a [NJ Exec Order 26.4b1] and had already eaten all their lunch in the [NJ Exec Order 26.4b1] room. At that time, the surveyor observed the resident [NJ Exec Order 26.4b1] their wheelchair in the hallway.</p> <p>On 1/30/25 at 1:30 PM, the survey team reviewed the electronic medical record (EMR) of the 5 residents (Residents #3, #13, #29, #37, and #42) which revealed the following:</p> <p>A review of the Admission Record facesheet, an admission summary, reflected that Resident #3, was admitted to the facility with diagnoses that included; [NJ Exec Order 26.4b1]</p> <p>A review of Resident #3's admission Minimum Data Set (MDS), an assessment tool dated [NJ Exec Order 26.4b1], included the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Exec Order 26.4b1] out of 15, which indicated a [NJ Exec Order 26.4b1]. Further review of the MDS indicated the resident was on a [NJ Exec Order 26.4b1].</p>	F 689			

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F 689	<p>Continued From page 25</p> <p>A review of the physician's order (PO) reflected Resident #3, had an active PO for a [REDACTED] NJ Exec Order 26.4b1</p> <p>A review of the individualized comprehensive care plan (ICCP) dated [REDACTED] NJ Exec Order 26.4b1 indicated Resident # 3 was at risk for [REDACTED] NJ Exec Order 26.4b1 related to [REDACTED] NJ Exec Order 26.4b1. Interventions included monitor for signs and symptoms (s/s) for [REDACTED] NJ Exec Order 26.4b1 provide [REDACTED] NJ Exec Order 26.4b1 as ordered.</p> <p>A review of the Admission Record, reflected that Resident #13, was admitted to the facility with diagnoses that included: [REDACTED] NJ Exec Order 26.4b1</p> <p>A review of Resident's #13 admission MDS, dated [REDACTED] NJ Exec Order 26.4b1 included the resident had a BIMS score of [REDACTED] NJ Exec Order 26.4b1 out of 15, which indicated a [REDACTED] NJ Exec Order 26.4b1 Further review of the MDS indicated the resident was on a [REDACTED] NJ Exec Order 26.4b1</p> <p>A review of the physician's order (PO) reflected Resident #13, had an active PO for a [REDACTED] NJ Exec Order 26.4b1</p> <p>A review of the ICCP dated [REDACTED] NJ Exec Order 26.4b1, reflected Resident #13 was at risk for [REDACTED] NJ Exec Order 26.4b1 related to [REDACTED] NJ Exec Order 26.4b1 Interventions included: [REDACTED] NJ Exec Order 26.4b1 as ordered and monitor for signs and symptoms of [REDACTED] NJ Exec Order 26.4b1</p> <p>A review of the Admission Record reflected that Resident #29 was admitted to the facility with diagnoses that included: [REDACTED] NJ Exec Order 26.4b1</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>A review of Resident #29's quarterly MDS, dated [redacted] included the resident had a BIMS score of [redacted] out of 15, which indicated a [redacted]. Further review of the MDS indicated the resident was on a [redacted].</p> <p>A review of the physician's order (PO) reflected Resident #29, had an active PO for a [redacted].</p> <p>A review of the ICCP dated [redacted] reflected Resident #29 was at risk for [redacted] related to [redacted]. Interventions included [redacted] as ordered.</p> <p>A review of the Admission Record, reflected that Resident #37, was admitted to the facility with diagnoses that included [redacted].</p> <p>A review of Resident #37's most recent comprehensive MDS, dated [redacted], included the resident had a BIMS score of [redacted] out of 15, which indicated a [redacted]. Further review of the MDS indicated the resident was on a [redacted].</p> <p>A review of the physician's order (PO) reflected Resident #37, had an active PO for a [redacted].</p> <p>A review of the ICCP dated [redacted] reflected Resident #37 was at risk for [redacted] related to [redacted]. Interventions included: provide [redacted] as ordered and monitor for signs and symptoms of [redacted].</p>	F 689			

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F 689	<p>Continued From page 27</p> <p>A review of the Admission Record, reflected that Resident #42, was admitted to the facility with diagnoses that included NJ Exec Order 26.4b1 [REDACTED]</p> <p>A review of Resident #42's quarterly MDS, dated NJ Exec Order 26.4b1 [REDACTED], included the resident had a BIMS score of NJ Exec Order 26.4b1 [REDACTED] out of 15, which indicated a NJ Exec Order 26.4b1 [REDACTED]. Further review of the MDS indicated the resident was on a NJ Exec Order 26.4b1 [REDACTED]</p> <p>A review of the physician's order (PO) reflected Resident #42, had an active PO for a NJ Exec Order 26.4b1 [REDACTED]</p> <p>A review of the ICCP dated NJ Exec Order 26.4b1 [REDACTED] reflected Resident #42 was at risk for NJ Exec Order 26.4b1 [REDACTED] related to NJ Exec Order 26.4b1 [REDACTED]. Interventions included: provide NJ Exec Order 26.4b1 [REDACTED] and monitor for signs and symptoms of NJ Exec Order 26.4b1 [REDACTED]</p> <p>On 1/30/25 at 1:41 PM, the surveyor conducted a telephone interview with the US FOIA (b)(6) [REDACTED] who stated that a NJ Exec Order 26.4b1 [REDACTED] and NJ Exec Order 26.4b1 [REDACTED]. She stated that there should be no NJ Exec Order 26.4b1 [REDACTED], and it should be NJ Exec Order 26.4b1 [REDACTED]. The US FOIA (b)(6) [REDACTED] stated that she was not a US FOIA (b)(6) [REDACTED] but that to get a NJ Exec Order 26.4b1 [REDACTED] it should be placed in a NJ Exec Order 26.4b1 [REDACTED]. She further stated that pasta should be placed in a NJ Exec Order 26.4b1 [REDACTED] to get the NJ Exec Order 26.4b1 [REDACTED]. The US FOIA (b)(6) [REDACTED] stated that it was important for residents to receive the correct NJ Exec Order 26.4b1 [REDACTED] to prevent NJ Exec Order 26.4b1 [REDACTED] and any consequences of NJ Exec Order 26.4b1 [REDACTED] which would be NJ Exec Order 26.4b1 [REDACTED] or NJ Exec Order 26.4b1 [REDACTED]</p> <p>On 1/30/25 at 2:02 PM, the surveyor interviewed the US FOIA (b)(6) [REDACTED] who stated that NJ Exec Order 26.4b1 [REDACTED] should be a NJ Exec Order 26.4b1 [REDACTED]. The US FOIA (b)(6) [REDACTED] stated that</p>	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 28</p> <p>pastina has been allowed in the facility and to his understanding it became [REDACTED] once it was in the mouth. He then stated he went by the facility's menu extensions [REDACTED] NJ Exec Order 26.4b1</p> <p>[REDACTED] and the [REDACTED] and the [REDACTED] overruled him. The [REDACTED] stated the importance of a [REDACTED] was so the resident did [REDACTED] NJ Exec Order 26.4b1.</p> <p>On 1/30/25 at 2:41 PM, the surveyor interviewed the [REDACTED] US FOIA (b)(6) in the presence of the survey team who stated that the [REDACTED] NJ Exec Order 26.4b1. She stated that it was important for residents to receive the [REDACTED] NJ Exec Order 26.4b1.</p> <p>On 1/30/25 at 2:53 PM, the surveyor conducted a telephone interview with the [REDACTED] US FOIA (b)(6) in the presence of the survey team who stated for a [REDACTED] NJ Exec Order 26.4b1.</p> <p>[REDACTED]. She stated that pastina was not [REDACTED] NJ Exec Order 26.4b1 unless it was [REDACTED] NJ Exec Order 26.4b1. She further stated that if it was a small, round, pearl-like texture that still would not be [REDACTED] NJ Exec Order 26.4b1. The [REDACTED] US FOIA (b)(6) stated if the resident received the [REDACTED] NJ Exec Order 26.4b1, that placed them at risk for [REDACTED] NJ Exec Order 26.4b1. The [REDACTED] US FOIA (b)(6) confirmed that pureed pasta should be a [REDACTED] NJ Exec Order 26.4b1.</p> <p>On 1/30/25 at 3:00 PM, the surveyor interviewed the [REDACTED] US FOIA (b)(6) and the survey team who stated that [REDACTED] NJ Ex Order 26.4b1 food was placed into a [REDACTED] NJ Exec Order 26.4b1 and the texture should be [REDACTED] NJ Exec Order 26.4b1. She stated that it was important for the residents to receive the [REDACTED] NJ Exec Order 26.4b1, so they did not [REDACTED] NJ Exec Order 26.4b1 or [REDACTED] NJ Exec Order 26.4b1.</p>	F 689			

