

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

PRINTED: 03/05/2024
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 11/22/2023	
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
E 000	Initial Comments			E 000			
F 000	<p>This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.</p> <p>INITIAL COMMENTS</p> <p>Complaints#: NJ00154003, NJ00166500, and NJ00166531</p> <p>Survey Date: 11/22/23</p> <p>Census: 62</p> <p>Sample: 16 (sample) + 3 (Closed Records) + 9= 28</p> <p>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.</p>			F 000			
F 584 SS=D	<p>Safe/Clean/Comfortable/Homelike Environment</p> <p>CFR(s): 483.10(i)(1)-(7)</p> <p>§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.</p> <p>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.</p>			F 584			1/3/24

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

TITLE

(X6) DATE

Electronically Signed

12/15/2023

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

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F 584	<p>Continued From page 1</p> <p>(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.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ00166500</p> <p>Based on observations, interview, record review, and review of other pertinent facility documents, the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft by failing to ensure resident's personal belongings were labeled and inventoried for one</p>	F 584	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. Resident # 214, NJ Ex Order 26.4(b)(1) in the facility. Resident #214's family will be contacted and re-imbursed for the value of the missing clothing items that were unable to be located at discharge due to the personal belongings inventory sheet</p>		

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F 584	<p>Continued From page 2</p> <p>(1) of five (5) residents sampled for closed records (Resident #214).</p> <p>This deficient practice was evidenced by the following:</p> <p>The surveyor reviewed the medical records of Resident #214.</p> <p>Resident #214's closed record included the following Progress Note: Resident #214 was discharged at 6:00 PM today with the [U.S. FOIA (b)(6)] but was unable to find resident's clothes that he/she came with [REDACTED] searched resident's room and also laundry area but couldn't [could not] find any clothing, not really clear it [if] clothes were labeled ...</p> <p>A review of Resident #214's Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [REDACTED]</p> <p>Resident #214's Comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b1] indicated a Brief Interview for Mental Status (BIMS) score of [NJ Exec Order 26.4b1], which reflected that the resident's NJ Exec Order 26.4b1.</p>	F 584	<p>not being filled out, clothing not being labeled with the resident's name and staff not communicating that the items were missing.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. All residents have the potential to be affected by the deficient practice. A comprehensive review of current residents will be conducted by unit clerk or designee to ensure that a personal inventory sheet is completed, and that clothing is properly labeled with the resident's name.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. All current staff will be re-educated by the facility educator or designee on the procedure of filling out the Personal Belongings Inventory List and having the items labeled with the resident name and the procedure for when and how to fill out a grievance form for any missing items that are reported by the resident or their responsible party. New staff will be educated during orientation and the agency orientation packet will be updated to include the procedure for filling out the Personal Belongings Inventory list and how and when to fill out a grievance form for any items that are reported missing. The personal belonging inventory list for all new admissions will be reviewed in the daily morning department head meeting</p>		

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F 584	<p>Continued From page 3</p> <p>On 11/17/23 at 9:03 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the process for resident's clothing and missing items. The U.S. FOIA (b)(6) stated that the resident's clothing were to be labeled. He added that the family brought in the clothing and that the clothing was labeled by the nurse and that it was documented on a clothing sheet but that he was not sure where the document was kept. The U.S. FOIA (b)(6) then stated that usually the family will report a missing item and that the laundry department was made aware. The U.S. FOIA (b)(6) added that he did not know if there was a document or log that was kept for missing items.</p> <p>On 11/20/23 at 10:25 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the process for resident's clothing and missing items. The U.S. FOIA (b)(6) stated that on admission the resident or family was asked if family would be doing the laundry or the facility. He added that either way the family was encouraged to have the resident's clothing labeled. The U.S. FOIA (b)(6) stated that on admission an inventory sheet would be completed. The U.S. FOIA (b)(6) stated that when a resident comes from the hospital, they do not have all their belongings. He added that when the family comes in, the family may bring in the clothes and we are not aware sometimes. The U.S. FOIA (b)(6) then stated that when we identify that clothes were brought in then we would bring them to the laundry department to get labeled.</p> <p>On that same date and time, the surveyor asked the U.S. FOIA (b)(6) if all residents should have an inventory sheet. The U.S. FOIA (b)(6) stated that all residents should have an inventory sheet, even if it was blank and</p>	F 584	<p>to ensure its completion, the form will be uploaded into the resident chart. If not completed, the Unit Clerk or designee will complete the inventory sheet, ensure all belongings are labeled, and the inventory sheet is uploaded into the resident chart.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The DON or designee will conduct weekly random audits of 5 current residents including new admissions x 4 weeks, then monthly x 3 months, then quarterly x 2 to ensure the personal belongings inventory sheet is filled out and the items are properly labeled. The Director of Social Services (DoSS) or designee will complete weekly audits of all grievances received x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters of all grievance forms to ensure that reports of missing items are investigated and resolved in a timely manner.</p> <p>5. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 584	<p>Continued From page 4</p> <p>the resident did not come in with clothes on admission. The [U.S. FOIA (b)(6)] then stated that if a family brought in a T-shirt and it was not labeled there would be a rack in the laundry department of clothing that was not labeled. He added that if a resident had a missing item, then the family would be taken to the rack to see if the item was there. The [U.S. FOIA (b)(6)] then stated that if the item was not there the facility would ask for a receipt and reimburse the family for the missing item.</p> <p>Furthermore, the surveyor then asked the [U.S. FOIA (b)(6)] if the facility kept a log of missing items. The [U.S. FOIA (b)(6)] stated that he would have to ask the [U.S. FOIA (b)(6)]. The surveyor asked where a complaint about missing items would go. The [U.S. FOIA (b)(6)] stated that if a family complained it went in the grievance. The surveyor requested the grievances for [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)].</p> <p>On 11/20/23 at 11:40 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] regarding the process for grievance and missing items. The [U.S. FOIA (b)(6)] stated that when a grievance was presented that she would meet with the family and the grievance would be investigated. She added that the appropriate department head would do the investigation, discuss it and attempt to resolve it. The surveyor asked the [U.S. FOIA (b)(6)] if missing items would be included in the grievance book. The [U.S. FOIA (b)(6)] stated that missing items would be included and she added that the book included individual forms and there was not a log sheet. The surveyor requested to view the book.</p> <p>On 11/20/23 at 11:49 AM, the [U.S. FOIA (b)(6)] provided the</p>	F 584			

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F 584	<p>Continued From page 5</p> <p>surveyor with eight (8) grievance forms for [REDACTED] and stated that there was not any grievance forms for [REDACTED]. The surveyor asked the [REDACTED] if a complaint of missing items would be included in the forms. The [REDACTED] stated that missing items would be included. The surveyor reviewed the provided forms and there was not a grievance form for Resident #214's missing items.</p> <p>At that same time, the [REDACTED] reviewed Resident #214's medical record and stated that she was not made aware of the missing clothes that the nurse wrote about. She then stated that she was not aware that anyone else was made aware. The [REDACTED] stated that she was out of the facility from July 02 to July 11 and that if it was reported to someone then that person should have followed up. She added that the nurses usually tell me or they should have told someone else. She then stated that if she was not aware that she could not do anything.</p> <p>On 11/20/23 11:53 AM, in the presence of the [REDACTED], the surveyor notified the [REDACTED] the concern that Resident #214 had missing items. The [REDACTED] stated that he was not aware of the situation at the time and that his understanding now was that it happened right when the resident left. The [REDACTED] stated that the resident did not do the inventory on admission but that it would be a good idea for resident to have it.</p> <p>On 11/20/23 at 11:58 AM, in the presence of the [REDACTED] the [REDACTED] stated that part of the nursing admission, there was a printed patient clothing list that should be filled out and should be uploaded to the resident's medical record. The</p>	F 584			

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F 584	<p>Continued From page 6</p> <p>U.S. FOIA (b)(6) provided the surveyor a blank form titled "Patient Clothing List." The U.S. FOIA (b)(6) confirmed that there was no "Patient Clothing List" uploaded into Resident #214's medical record.</p> <p>On 11/20/23 at 12:20 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding resident clothing and missing items. The U.S. FOIA (b)(6) stated that the laundry department would label resident clothing if the family did not label it. She added that if a family did the resident's laundry then it may not get labeled. The U.S. FOIA (b)(6) stated that there would be a sign at the resident's bedside or closet if the family was doing the laundry. The U.S. FOIA (b)(6) was not sure if the laundry department was washing Resident #214's clothes or the family was.</p> <p>There was no documented evidence that Resident #214 had a "Patient Clothing List. There was no documented evidence to indicate who was washing Resident #214's clothing. There was no documented evidence that Resident #214 had a grievance form or the missing items complaint was investigated or resolved.</p> <p>On 11/20/23 at 01:13 PM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b)(6) the concern regarding Resident #214's missing clothing, missing inventory sheet and missing grievance form.</p> <p>On 11/21/23 at 12:07 PM, in the presence of the survey team, U.S. FOIA (b)(6) stated that the staff was inserviced on the grievance</p>	F 584			

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F 584	<p>Continued From page 7</p> <p>process and the form that they fill out. He added that the facility posted a message for resident/families in the room informing them of the process and to reach out to a staff member and complete the form. The [REDACTED] added that if it rose to a serious situation then the [REDACTED] or himself would address it. He stated that they had the process and they added to it.</p> <p>On that same date and time, the surveyor asked if Resident #214 should have had an inventory sheet, a grievance and an investigation done. The [REDACTED] stated that "yes" it should have been done. The [REDACTED] added that the nurse did not tell anyone and that it was not like they were aware.</p> <p>A review of the facility provided policy titled, "Social Services Policy and Procedure for Resident Grievances (i.e. Missing Items)" with an updated date of June 2017, included the following:</p> <p>Policy: It is the policy of [Name of Facility] to address circumstances of missing items and promptly resolve reported grievances.</p> <p>Procedure: I. Process:</p> <ol style="list-style-type: none"> 1. When the SW (Social Worker) and/or Administrator/GO(Grievance Officer) are the recipient of the missing item grievance, an interview with resident/designee will be conducted to identify what the missing item is (described in as much detail as possible) & location in which it was last seen. This will be documented on Grievance Form. 2. Following interview, an investigation will be immediately conducted, in resident's room to determine if item of which is missing can be located. This investigation will be conducted with both the Grievance officer (designee) along with 	F 584			