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F 689	<p>Continued From page 29</p> <p>On 1/30/25 at 3:07 PM, the [US FOIA (b)(6)] in the presence of the [US FOIA (b)(6)] and the survey team stated that "no resident was harmed" and pastina was acceptable to be served as a [NJ Exec Order 26.4b1]. He further stated that it had been the practice of the facility to serve pastina without modifying it because it was [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] acknowledged that a [NJ Exec Order 26.4b1].</p> <p>On 1/31/25 at 10:07 AM, the surveyor interviewed CNA #4 who stated that a [NJ Exec Order 26.4b1] should be [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] like. CNA #4 then stated that pastina and couscous were not [NJ Exec Order 26.4b1].</p> <p>On 1/31/25 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1) who stated that a [NJ Exec Order 26.4b1] should be [NJ Exec Order 26.4b1] with no [NJ Exec Order 26.4b1]. She stated that it was important that residents received the [NJ Exec Order 26.4b1] because the resident could [NJ Exec Order 26.4b1].</p> <p>On 1/31/25 at 10:15 AM, the surveyor interviewed the Registered Nurse (RN #1) who stated that a [NJ Exec Order 26.4b1]. She stated that she was [NJ Exec Order 26.4b1] it was on the [NJ Exec Order 26.4b1] as the resident could [NJ Exec Order 26.4b1] on that [NJ Exec Order 26.4b1].</p> <p>On 01/31/25 at 11:19 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that a [NJ Exec Order 26.4b1], it should be [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated that there should be [NJ Exec Order 26.4b1] and that pastina and couscous were not part of the [NJ Exec Order 26.4b1] as the resident could [NJ Exec Order 26.4b1].</p>	F 689			

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F 689	<p>Continued From page 30</p> <p>On 2/3/25 at 2:03 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the NJ Exec Order 26.4b1. At that time, the surveyor showed the US FOIA a picture of the pasta that was served NJ Exec Order 26.4b1 to the residents on NJ Exec Order 26.4b1. The US FOIA stated, "that is grainy, it looks like couscous to me." She then stated that it had to be NJ Exec Order 26.4b1 and aid in NJ Exec Order 26.4b1.</p> <p>An acceptable Removal Plan was received on 1/31/25 at 8:54 AM, which indicated the action the facility would take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including Residents #3, #13, #29, #37, and #47 were assessed for signs and symptoms of NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 Manual was updated to remove pastina (small pasta) and couscous (small-round type of pasta) as NJ Exec Order 26.4b1; staff were educated on acceptable options for residents on NJ Exec Order 26.4b1 and the importance of checking the meal trays to ensure they received the NJ Exec Order 26.4b1.</p> <p>The survey team verified the implementation of the Removal Plan during the continuation of the on-site on 1/31/25.</p> <p>NJAC 8:39-17.4 (a)1-2; 27.1(a)</p>	F 689			
F 692 SS=D	<p>Nutrition/Hydration Status Maintenance</p> <p>CFR(s): 483.25(g)(1)-(3)</p> <p>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and</p>	F 692			3/18/25

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F 692	<p>Continued From page 31</p> <p>percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. 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 obtain a [NJ Exec Order 26.4b1] according to the facility's policy for a resident with a history of [NJ Exec Order 26.4b1].</p> <p>This deficient practice was identified for 1 of 3 residents (Resident #19) reviewed for [NJ Exec Order 26.4b1] and evidenced by the following:</p> <p>On 1/30/25 at 1:01 PM, the surveyor observed Resident #19 in his/her room being served lunch. The resident received [NJ Exec Order 26.4b1] of ground spaghetti and meatballs with sauce, vegetables, and bread. The resident stated he/she enjoyed the food.</p> <p>At 1:43 PM, the surveyor observed Resident #19 had consumed [NJ Exec Order 26.4b1] of his/her</p>	F 692	<p>Resident #119 remains in the facility and was [NJ Exec Order 26.4b1]. The Registered Dietician (RD) determined that [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1] most likely inaccurate and the resident did not have a [NJ Exec Order 26.4b1]. The primary physician for Resident #119 was notified of the [NJ Exec Order 26.4b1]. Resident #119 will have weekly [NJ Exec Order 26.4b1] x 4 weeks to ensure [NJ Exec Order 26.4b1] remains [NJ Exec Order 26.4b1].</p> <p>All current residents have the potential to be affected by the deficient practice. A comprehensive review of all current resident weights has been conducted by the RD and residents with a weight discrepancy of five pounds have been re-weighed per the facility policy.</p> <p>The facility Weight Policy has been reviewed and determined that no updates</p>		

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F 692	<p>Continued From page 32 lunch meal.</p> <p>The surveyor reviewed the medical record for Resident #19.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, NJ Exec Order 26.4b1</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. Further review of the MDS revealed the resident had a NJ Exec Order 26.4b1 or more in the NJ Exec Order 26.4b1, or NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 while not on a physician-prescribed NJ Exec Order 26.4b1.</p> <p>A review of the individual comprehensive care plan (ICCP) included a focus area, revised NJ Exec Order 26.4b1, that the resident had a NJ Exec Order 26.4b1. Interventions included: NJ Exec Order 26.4b1 "Weekly NJ Exec Order 26.4b1 x 4 weeks," and "Monitor NJ Exec Order 26.4b1 per protocol."</p> <p>A review of the NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1, included the resident had a NJ Exec Order 26.4b1. Further review of the NJ Exec Order 26.4b1 included recommendations to start weekly NJ Exec Order 26.4b1 for four weeks.</p> <p>A review of the NJ Exec Order 26.4b1 and Vitals Summary, as of NJ Exec Order 26.4b1 included the following NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1, the resident NJ Exec Order 26.4b1</p>	F 692	<p>were required at this time.</p> <p>Nursing staff have been educated by the Facility Staff Educator on the policy and procedure for obtaining a re-weight when there is a discrepancy of five pounds and to notify the RD if there is a verified weight loss via the dietary communication slip. The licensed nursing staff will verify weights obtained by the Certified Nursing Assistant (CNA) and if a weight discrepancy of five pounds from the previous weight is noted the nurse will instruct and observe the CNA obtain a re-weight to verify the accuracy of the weight. The licensed nurse will then notify the RD of the weight discrepancy so interventions can be implemented in a timely manner.</p> <p>The Director of Nursing (DON) or designee will conduct weekly audits x 4 weeks, then monthly x 3 months to ensure that residents with a weight discrepancy of five pounds or more are re-weighted, and the RD is notified in a timely manner. The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring.</p>		