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F 584	Continued From page 8 a second person in the room. 3. Both laundry and activities departments will be inspected to determine if item can be located ... All grievances gathered will be placed in a binder labeled "Resident Grievance's which will be kept in the GO's office for review. NOTE: Blank grievance forms will be available at all nurses' stations for the residents/representatives/visitors to utilize. A review of the facility provided policy titled, "Social Services Policy and Procedure for Resident Grievances" with an updated date of June 2017 included the following: ...Resident's and their representatives will be notified through the admission process and/or through postings in prominent locations throughout the facility of the GO's name and contact info as well as their right to voice grievances: Orally In writing ... At any time ... II. Process... 1 ...a. When the recipient of the grievance is not the SW and or Administrator/GO, it is to be reported [to] one of them immediately; in their absence they will be contacted/informed via email and/or phone. The facility did not provide a policy related to the "Patient Clothing List." N.J.A.C. 8:39-4.1(a)11 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 584			
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F 656	<p>Continued From page 9</p> <p>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this</p>			F 656			

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F 656	<p>Continued From page 10 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to develop a comprehensive care plan (CP) to address NJ Exec Order 26.4b1 medication NJ Ex Order 26.4(b)(1) use for one (1) of sixteen (16) sampled residents (Resident #24).</p> <p>This deficient practice was evidenced by the following:</p> <p>On 11/16/23 at 11:18 AM, the surveyor interviewed Resident #24 who stated that he/she NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed Resident #24's medical record.</p> <p>Resident #24's Admission Record (an admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; NJ Exec Order 26.4b1</p> <p>A review of Resident #24's Minimum Data Set</p>	F 656	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. Resident # 24 was discharged on NJ Exec Order 26.4b1 with return not anticipated and upon return to the facility the new updated clinical record did not reflect a NJ Exec Order 26.4b1 medication care plan. The residents comprehensive care plan was updated immediately to address NJ Exec Order 26.4b1</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. All current residents who smoke or use psychotropic medications have the potential to be affected by the deficient practice. Current residents that are smokers and/or utilize psychotropic medications have been reviewed and have care plans in place, there were no additional findings.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The facility Educator or designee re-educated the U.S. FOIA (b) (6) to the comprehensive care plan process. A review of discharge with return not anticipated care plans, if a new care plan</p>		

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F 656	<p>Continued From page 11</p> <p>(MDS), an assessment tool used to facilitate care management, in the computerized medical record revealed that the resident had a Discharge Return Not Anticipated MDS dated [REDACTED] and had an Admission MDS approximately a few weeks after the Discharge Return Not Anticipated MDS.</p> <p>The Admission MDS indicated that the type of entry was an admission not a reentry. Further review indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED], which reflected that the resident's cognition was intact. The Admission MDS indicated that the resident currently [REDACTED] and was taken [REDACTED] and [REDACTED] and [REDACTED] NJ Exec Order 26.4b1</p> <p>Resident #24's "Resident [REDACTED] Assessment" dated [REDACTED] indicated the resident's status was [REDACTED] NJ Exec Order 26.4b1. A review of Resident #24's [REDACTED] "Contract" indicated that the resident signed the contract on [REDACTED]</p> <p>A review of the Order Summary Report dated [REDACTED] included the following orders: NJ Exec Order 26.4b1 [REDACTED] give [REDACTED] NJ Exec Order 26.4b1 [REDACTED] Give NJ Exec Order 26.4b1 [REDACTED] and [REDACTED]</p>	F 656	<p>is generated to ensure they reconciled the previous care plan with the new one. The MDS Coordinator or designee will review current residents who return not anticipated newly generated care plan with the previous one to ensure a comprehensive care plan was developed for smoking and psychotropic medication use.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The DON or designee will audit the new one and re-admission newly generated care plan to ensure a comprehensive person-centered care plan was developed for anyone who smokes and utilizes psychotropic medications. These audits will be performed weekly x 4 weeks, monthly x 3 months, and quarterly x 2 quarters.</p> <p>5. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 656	<p>Continued From page 12</p> <p>NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1</p> <p>A review of Resident #24's individualized comprehensive CP revealed that there was no CP initiated for NJ Exec Order 26.4b1 medication use for the resident's current admission.</p> <p>On 11/17/23 at 8:58 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the process for resident's that NJ Ex Order 26.4(b)(1). The U.S. FO stated that the resident needed an assessment by the nurse and that they would have a NJ Exec Order 26.4b1 CP. The surveyor asked the U.S. FO who initiated the CP at the facility. The U.S. FO stated that the nurses could do them. He added that the goal was to keep the residents safe.</p> <p>On 11/17/23 at 9:07 AM, the surveyor asked the U.S. FOIA (b)(6) who was responsible for initiating CPs. The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) would be responsible but that he also updated them. The surveyor requested a printed copy of Resident #24's current CP.</p> <p>On 11/17/23 at 9:27 AM, in the presence of another surveyor, the U.S. FOIA (b)(6) provided the surveyor a printed copy of Resident #24's current CP which did not have a CP for NJ Ex Ord. He also provided the surveyor a printed copy of Resident #24's last admission CP that was not an active CP for the</p>	F 656			

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F 656	<p>Continued From page 13</p> <p>resident's current admission. The [U.S. FOIA (b) (6)] stated that the resident was admitted to the facility after the resident went to the hospital for [NJ Ex Order 26.4(b)] and that the nurse opened a new baseline CP which was not a complete CP.</p> <p>On that same date and time, the surveyor asked the [U.S. FOIA (b) (6)] what the process was for CP. The [U.S. FOIA (b) (6)] stated that when a resident was admitted, there was an admission observation assessment which was a comprehensive assessment that would generate "triggers" based on the input and that the nurse would open a new CP. He added that the nurse does not know whether the new CP was needed or not. The [U.S. FOIA (b) (6)] stated that it was his responsibility to know if the CP was complete. He added that if Resident #24's quarterly MDS [which was not due to be done yet] would have been done then he would have known that the CP was not complete.</p> <p>At that time, the surveyor asked what a discharge return not anticipated MDS indicated. The [U.S. FOIA (b) (6)] stated that it meant that the resident returned to the community and would not be returning to the facility and that the CP would be closed by him. The [U.S. FOIA (b) (6)] stated that the resident was discharged and return was not anticipated but that the resident [NJ Ex Order 26.4(b)(1)] after discharge and was in [NJ Ex Order 26.4(b)(1)] for four (4) or five (5) days. He added that he would have eventually integrated the old CP into the new CP. The surveyor asked who was responsible for CPs. The [U.S. FOIA (b) (6)] stated that everyone was responsible. He added that if the CP was interdisciplinary then everyone should review the CP. The surveyor asked if the nurses on the unit initiated CPs. The [U.S. FOIA (b) (6)] stated that the nurses</p>	F 656			

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F 656	<p>Continued From page 14</p> <p>did not. He added that there is a hyperlink on the assessment that was linked to the CP but that the nurses did not do the CP.</p> <p>Furthermore, the surveyor asked the process for a resident that [U.S. FOIA (b) (6)] The [U.S. FOIA (b) (6)] stated that when a resident that [U.S. FOIA (b) (6)] was admitted that the resident was immediately assessed by nurse and the nurse would give him the assessment and he would put it in the CP. He added that the [U.S. FOIA (b) (6)] could also put it in the CP and the [U.S. FOIA (b) (6)] often does. The surveyor asked the [U.S. FOIA (b) (6)] what was missing on Resident #24's CP. The [U.S. FOIA (b) (6)] stated that it was not personalized. The surveyor asked if Resident #24's CP should have included NJ Exec Order 26.4b1 medication use. The [U.S. FOIA (b) (6)] stated yes.</p> <p>On 11/20/23 at 10:12 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] regarding the process for CP. The [U.S. FOIA (b) (6)] stated that when a resident was admitted or readmitted, the nurse would do an assessment that would generate a basic CP. He added that then the MDSC would individualize the CP going forward. The [U.S. FOIA (b) (6)] then stated that sometimes he would help with CPs that he did not wait for [U.S. FOIA (b) (6)] if he had an update for a CP. The surveyor asked the [U.S. FOIA (b) (6)] if certain areas should be on the CP right away. The [U.S. FOIA (b) (6)] stated that the assessment triggers the most basic CP to be done. The surveyor then asked if something is not triggered by the assessment then how would certain areas be captured. The [U.S. FOIA (b) (6)] stated that they address that during clinical meeting that happen every morning Monday through Friday and the interdisciplinary team reviewed the 24 hour report. He added that the team would discuss the residents and then</p>	F 656			

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F 656	<p>Continued From page 15</p> <p>would update the CP. The surveyor asked if [REDACTED] needed a CP. The [REDACTED] stated that it did and that it should come up on the initial assessment.</p> <p>On that same date and time, the surveyor then asked the [REDACTED] about Resident #24's CP. The [REDACTED] stated that when the resident was discharged and returns the facility would just revise the CP. The [REDACTED] then stated that if the resident was a discharge return not anticipated then when the resident was admitted then the resident should have a complete new CP. The surveyor asked the [REDACTED] if Resident #24 should have a CP for [REDACTED] medication use. The [REDACTED] stated that the resident should have had one.</p> <p>On 11/20/23 at 01:12 PM, in the presence of the survey team, the surveyor notified the [REDACTED] the concern that Resident #24 did not have a CP for [REDACTED].</p> <p>On 11/21/23 at 12:20 PM, in the presence of the survey team, the [REDACTED] stated that when a resident comes back to the facility when the MDS was return not anticipated that the resident should have a new CP and that the best way to do it was to reconcile from history. The [REDACTED] added that Resident #24's CP was not updated in a timely manner. The surveyor asked the [REDACTED] if Resident #24 should have had the [REDACTED] use CP. The [REDACTED] stated yes.</p>	F 656			

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F 656	<p>Continued From page 16</p> <p>A review of the facility provided policy titled, "Resident Smoking Policy and Procedure" with a revised date of 10/26/23, included the following: Procedure: II. Assessment Process: ...B) Residents who smoke and have been deemed as needing assistance will have an individualized plan of care that addresses their smoking. The care plan will be kept current an updated as needed in accordance with any variance of the individual's capabilities and needs.</p> <p>A review of the facility provided policy titled, "Psychotropic Medications" dated 10/22/23, included the following: Procedure: 1. Psychoactive (psychotropic) medications-a general classification encompassing those organic or inorganic substances which have in common the ability to alter mental, emotional, and behavioral disorder: Antipsychotic Antidepressants Antianxiety Hypnotics ... 8. Psychoactive medications should have a care plan.</p> <p>A review of the facility provided policy titled, "Care Plan Policy" with a revised date of 5/1/2023, included the following: Policy: It is the policy of [facility name redacted] that each resident will have a comprehensive care plan which will include possible intervention, measurable objectives and target time to meet a resident's medical, nursing, physical and psychosocial needs. Purpose: The purpose of the program is to:</p>	F 656			

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F 656	<p>Continued From page 17</p> <p>To establish an interdisciplinary team care planning process that ensures that the resident care and treatment is planned and updated appropriately for the resident's needs and severity of condition, impairment, disability, safety or disease.</p> <p>To ensure a planning process that maximizes and maintains each resident's optimal physical, psychosocial, and functional status.</p> <p>To ensure a care-management system in which the care and treatment planning process is timely, systematic, comprehensive, and incorporates input from all disciplines</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. The Admitting Nurse will initiate the care plan on admission with the identified areas of concern. This will be used as a working tool until the comprehensive assessment is completed. 2. A comprehensive assessment of the resident's needs will be initiated by the multidisciplinary team and completed within fourteen (14) days of the resident's admission, annual assessment, and upon significant change in status. If the assessment is completed on the calendar day 14 of the stay, many appropriate care area issues, risk factors, or conditions may have already been identified, new causes may have been considered, and new interventions may have been initiated. A complete care plan is required no later than 7 days after the comprehensive assessment is completed. 3. The interdisciplinary team will review and revise the Comprehensive Care Plan and all interventions thereafter during quarterly, Annual and with any significant change care conference to ensure all interventions are appropriate and set up next target date ... 	F 656			

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F 656 F 684 SS=G	<p>Continued From page 18 N.J.A.C. 8:39-11.2 (d) Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint# NJ00154003</p> <p>Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) follow a Physician's Order (PO) for a [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] that was ordered on [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] to be done on [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] and b.) notify the resident's physician that staff was unable to obtain the [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] according to the standards of clinical practice. This deficient practice was identified for one (1) of 16 residents, (Resident #215) reviewed for quality of care.</p> <p>The CBC was drawn on [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED], which was 4 days later which revealed [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED].</p> <p>This deficient practice was evidenced by the following:</p>	F 656 F 684	<p>I. Corrective action(s) accomplished for resident(s) affected: 1. Resident #215 is [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] of the facility.</p> <p>II. Residents identified having the potential to be affected and corrective action taken: 2. All residents have the potential to be affected by the deficient practice. Residents who have a physician order for lab work had the clinical records audited to ensure all ordered lab work was completed. No other laboratory work was missing. The facility Electronic Health Record (EHR) has been recently upgraded with the laboratory portal.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur: 3. The Facility Educator in serviced the licensed nursing staff on the policy and</p>		1/3/24

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F 684	<p>Continued From page 19</p> <p>The surveyor reviewed the medical records for Resident #215.</p> <p>Resident #215's Admission Record (an Admission Summary) reflected that that resident was a long-term care resident at the facility and had diagnoses which included but were not limited to NJ Exec Order 26.4b1</p> <p>[REDACTED]</p> <p>A review of the Physician's history and physical, dated NJ Exec Order 26.4b1, included under the heading laboratory data and diagnostic studies that the resident's admission NJ Exec Order 26.4b1. It also indicated that the resident was on NJ Exec Order 26.4b1</p> <p>[REDACTED]</p> <p>The resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b1, reflected</p>	F 684	<p>new lab portal procedure for obtaining laboratory work as ordered by the physician with emphasis on if the laboratory work was missed to notify the primary physician for further instructions. Licensed nursing staff were also educated on how to run the lab and diagnostic record in the electronic health record (EHR) on the facility's scheduled laboratory days to confirm all laboratory work that was ordered by the physicians were obtained timely. This education will also be provided to newly hired licensed nurses during orientation and will be added to the agency licensed staff orientation packet.</p> <p>The Director of Nursing (DON) or designee will run the lab and diagnostic report in the EHR daily to verify all laboratory work per the physician order were obtained and reconciled with the phlebotomist's order requisition sheet and recorded on the newly created facility lab tracking log. If any labs were missed the primary physician will be immediately notified for further instructions. When an order for lab work is obtained and entered into the resident EHR, the lab requisition is printed and placed in the lab book and entered on the lab log sheet. The order is also sent electronically to the lab. The lab technician arrives at the facility with a list of lab work to be completed and then signs the lab tracking log verifying that all lab work was obtained, and nothing was missed. The DON or designee runs the lab and diagnostic report in the EHR daily and will check each resident chart to</p>		

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F 684	<p>Continued From page 20</p> <p>that the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] which indicated the resident was [REDACTED]</p> <p>The electronic Medication Administration Record (eMAR) indicated that the resident was on [REDACTED] the start date was [REDACTED]</p> <p>A review of the resident's Progress Notes (PN) dated [REDACTED], written by the [REDACTED] U.S. FOIA (b)(6) [REDACTED] (who is currently the [REDACTED] U.S. FOIA (b)(6) [REDACTED]) indicated that the resident had [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] The [REDACTED] U.S. FOIA (b)(6) [REDACTED] called the resident's physician to notify the change in the resident's status and received new orders for a [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>A review of the resident's [REDACTED] NJ Ex Order 26.4b1 [REDACTED] Order Summary Report (OSR) reflected a PO dated [REDACTED] NJ Ex Order 26.4b1 [REDACTED] for the [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The PO indicated that the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] was to be done on [REDACTED] NJ Ex Order 26.4b1 [REDACTED]</p> <p>A review of the resident's PN from [REDACTED] NJ Ex Order 26.4b1 [REDACTED], did not indicate that the resident's physician was made aware that the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] sample was not obtained from the resident or [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. There was no documented evidence that the resident's physician was notified that the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] was not obtained on [REDACTED] NJ Ex Order 26.4b1 [REDACTED].</p> <p>A review of the Laboratory Requisition Form (LRF) dated [REDACTED] NJ Ex Order 26.4b1 [REDACTED] reflected that the facility requested a [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] to be obtained for the resident three (3) days later.</p> <p>A review of the resident's Care Plan (CP) revised [REDACTED] NJ Ex Order 26.4b1 [REDACTED] indicated a focus area that the resident is receiving an [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] medication.</p>	F 684	<p>ensure the lab work was completed and results were obtained. This process will ensure that in the event the lab book and log are misplaced, the lab work can still be completed as ordered since all the information is in the resident EHR and requisitions can be reprinted and reconciled with the list of lab work that was electronically transmitted to the lab when the order was originally place.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The Assistant Director of Nursing (ADON) or designee will complete an audit on 6 residents' laboratory work weekly x 4 weeks, monthly x 3 months, quarterly x 2 quarters to ensure that all laboratory work ordered by the physician were completed, and if missed the attending physician was notified immediately for further instructions. The results of these audits will be given to the Director of Nursing (DON) for review and if any issues are found immediate corrective action will be initiated.</p> <p>5. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 684	<p>Continued From page 21</p> <p>The goal of the resident's CP was that the resident would continue to benefit from the medication without complications and remain free from signs and symptoms. The interventions in the resident's CP indicated to monitor and document any [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1), and [REDACTED] NJ Ex Order 26.4(b)(1). Keep the physician informed as appropriate.</p> <p>On 11/21/2023 at 11:56 AM, the surveyor interviewed the [REDACTED] U.S. FOIA (b)(6). [REDACTED] stated "we write the Laboratory Requisition Form and put them in a binder. When the lab [laboratory] comes, they check the binder for the requisition and draw the ordered test." The [REDACTED] U.S. FOIA (b)(6) stated, "that every nurse's station has a binder for the lab technician". The [REDACTED] U.S. FOIA (b)(6) further stated, "I am not sure why it was missed; the night shift is supposed to do 24-hour chart checks for orders and results and an incident report should have been written for the missed opportunity."</p> <p>A review of the PN dated [REDACTED] NJ Ex Order 26.4(b)(1) at 02:24 PM, revealed that the resident was already discharged from the facility and walking to the vehicle when the [REDACTED] NJ Exec Order 26.4b1 was called in by the laboratory to the [REDACTED] U.S. FOIA (b)(6). Further review of the PN written by the [REDACTED] U.S. FOIA (b)(6) indicated, "The lab called with [REDACTED] NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 today [REDACTED] NJ Exec Order 26.4b1 upon them leaving the building. [REDACTED] U.S. FOIA (b)(6) made aware and ordered for family to take resident #215 to the emergency room (ER). I went outside to make family aware however family insisted on taking the resident [REDACTED] NJ Ex Order 26.4(b)(1) and stated they would follow up with the [REDACTED] U.S. FOIA (b)(6) U.S. FOIA (b)(6)."</p>	F 684			