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F 692	<p>Continued From page 33</p> <p>On [REDACTED] the resident [REDACTED] NJ Exec Order 26.4b1. According to the documented [REDACTED] the resident experienced a [REDACTED] NJ Exec Order 26.4b1 [REDACTED].</p> <p>A review of the Progress Notes, dated [REDACTED] NJ Exec Order 26.4b1 through [REDACTED] NJ Exec Order 26.4b1 did not include evidence that a re-weight was attempted after the documented [REDACTED] NJ Exec Order 26.4b1, or that the [REDACTED] US FOIA (b)(6) [REDACTED] or physician was notified of the [REDACTED] NJ Exec Order 26.4b1 [REDACTED].</p> <p>On 1/31/25 at 9:58 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #4 who stated the nurse schedules the [REDACTED] NJ Exec Order 26.4b1 that the CNAs need to obtain. The CNA further stated she reports the [REDACTED] NJ Exec Order 26.4b1 to the nurse, but does not look at the resident's [REDACTED] NJ Exec Order 26.4b1 for comparison. The CNA explained that if a resident needed to be [REDACTED] NJ Exec Order 26.4b1, the nurse would instruct the CNA to obtain the [REDACTED] NJ Exec Order 26.4b1 at that time. The CNA added that it was important to obtain resident [REDACTED] NJ Exec Order 26.4b1 as ordered "to see if the [REDACTED] NJ Exec Order 26.4b1 is [REDACTED] NJ Exec Order 26.4b1.</p> <p>On 1/31/25 at 10:12 AM, the surveyor interviewed the [REDACTED] US FOIA (b)(6) [REDACTED] who was the nurse for Resident #19 that day. The [REDACTED] US FOIA (b)(6) [REDACTED] stated residents were [REDACTED] NJ Exec Order 26.4b1 on a schedule depending on their specific circumstances and that [REDACTED] NJ Exec Order 26.4b1 were documented in the electronic medical record (EMR) by the nurse or [REDACTED] US FOIA (b)(6) [REDACTED]. The [REDACTED] US FOIA (b)(6) [REDACTED] further stated that if a resident had a [REDACTED] NJ Exec Order 26.4b1 change of [REDACTED] NJ Exec Order 26.4b1 should be obtained to verify the [REDACTED] NJ Exec Order 26.4b1. The [REDACTED] US FOIA (b)(6) [REDACTED] explained that a [REDACTED] NJ Exec Order 26.4b1 change [REDACTED] NJ Exec Order 26.4b1 or more should be communicated to the physician "to make sure whatever is best for the resident is done."</p>	F 692			

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F 692	<p>Continued From page 34</p> <p>On 1/31/25 at 10:15 AM, the surveyor interviewed the ^{US FOIA} who stated that residents were placed on ^{NJ Exec Order 26.4b1} when their ^{NJ Exec Order 26.4b1} needed to be monitored for ^{NJ Exec Order 26.4b1}, and that the ^{NJ Exec Order 26.4b1} were documented in the EMR by the nurse or the ^{US FOIA}. The ^{US FOIA} explained that if a resident had a ^{NJ Exec Order 26.4b1} or more since the ^{NJ Exec Order 26.4b1} should be obtained immediately to confirm if the ^{NJ Exec Order 26.4b1} was accurate. The ^{US FOIA} further stated that for true ^{NJ Exec Order 26.4b1}, she would document ^{NJ Exec Order 26.4b1} assessment in the resident's progress notes and notify the physician. The ^{US FOIA} stated that it was important for staff to notify her or the physician of a ^{NJ Exec Order 26.4b1} in order to implement the appropriate interventions. At that time, the surveyor informed the ^{US FOIA} of the ^{NJ Exec Order 26.4b1} that was documented in Resident #19's EMR or ^{NJ Exec Order 26.4b1}. The ^{US FOIA} stated she was ^{NJ Exec Order 26.4b1} that was obtained on ^{NJ Exec Order 26.4b1}, and that the staff should have ^{NJ Exec Order 26.4b1} the resident and notified the ^{US FOIA} or physician if there was a ^{NJ Exec Order 26.4b1} or ^{NJ Exec Order 26.4b1} or more.</p> <p>On 1/31/25 at 10:45 AM, the ^{US FOIA} informed the surveyor that she obtained a ^{NJ Exec Order 26.4b1} for Resident #19 after surveyor inquiry. The ^{US FOIA} stated that the resident's ^{NJ Exec Order 26.4b1} and that the ^{NJ Exec Order 26.4b1} was most likely inaccurate.</p> <p>On 1/31/25 at 10:50 AM, the surveyor interviewed the ^{US FOIA (b)(6)} who stated that residents with a ^{NJ Exec Order 26.4b1} or more should be ^{NJ Exec Order 26.4b1} within 24 hours so that the ^{US FOIA} or physician could evaluate the need for an intervention. At that time, the surveyor</p>	F 692			

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F 692	Continued From page 35 informed the [US FOIA (b)] of Resident #19's documented NJ Exec Order 26.4b1. The [US FOIA (b)] confirmed that when the [NJ Exec Order 26.4b1] was obtained on [NJ Exec Order 26.4b1], the staff should have obtained a [NJ Exec Order 26.4b1] to verify the resident's [NJ Exec Order 26.4b1]. A review of the facility's "Weight Policy," dated 11/2024, included the following: a. The nursing staff is responsible to obtain weights as assigned. -Reweight is required if the resident has a weight change +/- 5 lbs. -Dietician will follow up with any weight discrepancies ASAP [as soon as possible]. d. Weight Refusal The nursing staff will notify the Unit Manager/Designee of any resident who refuses to be weighed. Nurse and Dietician will meet with the resident to encourage him or her to get weighed. If resident continues to refuse, dietician will document and initiate/update care plan as needed. A review of the facility's "Unintentional/Unplanned Weight Change" policy, dated 11/2024, included the following: Purpose: To intervene appropriately with residents having unintentional/unplanned weight change. 1. Determination is made through monthly/weekly weight reviews by the dietician in communication with nursing that a resident has unintentional/unplanned weight change.	F 692			
F 812 SS=F	NJAC 8:39 - 27.2 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812			3/18/25

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NAME OF PROVIDER OR SUPPLIER ROLLING HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16 CRATETOWN ROAD LEBANON, NJ 08833		
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F 812	<p>Continued From page 36</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§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.</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: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness.</p> <p>This deficient practice was evidenced by the following: On 1/29/25 from 9:28 AM to 11:31 AM, the surveyor, accompanied by the Dietary Aide (DA #1) and the US FOIA (b)(6) toured the kitchen and observed the following:</p> <p>1. On 1/29/25 at 10:09 AM the surveyor observed a high temperature dish machine running at 136 degrees Fahrenheit (F). The US FOIA (b)(6) stated that per the manufacture's</p>	F 812	<p>No residents were identified as being affected by the identified deficient practice.</p> <p>Maintenance will ensure that the high-temperature dishwasher is repaired to ensure it reaches the correct temperatures of 150°F or above for the wash cycle and 180°F or above for the rinse cycle as per the manufacturer's guidelines.</p> <p>In the interim, staff will use the chemical sanitizer until the dishwasher is fully functional. The chemical sanitizer is being used before every meal service and is tested before each use to ensure a</p>		