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F 684	<p>Continued From page 22</p> <p>On 11/16/2023 at 9:30 AM, the surveyor requested Resident #215's incidents/accidents and reportable (I/A/R) from the U.S. FOIA (b) (6) [REDACTED] came back and informed the survey team that they did not have any to provide the surveyor.</p> <p>On 11/16/2023 at 11:00 AM, the surveyor asked the U.S. FOIA (b) (6) [REDACTED] to provide any grievance reports for resident #215.</p> <p>The surveyor reviewed a grievance report dated NJ Ex Order 26.4(b) [REDACTED], that was filed by the U.S. FOIA (b) (6) [REDACTED] regarding resident #215. The following were included in the NJ Ex Order 26.4(b) [REDACTED] grievance:</p> <ol style="list-style-type: none"> 1. "We just found out an issue with the labs not being completed for resident #215 while they were in the facility." 2. The requisition form for the lab was never processed and left for the lab tech, so the 1st lab was missed. 3. Upon 2nd opportunity to do lab work, it was performed only to find out the resident's NJ Ex Order 26.4(b) [REDACTED]. We ended up discharging the resident with this NJ Ex Order [REDACTED]. 4. Note: this came to the U.S. FOIA (b) (6) [REDACTED] attention when the physician reported it after a phone call from the U.S. FOIA (b) (6) [REDACTED] of resident #215 reporting the NJ Ex Order 26.4(b) [REDACTED]. 5. Conclusion: <ul style="list-style-type: none"> A. The lab was missed due to the misplacement of the book. B. As far as the resident discharging with a NJ Ex Order 26.4(b)(1) [REDACTED], there is no evidence to support that nursing failed to perform their duties. The family was notified of the resident's lab results 	F 684			

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F 684	<p>Continued From page 23 and it was their informed decision to leave.</p> <p>On 11/21/23 at 12:40 PM, the surveyor asked the [REDACTED] for a facility policy, processes, and responsibility for physician order processing, laboratory requisitions, and results review.</p> <p>On 11/21/23 at 12:41 PM, the [REDACTED] stated they were not able to provide such a policy and provided the surveyor with a policy from the local Acute Care provider titled "specimen collection and handling procedures" which did not address the surveyor's findings.</p> <p>On 11/21/23 at 12:54 PM, the surveyor in the presence of the survey team discussed the above findings with the [REDACTED].</p> <p>On 11/22/23 at 10:36 AM, the [REDACTED] stated "yes," the labs were missed on Monday [REDACTED].</p> <p>On that same date and time, the surveyor asked the facility management, "Why the lab was not drawn, and should it have been done on [REDACTED] as ordered? The facility had no response. The [REDACTED] stated, "at this time, I know we did miss the lab on that day [REDACTED].</p> <p>On 11/22/23 at 02:25 PM, the survey team met with the [REDACTED]. There was no additional information provided by the facility.</p>	F 684			
F 686 SS=E	<p>NJAC 8:39-27.1(a) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p>	F 686			1/3/24

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F 686	<p>Continued From page 24</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ00166500</p> <p>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a) document an incident report and perform an investigation for a [REDACTED] NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 (NJ Ex G) for two (2) of two (2) residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #3 and #214) according to standards of clinical practice and facility's policy and procedure, b) accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for one (1) of two (2) residents reviewed for [REDACTED] NJ Ex G (Resident #214), and c) evaluate and complete an assessment of a [REDACTED] NJ Ex Order 26.4(b)(1) immediately upon identification, initiate [REDACTED] NJ Ex Order 26.4(b)(1) care protocol, and consistently implement timely interventions in adherence with the facility [REDACTED] NJ Ex Order 26.4(b)(1) management policy that included obtain a physician's orders and update the care plan for</p>	F 686	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. Resident # 214 [REDACTED] NJ Ex Order 26.4(b)(1) in the facility. The MDS for resident # 214 was modified to accurately reflect the [REDACTED] NJ Ex G. An incident report and investigation were immediately completed for resident # 3 and the care plan was updated. The attending physician was immediately notified and assessed resident #3. The previous treatment was discontinued, and a new treatment was ordered. Resident #3 was added to weekly [REDACTED] NJ Ex Order 26.4(b)(1) rounds.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. All residents have the potential to be affected by the deficient practice. All current residents have had a skin check</p>		

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F 686	<p>Continued From page 25</p> <p>one (1) of two (2) residents reviewed for ^{NJ Ex O} (Resident #3).</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 11/16/23 at 9:00 AM, the surveyor reviewed Resident #214's closed medical record.</p> <p>Resident #214's Admission Record (AR; or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; ^{NJ Exec Order 26.4b1}</p> <p>A review of Resident #214's Comprehensive MDS (CMDS) dated ^{NJ Exec Order 26.4}, indicated a Brief Interview for Mental Status (BIMS) score of ^{NJ Exec Order 26.4b1} which reflected that the resident's ^{NJ Exec Order 26.4b1}. Further review of Section M ^{NJ Ex Order 26.4(b)(1)} indicated that the resident did not have one or more ^{NJ Exec Order 26.4b1}.</p> <p>A review of Resident #214's Progress Note (PN) included the following note: Effective Date: ^{NJ Ex Order 26.4(b)}; Type: Weekly ^{NJ Ex Order 26.4} Progress Note; Note text: Resident #214 has ^{NJ Exec Order 26.4b1} status is ^{NJ Exec Order 26.4b1} type is ^{NJ Exec Order 26.4b1} with ^{NJ Ex Order 26.4(b)}</p>	F 686	<p>done by a licensed nurse to ensure there are no new skin impairments that require an incident, investigation and updated care plan, and an appropriate treatment is in place, no new issues were found. A comprehensive review of residents with pressure ulcers for the last 3 months will be conducted to ensure they were coded accurately on the MDS. If any were found to be coded incorrectly the MDS will be modified.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The facility educator or designee will educate licensed nursing staff on the policy and procedure for implementing an incident report and investigation for all new facility acquired skin impairments immediately to ensure the root cause is determined and appropriate interventions and wound treatments are put in place and added to the resident person-centered care plan. This education will also be provided to newly hired licensed nursing staff during orientation and will be added to the agency licensed nursing staff orientation packet. The facility educator will also educate non-licensed direct care staff on reporting any new skin alterations to the primary care nurse or supervisor immediately. The MDS coordinator is no longer employed at the facility. Upon hire of a new MDS coordinator the Regional MDS coordinator will educate the new MDS</p>		

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F 686	<p>Continued From page 26</p> <p>A review of Resident #214's initial "Admission Observation- [REDACTED] that was prior to the [REDACTED] PN, indicated that the resident had a [REDACTED] [REDACTED] had [REDACTED] at [REDACTED] [REDACTED] had [REDACTED] of [REDACTED]. There was no documentation that the resident's [REDACTED].</p> <p>A review of Resident #214's three "Single [REDACTED] -Weekly Tracking" forms each dated [REDACTED], included a [REDACTED] [REDACTED] The forms dated [REDACTED] did not include a [REDACTED].</p> <p>A review of Resident #214's multiple "Single [REDACTED] -Weekly Tracking" forms each dated [REDACTED] included a [REDACTED] [REDACTED] The origin of the [REDACTED] section was not filled out to indicate if the [REDACTED] was hospital acquired, community acquired or facility acquired. The [REDACTED] [REDACTED] indicated was [REDACTED] with [REDACTED].</p> <p>A review of Resident #214's Universal Transfer Form when the resident was initially transferred from the hospital to the facility as an initial admission indicated under [REDACTED] Condition: No [REDACTED].</p> <p>A review of Resident #214's Discharge Return Anticipated MDS, dated [REDACTED], indicated under Section M that the resident did not have one or more [REDACTED] [REDACTED]. The MDS was not accurately coded to include the [REDACTED] of the [REDACTED].</p>	F 686	<p>coordinator on the importance of coding pressure ulcers accurately per the Resident Assessment Instrument (RAI) Manual.</p> <p>Facility Infection Preventionist Nurse or designee will ensure newly admitted residents and residents who are determined to be with increased risk for skin breakdown will be evaluated by the wound team weekly x 2 to ensure preventive measures are in place and added to the care plan and that an appropriate treatment is in place for any skin alterations. All residents have their skin evaluated weekly by a licensed nurse and results documented in the clinical record and any new facility acquired skin injury will have an incident report entered into the Risk Management System (RMS) to ensure the appropriate interventions and treatments are put into place. The 24-hour report will also be reviewed daily by the DON or designee to ensure any new skin impairments that are noted have been evaluated, have the appropriate treatment in place, and that they have been investigated to determine the root cause and new interventions have been added to the resident centered plan of care.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The DON or designee will conduct random audits of 5 residents at high risk for skin breakdown weekly x 3 weeks,</p>		