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F 812	<p>Continued From page 37</p> <p>recommendations the dish machine should wash above 150 degrees and rinse above 180 degrees. DA #1 placed a rack of soiled trays in the dishwasher and when the cycle was complete dipped a test strip onto a wet tray immediately. DA #1 then showed, the test strip failed to change colors which indicated that the concentration was less than 10 Parts Per Million (PPM). At that time, the surveyor observed the chemical sanitizer test strip bottle was expired with a date of 10/1/24. DA #1 located a new bottle of test strips with an expiration date of 4/1/26 and repeated the test. Again, the test strip failed to change color and was less than 10 PPM according to the color scale on the bottle.</p> <p>2. The surveyor requested the monthly temperature (temp) dish machine log. A review of the high temp dish machine log revealed the following: on 1/28/25 the temperature at breakfast for the wash cycle was 146 F and rinse cycle was 94 F; on 1/29/25 the wash cycle temp was 145 F, and the rinse cycle was 95 F.</p> <p>3. On 1/29/25 at 10:38 AM, the surveyor observed the [US FOIA (b)] not wearing a hair net.</p> <p>On 1/29/25 at 10:09 AM, the surveyor interviewed DA #1 who stated that the dishwasher was not tested today (1/29/25). DA #1 then stated that they did not record the chlorine test strips only the temperatures of the dish machine and the sink. DA #1 stated that the [US FOIA (b)] was aware of the issue with the dish machine.</p> <p>On 1/29/25 at 10:38 AM, the surveyor interviewed the [US FOIA (b)] who stated that there were lime deposits</p>	F 812	<p>concentration of 50□100 PPM.</p> <p>The maintenance team has performed a complete de-liming of the dishwasher to address any issues with lime deposits, which were identified as a contributing factor.</p> <p>The expired chemical test strips were discarded and replaced immediately, and proper test strips will be used to monitor sanitizer levels daily. These strips will be stored properly, and their expiration dates will be monitored regularly.</p> <p>Staff will be retrained on the proper use and testing of chlorine test strips to verify sanitizer concentration.</p> <p>The [US FOIA (b)] was immediately re-educated on the importance of wearing a hair net at all times while in the kitchen.</p> <p>All residents residing in the facility have the potential to be affected by the identified deficient practices. A comprehensive review has been conducted by the Director of Nursing 30 days prior to the identified deficient practice and no residents were found to have had a food borne illness or infection related to dishwasher temperatures and chemical sanitizer malfunctioning. The dishwasher was immediately repaired on 1/29/25 by the Director of Maintenance.</p>		

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F 812	<p>Continued From page 38</p> <p>affecting the dish machine and the temperatures. She stated that the wash cycle should be 150 F or above, the rinse cycle should be 180 F and above, or the chemical sanitizer should be 50 PPM or above. The [US FOIA (b)] stated that the importance of this was to prevent food borne illnesses. The [US FOIA (b)] also stated that a hair net should be worn in the kitchen for safe handling practices.</p> <p>On 2/4/24 at 9:16 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the expectation for the dish washer who be it reached the required temperatures and if it did not then it should go into the chemical sanitizer. The [US FOIA (b)(6)] stated that the chemical sanitizer should reach 50 -100 PPM. The [US FOIA (b)(6)] stated that if the facility had to use chemical sanitizer, they would utilized it before every meal. The [US FOIA (b)(6)] emphasized he was unaware that it was not being tested. He then stated that the dishwasher was "the heart of the kitchen." The [US FOIA (b)(6)] stated that his expectation for anyone walking in the kitchen was to wear a hair net, so that hair follicles did not fall into the food and cause contamination.</p> <p>A review of the undated facility's manufacturer specifications for the dish machine included, "high temperature dish machine the wash temperature is to be between 150 - 165 F and the rinse temperature 180F ...if low temperature or using chemical sanitize that the wash be 120F and that the chemical reads 50 PM Hydrochloride."</p> <p>A review of the facility's undated "Maintenance of the Dish Machine" policy included, "Dish machine will be properly maintained to assure proper functioning ... the dish machine will be regularly</p>	F 812	<p>All kitchen staff, including Dietary Aides and Food Service Director have been re-educated by the Licensed Nursing Home Administrator on the importance of proper sanitization practices, including the necessary temperatures for the dishwasher and the proper use of chemical sanitizers.</p> <p>All kitchen staff have been educated by the Licensed Nursing Home Administrator on the importance of wearing hair nets to prevent food contamination. This will be strictly enforced, and failure to comply will result in immediate corrective action.</p> <p>The Dish Machine Temperature Log will be updated daily, including both temperature readings and chemical sanitizer levels for every wash cycle. The FSD will review the logs weekly for compliance and act immediately if readings are out of range.</p> <p>The Director of Maintenance and Food Service Director will conduct a daily review of the dishwashing process to ensure that both temperature and chemical sanitizer levels are within required ranges. If issues persist, alternative cleaning methods will be implemented as needed.</p> <p>The FSD or designee will conduct weekly sanitation audits x 4 weeks, then monthly x 3 months to ensure the proper function and sanitization of the dish machine, kitchen equipment, cleanliness, and staff adherence to donning hair nets before</p>		

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F 812	Continued From page 39 cleaned and de-limed as needed." A review of the undated facility's "Dish Machine Temperature Log" policy, included, "the dishwasher staff will monitor and record dish machine temperature to assure proper sanitizing of dishesthe FSD will promptly assess any dish machine problems and act immediately to assure the sanitation of dishes." NJAC 8:39-17.2(g)	F 812	entering the kitchen and food safety protocols. The Regional FSD or designee will conduct ongoing quarterly reviews of the food safety practices in the kitchen to ensure continued compliance with all sanitation and food safety standards. The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for ongoing monitoring.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880			3/18/25

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F 880	<p>Continued From page 40</p> <p>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:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</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</p>	F 880			

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F 880	<p>Continued From page 41 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: Based on observation, interview, and review of facility documents, it was determined that the facility failed to maintain proper infection control practices to ensure a.) staff performed appropriate hand hygiene while donning (putting on) and doffing (removing) gloves for 1 of 1 staff member observed, and b.) NJ Exec Order 26.4b1 [REDACTED] was initiated for 1 of 1 resident (Resident #24).</p> <p>This deficient practice was evidenced by the following:</p> <p>1.) On 1/29/2025 at 10:06 AM, during the initial tour of the [REDACTED] Unit, the surveyor observed the Environmental Services staff member (EVS #1) exit resident room [REDACTED] doffed gloves, disposed them in the garbage and donned another pair of gloves without performing hand hygiene, EVS #1 then entered resident room [REDACTED]</p> <p>At 10:08 AM, the surveyor observed EVS #1 exit room [REDACTED] doffed gloves, disposed the gloves in the garbage, donned another pair of gloves again without performing hand hygiene and entered room [REDACTED]</p> <p>On 1/29/2025 at 10:12 AM, the surveyor interviewed EVS #1 upon exiting room [REDACTED] who stated that gloves were changed twice during the cleaning of a resident's room; after cleaning the bathroom and after cleaning the room. EVS #1</p>	F 880	<p>Resident #24 remains in the facility. Resident # 24's NJ Exec Order 26.4b1 [REDACTED] was discontinued and removed on NJ Exec Order 26.4b1. Resident #24 was placed on NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 due to a NJ Exec Order 26.4b1. Environmental Services staff #1 was re-educated immediately by the Infection Preventionist (IP) Nurse on proper hand hygiene technique including when to perform hand hygiene. All residents who reside in the facility have the potential to be affected by improper hand hygiene of staff. Hand-hygiene audits were conducted by the IP Nurse and determined that staff were performing hand-hygiene per the facility policy. No other residents were affected by this deficient practice. Residents who have chronic wounds and/or midline IV catheters have the potential to be affected by the deficient practice of not placing them on EBP. A comprehensive review of residents with chronic wounds and/or midline IV catheters has been conducted by the Regional Nurse and IP nurse and all have EBP in place. All Environmental Service staff were re-educated on proper hand hygiene techniques including when to perform hand hygiene by the IP Nurse.</p>		