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F 686	<p>Continued From page 27</p> <p>On 11/16/23 at 10:58 AM, the surveyor reviewed the facility provided incident report that was previously requested for all incidents and/or investigations that Resident #214 had during the resident's stay. The incident report provided was for an [REDACTED] NJ Exec Order 26.4b1. There was no incident report/investigation for Resident #214's [REDACTED] NJ Exec Order 26.4b1.</p> <p>On 11/16/23 at 11:02 AM, in presence of the survey team and [REDACTED] NJ Exec Order 26.4b1, the surveyor asked the [REDACTED] U.S. FOIA (b)(6) if Resident #214 had any other incident reports or investigations in addition to what was provided. The [REDACTED] U.S. FOIA (b)(6) stated that the only incident or investigation was the [REDACTED] NJ Exec Order 26.4b1 that was provided to the surveyor.</p> <p>On 11/17/23 at 9:02 AM, the surveyor interviewed the [REDACTED] NJ Exec Order 26.4b1 regarding the process for [REDACTED] U.S. FOIA (b)(6). The [REDACTED] U.S. FOIA (b)(6) stated that the [REDACTED] NJ Exec Order 26.4b1 would be assessed, the physician notified and an incident report was made out. He added that an investigation would be done and the [REDACTED] U.S. FOIA (b)(6) would do the follow up.</p> <p>On 11/20/23 at 12:49 PM, the surveyor interviewed the [REDACTED] U.S. FOIA (b)(6) that was also the facility [REDACTED] NJ Exec Order 26.4b1 nurse regarding the process for a new [REDACTED] NJ Exec Order 26.4b1. The [REDACTED] U.S. FOIA (b)(6) stated that there is a [REDACTED] NJ Exec Order 26.4b1 care team that is contracted to come every Thursday and they see all residents that have a [REDACTED] NJ Ex Order 26.4(b)(1), all new admissions and any new cases that the nurses have brought to my attention. The surveyor asked if the [REDACTED] NJ Exec Order 26.4b1 care team documented their visits. The [REDACTED] U.S. FOIA (b)(6) stated</p>	F 686	<p>then quarterly x 2 quarters to ensure that any new skin impairments have RMS completed (if applicable) and that the resident's care plan has been updated with new interventions and an appropriate treatment is in place.</p> <p>The Regional MDS coordinator or designee will review residents with pressure ulcers to ensure they are coded accurately per the RAI manual monthly x 3 months, then quarterly x 2 months.</p> <p>5. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 686	<p>Continued From page 28</p> <p>that they usually have a scribe (a personal assistant to the physician who performs documentation) and send the report to the facility but that it was not always uploaded to the residents computerized medical record. The [redacted] stated that if there was a new [redacted] NJ Ex Order 26.4(b)(1), the nurse would tell me, call the physician, receive orders. She added that an incident report would be made by the nurse and then an investigation would be done.</p> <p>On that same date and time, the surveyor then asked about Resident #214's [redacted] NJ Ex Order 26.4(b)(1). The [redacted] stated that Resident #214 had [redacted] and the [redacted] team evaluated it. She added that they did [redacted] of the U.S. FOIA (b)(6) prep. The [redacted] stated that it was a [redacted] and [redacted] just before the resident went to the hospital. The surveyor asked if the [redacted] was present before the resident went to the hospital. The [redacted] stated that the resident did have a [redacted] before the resident went to the hospital. She added that the resident had [redacted] when admitted. The surveyor asked if an incident report and investigation was done. The [redacted] stated that she did not think anyone did an incident report but that she would have to verify that. The surveyor asked if an investigation should have been done. The [redacted] stated that she believed so. The surveyor requested the [redacted] physician notes.</p> <p>On 11/20/23 at 02:02 PM, the surveyor interviewed the [redacted] regarding the process for [redacted] NJ Ex Order 26.4(b)(1). The [redacted] stated that once a [redacted] is identified, a [redacted] assessment is done to determine [redacted] and [redacted] NJ Ex Order 26.4(b)(1). She added that the physician is informed, receive orders and then refer it to the [redacted] team. The [redacted] then</p>	F 686			

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F 686	<p>Continued From page 29</p> <p>stated that an incident report was created and an investigation would be done.</p> <p>On 11/21/23 at 9:30 AM, the surveyor reviewed the [redacted] physician visit reports which included the following: Visit Report for [redacted] Number: [redacted] [redacted] Location: [redacted] Type: [redacted] [redacted] Encounter: Initial; [redacted] Progress: Initial Exam; NJ Ex Order 26.4(b)(1) This [redacted] was not listed on the previous [redacted] physician visit report dated [redacted]</p> <p>On 11/21/23 at 12:59 PM, in the presence of the survey team, the surveyor notified the [redacted] U.S. FOIA (b)(6) the concern that Resident #214 did not have an incident report and investigation of a [redacted] to the [redacted] and that the Discharge Return Anticipated MDS was not coded accurately.</p> <p>On 11/22/23 at 11:06 AM, in the presence of the survey team, U.S. FOIA (b)(6), the [redacted] stated that they were going to do a "QAPI" (Quality Assurance and Performance Improvement, a data driven and proactive approach to quality improvement) on risk management because the process was not followed. The [redacted] stated that Resident #214 had a [redacted] here and should have had a risk management (incident report) and investigation done.</p> <p>At this time, the surveyor asked about the accuracy of the MDS. The [redacted] stated that sometimes if the risk management was not done, that will affect other things. He added that the nurse assessment and chart were relied on for</p>	F 686			

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F 686	<p>Continued From page 30</p> <p>the MDS. The [REDACTED] stated that the MDS was coded to what was seen. He added that it might have been coded incorrectly. The [REDACTED] stated that staff were reinserviced.</p> <p>Furthermore, the surveyor asked the [REDACTED] if Resident #214 should have had an incident report and investigation for the [REDACTED] and if the MDS should have coded that the resident had the [REDACTED]. The [REDACTED] stated that Resident #214 should have had an incident report, investigation and a MDS that was correct. He added that the MDS would be modified.</p> <p>2. On 11/15/23 at 10:18 AM, during the initial tour, the surveyor interviewed the [REDACTED] for the [REDACTED] unit. The [REDACTED] stated that Resident #3 had a [REDACTED].</p> <p>On 11/15/23 at 10:57 AM, the resident observed the resident sitting on a wheelchair, [REDACTED] for the [REDACTED] was visible and [REDACTED] was observed. The resident was [REDACTED] and stated he/she had [REDACTED] on the [REDACTED].</p> <p>On 11/15/23 at 12:23 PM, the [REDACTED] submitted the list of residents who were identified with a [REDACTED] to the surveyors. Resident #3 was not listed.</p> <p>On 11/20/23 at 12:03 PM, during an interview with the surveyor, the [REDACTED] informed the surveyor that Resident #3 was [REDACTED] for [REDACTED] and that he aided with the [REDACTED] care. The resident was [REDACTED] and provided mostly [REDACTED] to the resident.</p>	F 686			

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F 686	<p>Continued From page 31</p> <p>As for [REDACTED] the resident often refused. "I report to the nurse and the nurse records" the information.</p> <p>The surveyor reviewed the medical record for Resident #3.</p> <p>The resident's AR reflected that Resident #3 was admitted to the facility with diagnoses that included but were not limited to [REDACTED]</p> <p>[REDACTED]</p> <p>According to the quarterly MDS dated [REDACTED] Resident #3 was documented as having a BIMS score of [REDACTED] indicating that the resident was [REDACTED], required set up help for [REDACTED] and [REDACTED] and one-person physical assistance for the other [REDACTED].</p> <p>The MDS further revealed that the resident was at risk for developing [REDACTED] based on clinical assessment and had no [REDACTED]. The resident had [REDACTED] and [REDACTED].</p> <p>[REDACTED]</p> <p>[REDACTED]. The [REDACTED] and [REDACTED] treatment included [REDACTED] for chair and bed, [REDACTED] and [REDACTED] interventions, and application of [REDACTED].</p> <p>A review if the ongoing care plan (CP) revealed a focus that Resident #4 was at risk for [REDACTED].</p>	F 686			

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F 686	<p>Continued From page 32</p> <p>NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1). The reflected interventions that included daily NJ Ex Order 26.4(b)(1) monitoring during care by the CNA, notifying nurse of areas of concern initiated on NJ Ex Order 26.4(b)(1) and on NJ Ex Order 26.4(b)(1). There was no documented focus, goal, or intervention for the Resident's NJ Ex Order 26.4(b)(1) within the ongoing NJ Ex Order 26.4(b)(1).</p> <p>A review of the Order Summary Report (OSR) that contained active orders as of NJ Ex Order 26.4(b)(1) included an order for NJ Exec Order 26.4b1 to be applied to NJ Exec Order 26.4b1 every shift for NJ Ex Order 26.4(b)(1) ordered on NJ Ex Order 26.4(b)(1). No other treatment order was reflected on the OSR prior to surveyor inquiry.</p> <p>A review of the NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR) reflected that the nurse signed that the weekly NJ Ex Order 26.4(b)(1) ordered on NJ Ex Order 26.4(b)(1) was completed weekly on NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1).</p> <p>Further review of the TAR reflected that the nurse signed that the NJ Exec Order 26.4b1 ordered on NJ Ex Order 26.4(b)(1) was signed applied on every shift (three times a day) on NJ Ex Order 26.4(b)(1) to the morning of NJ Ex Order 26.4(b)(1).</p> <p>A review of Resident #3's Single NJ Ex Order 26.4(b)(1) Weekly Tracking dated NJ Ex Order 26.4(b)(1) identified a NJ Exec Order 26.4b1, and a NJ Exec Order 26.4b1. The forms dated NJ Ex Order 26.4(b)(1), did not identify the NJ Ex Order 26.4(b)(1).</p> <p>A review of the NJ Exec Order 26.4b1 Chart details dated NJ Ex Order 26.4(b)(1), did not include an assessment of the NJ Exec Order 26.4b1.</p>	F 686			