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F 880	<p>Continued From page 42</p> <p>was not able to speak to the process of hand hygiene for donning and doffing gloves.</p> <p>On 1/31/2025 at 10:43 AM, the surveyor interviewed the US FOIA (b)(6), who stated that hand hygiene should be performed before donning and after doffing gloves. The US FOIA (b)(6) then stated that gloves should be changed between rooms and hand hygiene should be performed. He stated that education was provided upon hire, anytime there was a change in policy and as needed. He then stated that the US FOIA (b)(6) educated the environmental services staff on hand hygiene.</p> <p>On 1/31/2025 at 10:56 AM, the surveyor interviewed the US FP who stated that the importance of hand hygiene was to prevent infections. She stated that hand hygiene should be performed before and after resident care, when exiting a room and finished with the resident, when delivering meal trays, contact with any types of fluids, and before donning and after doffing gloves. The US FP also stated that education was provided to environmental services staff on hand hygiene and a Spanish speaking translator was utilized if needed.</p> <p>On 2/3/2025 at 11:11 AM, the surveyor interviewed the US FOIA (b)(6), who stated that hand hygiene should be performed prior to anything with resident care, before donning and after doffing gloves, and between residents' rooms. The US FOIA (b)(6) also stated that hand hygiene education was given annually to staff and that US FP conducted random audits.</p> <p>On 2/4/2025 at 10:16 AM, the US FOIA (b)(6)</p>	F 880	<p>All licensed nursing staff have been educated by the IP Nurse to implement Enhanced Barrier Precautions for residents with Midline IV catheters and/or chronic wounds.</p> <p>The EBP policy was reviewed and updated as needed for the midline catheters and chronic wounds.</p> <p>The IP Nurse or designee will conduct weekly audits x 4 weeks, then monthly x 3 months for residents with chronic wounds and/or midline IV catheters to ensure that they have Enhanced Barrier Precautions in place.</p> <p>The Environmental Services Director or designee will conduct weekly hand hygiene observations x 4 weeks, then monthly x 3 months on three EVS staff to ensure they are completing hand hygiene properly and at the correct times.</p> <p>The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring.</p>		

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F 880	<p>Continued From page 43</p> <p>US FOIA (b)(6), in the presence of the US FOIA (b) and the survey team, acknowledged the above findings.</p> <p>A review of facility's "Hand Hygiene Policy" dated 3/19/24, included, "Hand Hygiene Guidelines When to Perform Hand Hygiene ... F. Decontaminate hands before entering a patient room. G. Decontaminate hands upon exiting a patient room ... J. Decontaminate hands before reaching into a glove box to obtain gloves ... u. Decontaminate hands after removing gloves."</p> <p>A review of facility's "Inservice Record/Meetings" policy dated 12/20/2024, included, "Topic(s) hand hygiene...Discussion: Preventing infections, hand sanitizer versus [vs] soap and water, gloves." It further reflected it was signed by EVS#1.</p> <p>2.) On 1/29/2025 at 10:51 AM, during tour of the NJ Exec Order 26.4b1 Unit the surveyor observed Resident #24 with and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1 No NJ Exec Order 26.4b1 signage was observed posted inside or outside the resident's room.</p> <p>On 1/30/2025 at 10:09 AM, the surveyor reviewed the physician's orders (PO) for Resident #24, which included the following: A PO dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1</p>	F 880			

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F 880	<p>Continued From page 44</p> <p>A PO dated [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b1] every shift & document site appearance, and any signs and symptoms (s/s) of [NJ Exec Order 26.4b1] every shift for [NJ Exec Order 26.4b1] every shift and document.</p> <p>A PO, dated [NJ Exec Order 26.4b1]</p> <p>A review of the individual comprehensive care plan (ICCP) included a focus area dated [NJ Exec Order 26.4b1], that the resident has the potential for complications related to [NJ Exec Order 26.4b1]. Interventions included, monitor for [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1].</p> <p>On 1/31/2025 at 10:55 AM surveyor interviewed the [US FOIA (b)] who stated resident #24, should have been on [NJ Exec Order 26.4b1] with the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1].</p> <p>On 2/3/2025 at 11:11 AM, the surveyor interviewed the [US FOIA (b)] who stated that for residents on [NJ Exec Order 26.4b1] signage should be posted and added to the ICCP. She then the [US FOIA (b)] would oversee to ensure the signage was posted. The [US FOIA (b)] stated [NJ Exec Order 26.4b1] should be [NJ Exec Order 26.4b1].</p> <p>[NJ Exec Order 26.4b1] was a [NJ Exec Order 26.4b1].</p> <p>Reference: Center for Disease Control and Prevention, Long-Term Care Facilities, document titled "Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes" dated June 28, 2024, states, " ...22. What is the definition of "indwelling medical device"? An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of</p>	F 880			

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F 880	<p>Continued From page 45</p> <p>indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)) ... Although the data are limited, CDC does not currently consider peripheral I.V.s (except for midline catheters) ... as indications for Enhanced Barrier Precautions ..."</p> <p>A review of the facility's undated "Enhanced Barrier Precautions" policy included, states, "Procedure EBP is used in conjunction with standard precautions and expand the use of PPE [personal protective equipment] to don gown and gloves during high-contact resident care activities...EBP is targeted to these highest risk activities...wound and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO [multi-drug resistant organisms]..."</p> <p>A review of the facility's "Infection Prevention and Control Plan 2024" policy dated 3/27/23 included, "Goals for the Infection Prevention and Control Program are: 1. To provide a safe, clean environment for staff, residents and visitors and to institute measures to prevent acquisition of infection that may jeopardize the resident's recovery...12. To reduce cross contamination throughout [facility name]...Development of Goals...4. To identify and prevent transfer of infections...among residents, staff team members...This is accomplished by using, but not limited to, standard precautions, aseptic technique and any addition isolation precautions as needed and appropriate."</p> <p>NJAC 8:39-19.4(n)</p>	F 880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER ROLLING HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16 CRATETOWN ROAD LEBANON, NJ 08833		
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F 921 SS=D	<p>Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)</p> <p>§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain a safe and sanitary food storage room. This deficient practice was identified in 1 of 1 emergency food storage rooms and was evidenced as follows:</p> <p>On 1/31/2025 at 10:00 AM, the surveyor and the US FOIA (b)(6)) toured the emergency food storage room in the basement. The surveyor heard intermittent liquid dripping and observed a brown puddle of liquid on the floor. In the nearby vicinity, an open box containing serving utensils and two (2) boxes of coffee cup lids and were located on the lower shelf. The boxes appeared to be disfigured and discolored containing brown splatter marks.</p> <p>At the same time, the surveyor observed an opening in the ceiling near the window. Two brown long drip lines were noted on the wall. The surveyor further observed crates that contained numerous soiled gallon water bottles.</p> <p>At that time, the surveyor interviewed the US FOIA (b)(6) who stated that nothing should leak into the emergency food supply, the serving utensils, or the boxes of lids.</p> <p>On 1/31/2025 at 11:37 AM, the surveyor interviewed the US FOIA (b)(6))</p>	F 921	<p>No residents were identified to have been affected by the deficient practice. The brown puddle of liquid on the floor was immediately removed and the entire area cleaned. The open boxes of serving utensils and two (2) boxes of coffee cup lids were immediately discarded. The opening in the ceiling near the window has been repaired and the soiled gallon water bottles were all discarded and replaced.</p> <p>All residents residing in the facility have the potential to be affected by the deficient practice of a safe and sanitary emergency food storage room in the facility.</p> <p>The US FOIA (b)(6) have been re-educated by the Licensed Nursing Home Administrator on the "Storage Areas" policy that includes that food should be stored in an area that is clean, dry and free from contaminants. The Storage Areas Policy has been reviewed and revised to check the emergency storage area weekly to ensure the area is clean and dry and free from contaminants.</p> <p>The Director of Maintenance or designee</p>		3/18/25

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

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F 921	<p>Continued From page 47</p> <p>who stated that the building should be intact and there should not be any leaks.</p> <p>A review of the Corporate-led rounds on 1/26/25 revealed that pooling was noted on the floor of the emergency food storage room, and water gallons were in crates with water damage and debris.</p> <p>On 2/3/2025 at 11:07 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of the US FOIA (b)(6) and the survey team, who acknowledged that anything hazardous to the residents should be addressed in a timely manner. He further stated that the condition of the building should be kept nice, and any concerns should be brought to the attention of the US FOIA (b)(6) right away.</p> <p>A review of the facility's undated "Storage Areas" policy included, "Food is stored in an area that is clean, dry and free from contaminants."</p> <p>NJAC 8:39-31.4(a)</p>	F 921	<p>will conduct a daily audit x 4 weeks, then weekly x 3 months to ensure the emergency storage area is clean, dry and free from contaminants.</p> <p>The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring.</p>		

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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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ#'s: 174181 and 174259 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 3 of 3 weeks of complaint staffing and 2 of 2 weeks of staffing prior to the recertification survey dated 2/6/25 and b.) have two (2) trained and appointed designated staff members and train facility staff within the required time frames for the Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female	S 560	No residents were identified as being negatively impacted by these practices. All facility residents had the potential to be impacted by these practices. An audit of the last three months of grievance forms was reviewed and identified no issues related to LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning, Intersex and HIV+) concerns. It was determined that no residents were impacted by this practice. A review of resident care records for the time periods 05/19/2024 to 06/08/2024 and 01/12/2025 to 01/25/2025 was conducted. No complaints or grievances	3/18/25

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

TITLE

(X6) DATE

Electronically Signed

03/03/25

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S 560	<p>Continued From page 1</p> <p>biological traits] positive (LGBTQI+) and Human Immunodeficiency Virus positive [HIV+: a virus that attacks cells that help the body fight infection]) program.</p> <p>This deficient practice was evidenced by the following:</p> <p>1.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift.</p> <p>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</p> <p>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.</p> <p>A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following:</p> <p>1. For the 3 weeks of Complaint staffing from 05/19/2024 to 06/08/2024, the facility was</p>	S 560	<p>related to resident care on the day shifts were discovered. This indicates that no residents were adversely affected by the deficient practice.</p> <p>The Licensed Nursing Home Administrator was re-educated by the Vice President of Clinical Services that the facility must maintain one administrative staff and one direct care staff member at the facility who has completed general training for the LGBTQI+ program. The Infection Preventionist Nurse has completed the required LGBTQIP+ training on 02/16/2025 and is now the second certified staff member. In the event one of the certified team members terminates employment, another administrative staff or direct care staff member will be selected and certified to maintain compliance.</p> <p>To prevent recurrence of the staffing shortage, the facility has implemented the following measures:</p> <p>Education & Accountability: The Staffing Coordinator has received thorough re-education by the Director of Nursing on The State of New Jersey Department of Health requirement on the minimum ratio of one Certified Nurse Aide (CNA) to every eight residents for day shift and one Certified Nurse Aide (CNA) to every fourteen residents for the overnight shift.</p> <p>Proactive Staffing: The Staffing Coordinator/Designee will conduct daily assessments of staffing needs to proactively identify and address potential shortages.</p> <p>Contingency Plan: In the event of a CNA shortage where the ratio of one CNA to</p>	

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S 560	Continued From page 2 deficient in CNA staffing for residents on 19 of 21 day shifts and deficient in total staff for residents on 3 of 21 overnight shifts as follows: -05/19/24 had 3 CNAs for 63 residents on the day shift, required at least 8 CNAs. -05/20/24 had 4 CNAs for 62 residents on the day shift, required at least 8 CNAs. -05/21/24 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -05/22/24 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -05/23/24 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -05/24/24 had 5 CNAs for 62 residents on the day shift, required at least 8 CNAs. -05/25/25 had 5 CNAs for 65 residents on the day shift, required at least 8 CNAs. -05/26/24 had 4 CNAs for 65 residents on the day shift, required at least 8 CNAs. -05/26/24 had 4 total staff for 65 residents on the overnight shift, required at least 5 total staff. -05/27/24 had 4 CNAs for 64 residents on the day shift, required at least 8 CNAs. -05/28/24 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs. -05/29/24 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs. -05/30/24 had 4 CNAs for 64 residents on the day shift, required at least 8 CNAs. -05/31/24 had 3 CNAs for 65 residents on the day shift, required at least 8 CNAs. -05/31/24 had 4 total staff for 65 residents on the overnight shift, required at least 5 total staff. -06/01/24 had 4 CNAs for 65 residents on the day shift, required at least 8 CNAs. -06/01/24 had 3 total staff for 65 residents on the overnight shift, required at least 5 total staff.	S 560	every eight residents on day shift and one CNA to every fourteen residents on the overnight shift will not be met, a multi-pronged plan is in place: The nurse manager/supervisors will recruit CNA staff from the previous or upcoming shift to work, The Staffing Coordinator and nurse management have the authority to utilize agency companies for staffing support, and The CNA supply clerk may be reassigned to assist with providing direct resident care. Recruitment: The facility is actively recruiting new employees. Strategies include offering referral and sign-on bonuses, utilizing online advertisements, and recruiting candidates from local CNA training programs. The Administrator will notify the QAA Committee who the two LGBTQIP+ team members are and any changes or plans for additional training of staff at each QAA meeting to ensure continuous monitoring and prevent recurrence for the next two quarters. The Administrator or their designee will conduct weekly audits for 4 weeks of the CNA staffing schedule to determine compliance. Audits will then transition to monthly for 3 months to ensure sustained compliance. Audit findings and any corrective actions taken will be reviewed during the next two quarterly Quality Assessment and Assurance (QAA) meetings to ensure continuous monitoring and prevent recurrence.	