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F 686	<p>Continued From page 33</p> <p>On 11/20/23 at 11:13 AM, the surveyor observed the [redacted] for the [redacted] NJ Exec Order 26.4b1 care of Resident #3.</p> <p>At that time, the [redacted] and the surveyor observed the resident's [redacted] NJ Exec Order 26.4b1 [redacted] had an [redacted] NJ Ex Order 26.4(b)(1) [redacted] and no [redacted] NJ Ex Order 26.4(b)(1) was seen. The [redacted] stated that she was a surprised because she thought the [redacted] NJ Exec Order 26.4b1. She approximated the [redacted] NJ Ex Order 26.4b1.</p> <p>The [redacted] also stated that she would call the physician to notify of the change and to receive new orders.</p> <p>At 11/20/23 at 11:36 AM, the surveyor notified the [redacted] of the findings and concerns.</p> <p>On 11/20/23 at 11:38 AM, in the presence of the surveyors, the [redacted] stated that the expectation was that the nurse would call, then notify the physician and obtain new orders because the [redacted] NJ Exec Order 26.4b1 was a [redacted] NJ Ex Order 26.4(b)(1) treatment.</p> <p>The [redacted] should have been updated to reflect the new [redacted] NJ Exec Order 26.4b1. The nurse should have also initiated an investigation for the new [redacted] NJ Exec Order 26.4b1.</p> <p>At that time, the surveyor informed the [redacted] U.S. FOIA (b)(7) that during the initial tour on 11/15/23 the [redacted] U.S. FOIA (b)(7) and Resident #3 had informed the surveyor of the [redacted] NJ Exec Order 26.4b1.</p> <p>At that time, the [redacted] U.S. FOIA (b)(7) stated that the [redacted] U.S. FOIA (b)(7) should have known better. She was responsible for investigating, calling the doctor, and updating the [redacted] U.S. FOIA (b)(7). The [redacted] U.S. FOIA (b)(7) stated he would further investigate the matter.</p> <p>On 11/20/23 at 12:58 PM, in the presence of the</p>	F 686			

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F 686	<p>Continued From page 34</p> <p>survey team, the U.S. FOIA (b)(6) were made aware of the concerns regarding the failure to evaluate, and assess Resident #3 immediately after the initial identification of the U.S. FOIA (b)(6), to obtain a physician order, update the resident's CP and conduct an investigation for the U.S. FOIA (b)(6) prior to surveyor inquiry in accordance with the facility policy.</p> <p>On 11/21/23 at 12:04 PM, in the presence of the survey team, the U.S. FOIA (b)(6) stated a complete NJ Ex Order 26.4(b)(1) was done for Resident #3 yesterday, the physician was in the building, who placed an order for the U.S. FOIA (b)(6), an investigation/risk management report was completed, and the CP was updated, which were all initiated after surveyor discovery. The U.S. FOIA (b)(6) also stated that moving forward the U.S. FOIA (b)(6) nurse would speak with the CNAs to be better aware.</p> <p>At that time, the U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) confirmed she was aware of the U.S. FOIA (b)(6) and thought the U.S. FOIA (b)(6) order was taking care of the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) was asked why there was no full body assessment, investigation or updated CP when the U.S. FOIA (b)(6) was aware of the new NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) stated that was the reason the U.S. FOIA (b)(6) was disciplined.</p> <p>A review of the Risk Management report dated U.S. FOIA (b)(6) revealed that the resident had a U.S. FOIA (b)(6) located in the U.S. FOIA (b)(6) that measured at NJ Exec Order 26.4b1. The resident informed the U.S. FOIA (b)(6) that it had been a while that he/she was NJ Exec Order 26.4b1 during NJ Exec Order 26.4b1 as it would U.S. FOIA (b)(6).</p>	F 686			

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F 686	<p>Continued From page 35</p> <p>[NJ Exec Order 26-40b] The prescriber was notified, orders from the physician was received. The orders included a cleansing of the [NJ Exec Order 26-40b], an [NJ Exec Order 26-40b], and a [NJ Ex Order]. A full body assessment was also conducted that did not result to other [NJ Ex Order 26-40b].</p> <p>A review of the facility provided policy Wound Management dated 9/2023 included the following: Procedure</p> <ol style="list-style-type: none"> 1. All residents will be assessed for risk of skin breakdown upon admission, readmission using the Braden scale as per MDS requirements ... 2. Residents who are admitted to the facility with existing pressure ulcers and residents who develop wounds in the facility will be assessed and the wound care protocol will be initiated unless otherwise ordered by the physician. the second body assessment will be completed within 24 hours by an RN or designee.... 6. Wound assessments will be completed and documented in the medical records when a wound is discovered or upon admission and readmission and weekly thereafter..... 11. Weekly skin checks will be completed on all residents and documented in resident's medical record. In addition, any abnormalities will be documented on the 24-hour report and in nurse's notes. Follow through for an any abnormal skin condition will be done per protocol. 15. All facility acquired pressure ulcers will be investigated using the "Facility Acquired Investigation Tool" and "Risk Management Will Be Completed in [electronic medical record]". <p>Protocol for Weekly Bodychecks</p> <ol style="list-style-type: none"> 1. Weekly body checks will be performed on all residents. Documentation of new skin problems 	F 686			

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F 686	Continued From page 36 will be done on the electronic medical record for each patient. 2. Any new abnormality that is on the skin assessment must also be written in nurses notes and on the 24-hour report as well as in risk management in [electronic medical record]. 5. Any bruises skin tears etc. of unknown origin that have been found must have an incident report completed, along with an investigation (if needed), unless there already has been an incident report completed (check nurses notes). On 11/22/23 at 02:25 PM, the survey team met with the U.S. FOIA (b)(6) for Exit Conference. There was no additional information provided by the facility management.	F 686			
F 695 SS=D	NJAC 8:39-27.1(a)(e) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain the necessary NJ Exec Order 26.4b(1) care and services for a resident who was receiving NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b for one (1) of two (2) residents (Resident #38) reviewed for NJ Exec Order 26	F 695	I. Corrective action(s) accomplished for resident(s) affected: 1. 1. Resident #38 NJ Exec Order 26.4b NJ Ex Order 26.4b was adjusted from NJ Exec Order 26.4b NJ Ex Order 26.4b The resident's MD was		1/3/24

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F 695	<p>Continued From page 37 use.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 11/15/23 at 10:51 AM and 11/17/23 at 9:13 AM, the surveyor observed Resident #38 out of bed in a wheelchair reading a book. The resident had a NJ Exec Order 26.4b1 [redacted] [redacted] tubing that was labeled with a date, and NJ Ex Order 26.4(b)(1) were not NJ Ex Order 26.4(b). The tubing was attached to an NJ Exec Order 26.4b1 [redacted] [redacted] with the NJ Ex Order 26.4(b)(1) set at NJ Ex Order 26.4(b)(1)</p> <p>The surveyor reviewed the medical records for Resident #38.</p> <p>The Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but was not limited NJ Exec Order 26.4b1 [redacted]</p> <p>A review of the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated U.S. FOIA (b)(6), reflected a Brief Interview for Mental Status (BIMS) score of</p>	F 695	<p>notified.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. All residents on oxygen therapy have the potential to be affected by the deficient practice. All current residents on oxygen therapy were reviewed to ensure the LPM which the MD prescribed was correct. All were found to be compliant.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The facility educator re-in serviced the nursing staff on the importance of reviewing physician orders for oxygen liter flow to validate the liter flow on the oxygen concentrator/E-tank before they document on the Medication Administration Record. This education will also be provided to newly hired nursing staff during orientation and to the agency nursing staff orientation packet. Any residents receiving oxygen therapy, orders have been updated to include the nurse entering the correct liter flow after they validate the concentrator/E-tank setting to ensure the correct liter per minute as ordered by the physician. The Director of Nursing (DON) or designee on daily rounds will check the oxygen concentrator to validate the resident is receiving the correct amount of oxygen prescribed by the physician.</p>		

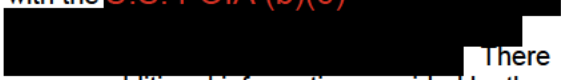
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F 695	<p>Continued From page 38</p> <p>[redacted] revealed that resident's cognitive status was [redacted] NJ Exec Order 26.4b1</p> <p>The Care Plan dated [redacted] revealed a focus for [redacted] NJ Exec Order 26.4b1</p> <p>A review of the [redacted] Active Order Summary Report included a physician order (PO) dated [redacted] NJ Exec Order 26.4b1 to [redacted] NJ Exec Order 26.4(b)(1) [redacted] NJ Exec Order 26.4b1</p> <p>A review of the [redacted] electronic Medication Administration Record (eMAR) revealed [redacted] NJ Exec Order 26.4b1 every shift for [redacted] therapy. Monitor [redacted] NJ Ex Order 26.4(b)(1) every shift, notify [redacted] U.S. FOIA (b)(6) if [redacted] is [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Exec Order 26.4b1. This order had a start date of [redacted] NJ Exec Order 26.4b1. Upon review of the eMAR, it revealed that there were three nurses signed it off for days, evening and night shift for three consecutive days on [redacted] NJ Exec Order 26.4b1</p> <p>On 11/21/23 at 12:25 PM, the surveyor interviewed the [redacted] U.S. FOIA (b)(6) [redacted] in the presence of the survey team. The [redacted] U.S. FOIA (b)(6) stated "The [redacted] NJ Exec Order 26.4b1 should be administer based on the doctor's order. The nursing staff is supposed to check the [redacted] NJ Exec Order 26.4b1 for [redacted] NJ Ex Order 26.4(b)(1) correctness. If there is an issue, they are supposed to inform me of it and write a note in the electronic medical record (eMR)."</p> <p>A review of policy titled, O2 Administration Policy and Procedure, dated 11/2018, updated 10/2019 included ... Process:</p>	F 695	<p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The Assistant Director of Nursing (ADON) or designee will conduct weekly audits of 5 resident with orders for oxygen x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters to ensure the oxygen setting on the concentrator/E-tank is the correct setting as prescribed by the physician.</p> <p>5. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 695	Continued From page 39 1. Verify that there is a physician order. 2. Review residents care plan to assess for any special needs of the resident. Assessment: Before administering O2, and while the resident is receiving O2 therapy, assess the following: 3. Signs and symptoms of O2 toxicity. 4. Lung sounds Steps in the procedure: 7. Adjust the O2 delivery device so that it is comfortable for the resident and the PROPER flow of O2 is being administered. On 11/22/23 at 02:25 PM, the survey team met with the U.S. FOIA (b)(6)  There was no additional information provided by the facility.	F 695			
F 728 SS=C	NJAC 8:39-11.2 (b); 27.1(a) Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or	F 728			1/3/24