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S 560	<p>Continued From page 3</p> <p>-06/02/24 had 5 CNAs for 64 residents on the day shift, required at least 8 CNAs.</p> <p>-06/03/24 had 5 CNAs for 63 residents on the day shift, required at least 8 CNAs.</p> <p>-06/04/24 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs.</p> <p>-06/05/24 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.</p> <p>-06/07/24 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs.</p> <p>2. For the 2 weeks of staffing prior to survey from 01/12/2025 to 01/25/2025, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows:</p> <p>-01/12/25 had 3 CNAs for 61 residents on the day shift, required at least 8 CNAs.</p> <p>-01/16/25 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs.</p> <p>-01/17/25 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs.</p> <p>-01/18/25 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs.</p> <p>-01/19/25 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.</p> <p>-01/20/25 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.</p> <p>-01/25/25 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs.</p> <p>On 2/3/25 at 12:07 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM-3:00 PM shift, one CNA for ten residents on the 3:00 PM-11:00 PM shift, and one CNA for fourteen residents on the 11:00 PM-7:00 AM shift. The SC stated that some days she was able to</p>	S 560		

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S 560	<p>Continued From page 4</p> <p>meet the staffing mandates except for when there were last minute call outs. The SC stated that she was also a CNA with a resident assignment and was assigned to twelve residents. The SC stated that she had eleven residents who required total assistance and she still had one resident that she had not yet provided care to.</p> <p>On 2/3/25 at 12:52 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM-3:00 PM shift, one CNA for ten residents on the 3:00 PM-11:00 PM shift, and one CNA for fourteen residents on the 11:00 PM-7:00 AM shift. The LNHA stated that the facility tried to meet the staffing ratios daily.</p> <p>A review of the facility's "Contingency Staffing Plan" created 8/1/24, included: Policy: To assure that there is sufficient qualified staff available at all times to provide nursing and related services in conjunction with other essential personnel to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being, as determined by residents assessments and individual plans of care: and considering the number, acuity and diagnoses of the facility's population in accordance with the facility assessment...</p> <p>2.) Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The</p>	S 560		

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S 560	<p>Continued From page 5</p> <p>memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021, and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking.</p> <p>Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+") older adults and people living with HIV ("HIV+") in long-term care facilities ("Facilities").</p> <p>The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status.</p> <p>Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status:</p> <ol style="list-style-type: none"> 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 	S 560		

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S 560	Continued From page 6 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R.	S 560			

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S 560	<p>Continued From page 7</p> <p>483.10(c)(6).</p> <p>Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.</p> <p>Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed.</p> <p>Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties.</p> <p>Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility.</p>	S 560			

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S 560	<p>Continued From page 8</p> <p>Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling.</p> <p>Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action.</p> <p>Training Facilities shall designate two employees, including one employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey.</p> <p>The required training shall address:</p> <ol style="list-style-type: none"> 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or 	S 560			

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER ROLLING HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16 CRATETOWN ROAD LEBANON, NJ 08833		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 560	<p>Continued From page 9</p> <p>about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns;</p> <p>5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community;</p> <p>6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and</p> <p>7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training.</p> <p>On 1/29/25 at 9:47 AM, during the entrance conference with the Licensed Nursing Home Administrator (LNHA), the surveyor requested a copy of the two certified staff members and the most recent training for all staff members related to LGBTQI+.</p> <p>On 1/30/25 at 12:33 PM, the surveyor interviewed the LNHA who stated they did not have the two certified LGBTQI+ representatives as the second certified staff member no longer worked at the facility. The LNHA stated it was important to have the two certified staff members and all staff members educated because it was a regulation. He then stated they wanted to ensure the</p>	S 560			

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S 560	Continued From page 10 residents and staff were treated right. The LNHA acknowledged they should have two certified staff members and recent training related to the LGBTQI+. On 2/4/25 at 10:17 AM, the LNHA in the presence of the Director of Nursing (DON) and the survey team stated that the last entire staff education for the LGBTQI+ was November 2023 and the second staff member was scheduled to enroll in the 2/7/25 certification training. The facility was unable to provide a policy related to LGBTQI+.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day	S1680		3/18/25

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S1680	Continued From page 11 Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680			

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S1680	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the Nursing Staffing Reports for the two weeks prior to survey from 1/12/2025 to 1/25/2025, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows:</p> <p>The facility was deficient in Registered Nurse (RN) staffing hours as follows:</p> <p>For the week of 1/12/25 Required Total Staffing Hours:174.75</p> <p>-On 1/12/25 the facility had 152 actual staffing hours, for a difference of -22.75 hours.</p> <p>A review of the facility's "Contingency Staffing Plan" created 8/1/24, included: To assure that there is sufficient qualified staff available at all times to provide nursing and related services in conjunction with other essential personnel to meet the resident's needs safely in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care; and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment...</p>	S1680	<p>No residents were identified as being affected by the deficient practice of minimum Registered Nurse staffing levels not being met.</p> <p>All residents have the potential to be affected by the deficient practice of minimum Registered Nurse staffing levels not being met.</p> <p>A comprehensive clinical review of the week of 1/12/2025 has been completed by the Regional Nurse Consultant (RNC) and no significant care issues were identified as a result of the Registered Nurse staffing hours being 22.75 hours below the required State of New Jersey minimum. The Staffing Coordinator and the Director of Nursing have been educated by the RNC on the Mandatory Nurse Staffing requirement of providing nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provided more than the minimum hours required at N.J.A.C. 8:29-25.1 (a), with emphasis on how to calculate the registered nurse hours required to meet the care needs of residents residing in the facility.</p> <p>The Director of Nursing or designee will audit nurse staffing levels weekly x 4 weeks, then monthly x 3 months to ensure that the facility meets the Mandatory Nurse Staffing requirements per N.J.A.C.</p>	

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S1680	Continued From page 13	S1680	8:39-25.1 (a). The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring.	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315302	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/2/2025	Y3
NAME OF FACILITY ROLLING HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16 CRATETOWN ROAD LEBANON, NJ 08833		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0623	Correction	ID Prefix F0625	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.15(d)(1)(2)	Completed
LSC	03/18/2025	LSC	03/18/2025	LSC	03/18/2025
ID Prefix F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0692	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	03/18/2025	LSC	03/18/2025	LSC	03/18/2025
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix F0921	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)	Completed
LSC	03/18/2025	LSC	03/18/2025	LSC	03/18/2025
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 2/7/2025		<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 061004	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/2/2025	Y3
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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	03/18/2025	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 <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 2/7/2025		<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 061004	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/2/2025
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1680	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed	Reg. #	Completed
LSC	03/18/2025	LSC	03/18/2025	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 <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 2/7/2025		<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			

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

PRINTED: 08/15/2025
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments	E 000			
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 2/5/25 and 2/7/25. Rolling Hills Care Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.</p> <p>Rolling Hills Care Center was built in 90's. It is composed of Type II construction. The facility is divided into 7- smoke zones. The generator powers approximately 80% of the building and the fuel source is propane.</p> <p>The building utilizes propane as a fuel source for heating and cooking.</p> <p>The fire sprinkler system is provided water from an underground water pump to a water storage tank under pressure.</p> <p>The facility has 67 licensed beds with a census of 59 residents.</p> <p>The facility was informed that due to the ongoing K-252 deficiency, a new updated FSES must be completed.</p>	K 000			

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

TITLE

(X6) DATE

Electronically Signed

03/03/2025

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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K 252 SS=D	<p>Number of Exits - Corridors CFR(s): NFPA 101</p> <p>Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/05/25 in the presence of the US FOIA (b)(6) it was determined that the facility's partial basement was not provided with two (2) acceptable and remote exits in accordance with NFPA 101: 2012 Edition, Section 7.4.1.1, 7.5, 7.5.1.3 and 19.2.4. This deficient practice had the potential to affect staff providing services to residents and was evidenced by the following:</p> <p>An observation at 11:33 AM of the partial basement under the kitchen, revealed the the primary and secondary exits in the basement were located in the same general area. The primary exit was a stairway leading to the 1st floor. The secondary exit was through a set of metal Bilko doors leading to the building's exterior. The building's mechanical systems, fire suppression system, a maintenance shop and the dietary emergency food supply storage were located in this basement. Residents were prevented access to the basement by a locked door that required a restricted key-code to open.</p>	K 252	<p>All Residents had the potential to be affected. No residents were affected, as the basement remains secured with restricted access.</p> <p>The facility has scheduled a Fire Safety Evaluation System (FSES) survey with a certified consultant to determine compliance alternatives. The Fire Safety Evaluation System (FSES) was completed on 3/26/25.</p> <p>Temporary measures include enhanced staff training on emergency egress and clear exit signage.</p> <p>The US FOIA (b)(6) was educated by the Licensed Nursing Home Administrator on the regulatory requirements regarding corridors needing two exits.</p> <p>The Maintenance Director will conduct monthly exit inspections for a period of six months, ensuring compliance with NFPA 101.</p> <p>Quarterly Life Safety Code audits will be</p>		3/26/25