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F 728	<p>Continued From page 40</p> <p>determined competent as provided in §483.150(a) and (b).</p> <p>§483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.</p> <p>§483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual-</p> <p>(i) Is a full-time employee in a State-approved training and competency evaluation program;</p> <p>(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or</p> <p>(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) verification that recently hired non-certified Nursing Aides (NA) were currently enrolled and actively taking classes in a New Jersey state-approved Certified Nursing Aide (CNA) Training Program, b.) validate completion of Module 1 in their CNA Training Program prior to allocating an independent resident assignment, and c.) there was a delineated policy and/or program in place for the hiring, staffing, and assignments of non-certified NAs for one (1) of one (1) non-certified NA's.</p>	F 728	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. 1. The non-certified Nurse Aide file was immediately updated with the verification information that was required upon hire for the facility. This Nurse Aide had completed the required 16 hours (Module 1) in their C.N.A. training program prior to allocating an independent resident assignment.</p> <p>II. II. Residents identified having the potential to be affected and corrective action taken:</p>		

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F 728	<p>Continued From page 41</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following: Facilities are advised as follows: I. TNAs (Temporary Nursing Assistant) A. Individuals who are working as TNAs must pass the nurse-aide written or oral exam and the State-approved clinical skills competency exam by May 11, 2023, or the end of the federal PHE (Public Health Emergency), whichever comes first. B. If a TNA does not pass the exams by the end of the federal PHE, the TNA may not work after May 11, 2023, unless the TNA meets the requirements of Paragraph C below. C. In order to work beyond May 11, 2023, TNAs must, by May 11, 2023: 1. Be enrolled in a NATCEP CNA training program, and 2. Have completed the first 16 hours of training, and 3. Be working in a facility before May 11, 2023. 4. Note that the TNA only has until September 10, 2023 to complete the NATCEP (Nurse Aide Training and Competency Evaluation Program) program and pass the exams. II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing</p>	F 728	<p>2. All residents have the potential to be affected by the deficient practice. A comprehensive assessment was completed of all this Nurse Aide's assignments and no resident were affected.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur: 3. Regional Nurse Consultant re-educated the U.S. FOIA (b) (6) regarding the requirements for the facility hiring of Nurse Aides with emphasis on the following: A. Verification that the Nurse Aide is enrolled and actively taking classes in a New Jersey State approved CNA training program. B. Validate completion of module 1 (16 hours) in the CNA training Program prior to allocation of assignment. C. There was a delineation policy in place for the hiring, staffing and assignments of non-certified Nurse Aides. D. Once all the above requirements have been met, documentation will be placed in the employee file. The facility has developed a policy for the hiring, staffing and assignment for Nurse Aides. The DON or designee will review monthly that any newly hired Nurse Aides have proof of the required documentation including a signed job description in their file prior to hire and starting orientation.</p> <p>IV. Corrective actions will be monitored</p>		

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F 728	<p>Continued From page 42</p> <p>home while completing the training and testing.</p> <p>On 11/22/23 at 9:00 AM, the surveyor reviewed eight selected new hire employee files from the facility provided "New Hire Roster since [REDACTED] NJ Exec Order 28.4(b)(1) [REDACTED]</p> <p>The surveyor reviewed the non-certified [REDACTED] U.S. FOIA (b)(6) employee file with a date of hire of [REDACTED] NJ Exec Order 28.4(b)(1) [REDACTED] and the file included the following: Temporary Nurse Aide (TNA) job description acknowledgement form signed and dated by the [REDACTED] U.S. FOIA (b)(6) [REDACTED] There was no document listing the job description for TNA. TNA Certificate of Completion dated [REDACTED] NJ Exec Order 28.4(b)(1) [REDACTED]. Enrollment Agreement from [school name redacted] for Certified Nursing Assistant program with a course start date of [REDACTED] signed by the [REDACTED] U.S. FOIA (b)(6) on [REDACTED] NJ Exec Order 28.4(b)(1) [REDACTED]</p> <p>There was no documented evidence that the [REDACTED] U.S. FOIA (b)(6) was currently enrolled and actively taking classes in a New Jersey state-approved CNA Training Program or completion of Module 1 in their CNA Training Program. There was no signed job description for a [REDACTED] U.S. FOIA (b)(6)</p> <p>On 11/22/23 at 9:43 AM, in the presence of another surveyor, the surveyor asked the [REDACTED] U.S. FOIA (b)(6) for information regarding the [REDACTED] U.S. FOIA (b)(6). The [REDACTED] U.S. FOIA (b)(6) stated that the [REDACTED] U.S. FOIA (b)(6) was on maternity leave and before she returned to work, the [REDACTED] U.S. FOIA (b)(6) went to CNA class and finished the 16 hours in class. He added that the [REDACTED] U.S. FOIA (b)(6) was within the 120 days [to become certified]. He added that he was going to speak with the [REDACTED] U.S. FOIA (b)(6) for more information.</p>	F 728	<p>to ensure the deficient practice will not recur:</p> <p>4. Director of Human Resources or designee will audit all files of newly hired Nurse Aides prior to them receiving an independent resident assignment to ensure all the requirements for the facility hiring and use of Nurse Aides per facility policy are met weekly x 4 weeks, monthly x 3 months, then quarterly x 2 quarters.</p> <p>5. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 728	<p>Continued From page 43</p> <p>On 11/22/23 at 10:18 AM, in the presence of another surveyor, the [redacted] stated that according to the [redacted], the [redacted] was on [redacted] leave of absence from [redacted] and that the [redacted] was not working in the facility until after the first 16 hours of class.</p> <p>On 11/22/23 at 11:14 AM, in the presence of another surveyor, the surveyor notified the [redacted] that there were no documents in the employee file for the completion of the 16 hours. The [redacted] looked through the [redacted] employee file and confirmed that there were no documents for the completion of the 16 hours. The surveyor requested the timecard for the [redacted].</p> <p>A review of the facility provided timecard indicated that the [redacted] started working again at the facility on [redacted] after being on a leave of absence that had started [redacted].</p> <p>On 11/22/23 at 11:19 AM, in the presence of another surveyor and [redacted], the [redacted] looked through the [redacted] employee file and confirmed that there were no documents for the completion of the 16 hours. The [redacted] stated that she thought that it was in there when she "pulled" the file.</p> <p>On 11/22/23 at 11:40 AM, in the presence of another surveyor, the surveyor interviewed the [redacted]. The [redacted] stated that she just finished CNA Training Program. She stated that she was going to take her skills competency test on [redacted] and then the written exam. She stated that in the past she had taken and passed the skills test on [redacted] but that she became pregnant and could not take the written test. The [redacted] stated that she had to start her CNA training</p>	F 728			

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F 728	<p>Continued From page 44</p> <p>program over and that she started it on [REDACTED] NJ Ex Order 26.4(b) She added that she had to complete 16 hours of class and then she came back to work on [REDACTED] NJ Ex Order 26.4(b)(1). The [REDACTED] stated that she did an orientation and worked with someone for two (2) weeks. She added that on 10/24/23 she had completed 90 hours of class and 40 hours of clinical.</p> <p>On 11/22/23 at 11:52 AM, the surveyor asked the [REDACTED] if she had documentation that she completed the 16 hours. The [REDACTED] stated that she did not have any documentation but that the school would have it. The [REDACTED] called the school and was told to send an email to the school. The [REDACTED] sent an email to the school to get the 16 hour documentation.</p> <p>On 11/22/23 at 12:25 PM, in the presence of another surveyor, the surveyor interviewed the [REDACTED] regarding her resident assignment. The [REDACTED] stated that she had her own resident assignment and that she assisted her residents to the bathroom, cleaned them and provided showers. She added that the only time she worked with someone was when a resident required two people for a transfer. The surveyor asked how long the [REDACTED] had her own assignment. The [REDACTED] stated that she had her own assignment for almost three months and that the only time she was with someone as a "buddy" was during her two weeks of orientation.</p> <p>On 11/22/23 at 12:31 PM, the surveyor interviewed the [REDACTED] U.S. FOIA (b)(6) that was on the South unit regarding the current assignment for the unit. The [REDACTED] provided the surveyor that day's assignment and confirmed</p>	F 728			

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F 728	<p>Continued From page 45</p> <p>that the [U.S. FOIA (b)(6)] had her own assignment.</p> <p>On 11/22/23 at 12:40 PM, in the presence of another surveyor, the surveyor interviewed the [U.S. FOIA (b)(6)]. [U.S. FOIA (b)(6)] stated that the [U.S. FOIA (b)(6)] currently worked on the South unit and that she had her own assignment.</p> <p>On 11/22/23 at 01:00 PM, in the presence of another surveyor, the surveyor interviewed the [U.S. FOIA (b)(6)] regarding [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] stated that the [U.S. FOIA (b)(6)] was responsible for the files for [U.S. FOIA (b)(6)] and CNAs. He added that he was responsible for the interview and requirements but that the [U.S. FOIA (b)(6)] was responsible for the "proof check". The surveyor asked the [U.S. FOIA (b)(6)] what were the documents that were required for a [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] stated that the [U.S. FOIA (b)(6)] had to have proof of 16 hours completed from their course, background check and reference check. He added that we did our own orientation and competency with the [U.S. FOIA (b)(6)]. The surveyor asked the [U.S. FOIA (b)(6)] about the [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] stated that the [U.S. FOIA (b)(6)] was previously a temporary nurse aide (TNA) when she was originally hired and that during the process of her becoming a CNA the [U.S. FOIA (b)(6)] became pregnant and did not finish the whole process. The surveyor asked the [U.S. FOIA (b)(6)] if the [U.S. FOIA (b)(6)] should have had documented evidence that she had completed the 16 hours prior to restarting her employment at the facility. The [U.S. FOIA (b)(6)] stated that there should have been documentation.</p> <p>On 11/22/23 at 01:55 PM, the [U.S. FOIA (b)(6)] provided documented evidence that the [U.S. FOIA (b)(6)] had completed the 16 hours that was a letter from the school that was dated 11/22/23. The [U.S. FOIA (b)(6)], in the</p>	F 728			