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K 252	Continued From page 2 In an interview at the time, the US FOIA confirmed the observation. The Administrator was informed that a new updated FSES (Fire Safety Evaluation System) survey must be completed or the deficient practice would require correction. The US FOIA (b)(6) confirmed they were aware of the FSES needing to be updated annually as a Plan of Correction. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference at 1:21 PM on 02/07/25.	K 252	conducted, with findings reported to the QAPI Committee for review every three months for a period of six months. The Administrator and Maintenance Director will oversee progress and ensure corrective actions are completed. Compliance will be maintained through ongoing staff education and annual FSES updates.		
K 353 SS=F	NJAC 8:39-31.2(e) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353			3/26/25

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K 353	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review on 02/05/25 and 02/07/25 in the presence of the US FOIA (b)(6), it was determined the facility failed to ensure the automatic dry pipe sprinkler system was maintained, inspected and tested once every 3 years for air leakage, in accordance with NFPA 25: 2011 Edition, Section 5.2.1 and 13.4.4.2.9. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Observations during a facility tour on 02/05/25 from 10:08 AM to 12:00 PM revealed:</p> <ol style="list-style-type: none"> 1. In the utility/biohazard room, the ceiling sprinkler head escutcheon plate was coming down 3/4-inch. 2. In the Medication supply room, the ceiling sprinkler head escutcheon plate was coming down. 3. The linen room the ceiling sprinkler head escutcheon plate was coming down. 4. In the activities room, two of 15 ceiling sprinkler head escutcheon plates were coming down. 5. In room N5, one of two sprinkler head escutcheon plates was coming down 1/2-inch. 6. In the boiler closet off laundry, a sprinkler head escutcheon plate was coming down 5/8-inch. 7. In the social services room, one of two sprinkler head escutcheon plates were coming down 5/8-inch. 	K 353	<p>No residents were identified to have been affected by the deficient practice. The facility contracted with a fire protection company to perform an Air Leakage Test on the dry pipe sprinkler system in accordance with NFPA 25 (2011 Edition), Section 13.4.4.2.9. This test will be completed by 3/25/25. The escutcheon plates identified as loose or improperly positioned were secured/repared in the utility/biohazard room, the Medication supply room, the linen room, two in the activities room, resident room N5, the broiler closet off laundry, the social services room, resident room S16 and S19.</p> <p>All residents who reside in the facility have the potential to be affected by the deficient practice. A facility-wide inspection was conducted by the Maintenance Director to ensure that all sprinkler escutcheon plates were properly installed and that no additional deficiencies existed. No other areas requiring corrective action were identified.</p> <p>The US FOIA (b)(6) received re-education from the Licensed Nursing Home Administrator on NFPA 25 requirements, including the mandatory three-year Air Leakage Test for dry pipe systems. The facility's contracted fire protection company has been instructed to include the Air Leakage Test in scheduled</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315302	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER ROLLING HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16 CRATETOWN ROAD LEBANON, NJ 08833		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 353	Continued From page 4 8. In room S16, one of two sprinkler head escutcheon plates were coming down 1-inch. 9. In room S19, one of four ceiling sprinkler head escutcheon plates was coming down 3/4-inch. In interviews at the times, the [US FOIA (b)(6)] confirmed the observations. A record review on 02/05/25 of the facilities fire sprinkler system's inspection, testing and maintenance reports revealed there was no report that an Air Leakage Test was performed on the dry pipe sprinkler system once every 3 years in accordance with NFPA 25, Chapter 13. In an interview at the time, the [US FOIA (b)(6)] [REDACTED] confirmed the record review. In an interview on 02/07/25 at 11:35 AM, the [US FOIA (b)(6)] [REDACTED] stated he did not think that an Air Leakage Test was required every 3 years on the dry pipe system and confirmed that the test was not performed. The facility's [US FOIA (b)(6)] was informed of the deficient practice during the Life Safety Code exit conference on 02/07/2025 at 1:21 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 25 HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall	K 353	inspections and provide written documentation for compliance records. The facility has implemented a preventive maintenance checklist to ensure that all sprinkler components, including escutcheon plates, are properly maintained and inspected monthly for a period of 6 months. This will include all sprinkler heads in the facility. The Maintenance Director or designee will conduct monthly audits x 4 of sprinkler escutcheon plates to ensure they are properly installed. The Licensed Nursing Home Administrator (LHNA) or designee will review sprinkler system maintenance records quarterly for a period of six months to ensure that required testing and maintenance are completed timely. Audit findings will be reported in the facility's Quarterly Quality Assurance and Performance Improvement (QAPI) meetings x 2 quarters for review and further recommendations as needed.		
K 521 SS=D		K 521			3/18/25

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

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K 521	<p>Continued From page 5</p> <p>comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/05/2025 in the presence of the [US FOIA (b)(6)] it was determined the facility failed to provide adequate ventilation by mechanical means or by means of a window for a resident bathroom in accordance with NFPA 101: 2012 Edition and NFPA 90A: 2012 Edition. This deficient practice had the potential to affect 2 residents and was evidenced by the following:</p> <p>An observation at 10:41 AM of resident room N2 revealed the bathroom in room N2 did not have a window and did not have an exhaust fan.</p> <p>In an interview at the time, the [US FOIA (b)(6)] confirmed the observation.</p> <p>The facility's [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 02/07/2025 at 1:21 PM.</p> <p>NJAC 8:39-31.8 (a) NFPA 90A</p>	K 521	<p>No residents were identified to have been affected by the deficient practice. The facility installed a mechanical exhaust vent in the bathroom of resident room N2 to ensure adequate ventilation, in compliance with NFPA 101 (2012) and NFPA 90A (2012).</p> <p>All residents who reside in the facility have the potential to be affected by the deficient practice. A facility-wide audit of resident rooms was conducted by the maintenance director to ensure all bathrooms without windows are equipped with functioning mechanical exhaust systems. No other deficiencies were identified.</p> <p>The Maintenance Director or designee will conduct an ongoing monthly inspection of all resident room bathrooms to verify proper ventilation. Any identified issues will be addressed immediately, and findings will be reported at the facility's Quarterly Quality Assurance and Performance Improvement (QAPI) meeting. The Licensed Nursing Home Administrator (LHNA) has re-educated the</p>		

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K 521	Continued From page 6	K 521	<p>US FOIA (b)(6) on regulatory requirements related to ventilation under NFPA 101 and NFPA 90A.</p> <p>The Licensed Nursing Home Administrator (LNHA) or designee will conduct random audits on 10 resident room ventilation systems quarterly for six months to ensure compliance. The results of these audits will be reviewed in the Quarterly Quality Assurance Meeting x 2 quarters for further recommendations and the need for ongoing monitoring.</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315302	MULTIPLE CONSTRUCTION A. Building 02 - BUILDING B. Wing	DATE OF REVISIT 5/9/2025
NAME OF FACILITY ROLLING HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 16 CRATETOWN ROAD LEBANON, NJ 08833	

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0252	03/26/2025	LSC K0353	03/26/2025	LSC K0521	03/18/2025
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 2/7/2025		<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			