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F 728	<p>Continued From page 46</p> <p>presence of another surveyor, confirmed that the facility just received the document from the school and that they did not previously have it.</p> <p>On 11/22/23 at 02:10 PM, in the presence of another surveyor, the surveyor notified the U.S. FOIA (b)(6) the concern that the facility failed to ensure that the U.S. FOIA was currently enrolled, actively taking classes and validated completion of Module 1 in the CNA Training Program before the U.S. FOIA had an independent resident assignment and that the U.S. FOIA did not have a signed job description.</p> <p>On 11/22/23 at 02:12 PM, the facility administration confirmed that they did not have a policy on U.S. FOIA and that they only had a U.S. FOIA responsibilities and requirements document that the facility provided to the surveyor. The surveyor requested a blank copy of a U.S. FOIA job description.</p> <p>The facility did not provide any additional information.</p> <p>A review of the facility provided undated and untitled document included the following: Nursing Assistant responsibilities include: ... Requirements and skills ... Relevant training and/or certifications as a Nursing Assistant ...</p> <p>N.J.A.C. 8:39-43.1</p>	F 728			
F 755 SS=D	<p>Pharmacy</p> <p>Srvcs/Procedures/Pharmacist/Records</p> <p>CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services</p>	F 755			1/3/24

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F 755	<p>Continued From page 47</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to a.) maintain a system of record keeping of DEA (Drug Enforcement Administration) Form-222 (a federal narcotic requisition form), that ensured</p>	F 755	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. The DON immediately reported to the Department of Community Affairs (DCA) Controlled Substance (CDS) unit that the missing DEA Form-222 Order Form</p>		

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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 11/22/2023
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 755	<p>Continued From page 48</p> <p>drug records were in order, and controlled dangerous substance (narcotics medications), with high potential for abuse were tracked with detail and b.) develop procedures that enabled prompt identification of loss or potential diversion of controlled substance.</p> <p>The deficient practice was evidenced by the following:</p> <p>21 CFR 1305.16(b) Whenever any used or unused DEA Forms 222 are stolen or lost (other than in the course of transmission) by any purchaser or supplier, the purchaser or supplier must immediately upon discovery of the theft or loss, report the theft or loss to the Special Agent in Charge of the Drug Enforcement Administration in the Divisional Office responsible for the area in which the registrant is located, stating the serial number of each form stolen or lost.</p> <p>21 CFR 1305.18 If the registration of any purchaser terminates (because the purchaser dies, ceases legal existence, discontinues business or professional practice, or changes the name or address as shown on the purchaser's registration) or is suspended or revoked under 1301.36 of this chapter for all Schedule I and II controlled substances for which the purchaser is registered, the purchaser must return all unused DEA Forms 222 to the Registration Section.</p> <p>On 11/20/23 at 02:25 PM, the surveyor and the U.S. FOIA (b)(6) reviewed the DEA Form-222 (a federal narcotic requisition form), used to enable accurate reconciliation of</p>	F 755	<p>Number 210912665, Order Form Number 210912667 and Order Form Number 210912672 were destroyed by the DON when the former Medical Director of the facility retired, the forms were unused not lost or stolen. No residents were affected by the deficient practice.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. All residents have the potential to be affected by the deficient practice. A complete audit of all DEA Form-222 was conducted by the DON and the Regional Nurse Consultant (RNC) and no other forms were noted to be missing or unaccounted for.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The facility has updated the policy and procedure regarding Controlled CDS. The DON was re-educated by the RNC on the policy and procedure regarding Controlled CDS and the importance of accurate reconciliation of the DEA Form-222.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The LHNA or Pharmacy Consultant will conduct audits of the DEA-Form 222 weekly x 4 weeks, monthly x 3 months and quarterly x 2 quarters to ensure they are accurately reconciled, and none are</p>		

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F 755	<p>Continued From page 49</p> <p>controlled-dangerous substances (medications, with high potential for abuse and tracked with detail) together. The surveyor and the [U.S. FOIA (b)(6)] observed three (3) forms were missing.</p> <p>Order Form Number 210912665; missing. Order Form Number 210912667; missing. Order Form Number 210912672; missing.</p> <p>At that time, the [U.S. FOIA (b)(6)] informed the surveyor that he had not realized that the DEA Form-222 were to be used and maintained in a sequential order, and that the [U.S. FOIA (b)(6)] had only informed him that day of its proper maintenance.</p> <p>On that same date and time, the [U.S. FOIA (b)(6)] was unaware that the DEA Form-222 were missing, was unable to locate the missing DEA Form-222, and was unable to provide information if the forms were used, voided, lost, or stolen.</p> <p>At that time, the surveyor discussed with the [U.S. FOIA (b)(6)] the concerns regarding the drug records that were not in order and the failure to maintain a system of record keeping, and gave an opportunity to submit further information regarding the missing DEA Form-222.</p> <p>On 11/20/23 at 12:58 PM, in the presence of the survey team, the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] were made aware of the concerns regarding the missing DEA Form 222 and failure to maintain a record system for accountability.</p>	F 755	<p>missing or used out of order. Unused order forms should be voided and returned to the Drug Enforcement Administration.</p> <p>5. The results of these audits will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 755	<p>Continued From page 50</p> <p>A review of the facility provided letter dated 11/21/23, sent by the [REDACTED] to the Department of Community Affairs (DCA) Controlled Drug Substance (CDS) unit reflected a statement from the [REDACTED]. The letter indicated that the [REDACTED] of the facility had changed. The previous [REDACTED] had retired, and the [REDACTED] had destroyed the old DEA Form-222 that was not executed. The [REDACTED] documented he was unaware that it had to be returned to the DEA office.</p> <p>On 11/21/23 at 12:04 PM, in the presence of the survey team, the [REDACTED] stated he had sent an email to the DCA CDS unit regarding the missing DEA Form-222 with an explanation.</p> <p>At that time, the [REDACTED] stated that he would conduct an audit of the DEA Form-222. He further stated that the maintenance of the record system was important and ensured against drug diversion and allowed for the facility tracking of the controlled dangerous substance.</p> <p>A review of the undated facility provided policy and procedure regarding Controlled CDS did not include a procedure for record keeping and maintenance of the DEA Form-222.</p> <p>On 11/22/23 at 02:25 PM, the survey team met with the [REDACTED]. There was no additional information provided by the facility.</p>	F 755			
F 759 SS=D	<p>NJAC 8:39-19.4(a)</p> <p>Free of Medication Error Rts 5 Prcnt or More</p> <p>CFR(s): 483.45(f)(1)</p>	F 759			1/3/24

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F 759	<p>Continued From page 51</p> <p>§483.45(f) Medication Errors. The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation conducted on 11/17/23 and 11/20/23, the surveyor observed four (4) nurses administer medications to six (6) residents. There were 27 opportunities, and two errors were observed which resulted in a medication error rate of 7.41%. This deficient practice was identified for two (2) of six (6) residents (Resident #47 and #55), that was administered by one (1) of four (4) nurses.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 11/17/23 at 8:33 AM, the surveyor observed the U.S. FOIA (b)(6)) prepare medications for Resident #47. The medications included a physician's order of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1</p> <p>At that time, the nurse stated she did not have the medication NJ Exec Order 26.4b1 in the medication cart and left to retrieve it from the medication room.</p>	F 759	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. Resident #47 attending physician was notified that the NJ Exec Order 26.4b1 administration, no new orders were given. Resident # 55 attending MD was notified that the NJ Exec Order 26.4b1 administration, no new orders were given. The Pharmacy was immediately notified to send the medications needed for Resident #47 and #55. The medications for both residents were received in time to be administered at the next scheduled time. Resident #47 and resident #55 had no negative outcome related to the medications being not available.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. All residents have the potential to be affected by the deficient practice. The Pharmacy Consultant reviewed the medication supply for current residents to ensure that all medications are available for administration, no other medications</p>		

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F 759	<p>Continued From page 52</p> <p>At 8:37 AM, the [REDACTED] finished preparing the medications for Resident #47 that included [REDACTED] NJ Exec Order 26.4b1 [REDACTED] and confirmed with the surveyor that she was ready to administer the resident's medication.</p> <p>At 8:42 AM, the [REDACTED] explained to Resident #47 that she about to administer the [REDACTED] and the resident refused.</p> <p>At that time, the surveyor and the [REDACTED] left the resident's room. The surveyor and the [REDACTED] reviewed the electronic Medication Administration Record (eMAR) together against the [REDACTED] the [REDACTED] attempted to administer which revealed the following:</p> <p>-The eMAR reflected an order for [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>-The [REDACTED] prepared by the [REDACTED] for administration contained [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>[REDACTED] Indicated as an [REDACTED] NJ Ex Order 26.4(b)(1) against further [REDACTED] or to [REDACTED] NJ Ex Order 26.4(b)(1), temporary [REDACTED] due to [REDACTED] NJ Ex Order 26.4(b)(1) or [REDACTED] NJ Ex Order 26.4(b)(1).</p> <p>At that time, the [REDACTED] informed the surveyor that the [REDACTED] she had obtained from the medication room was a house stock item and the only kind the facility had in stock.</p>	F 759	<p>were unavailable.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The facility Educator will re-educate the licensed nursing staff on the policy and procedure for [REDACTED] medication administration with emphasis on medication inspection, confirming that the medication name and dose are correct, prior to medication administration that they verify each medication preparation that the medication is the Right Drug, at the Right Dose, the Right Route, at the Right Rate, at the Right Time, for the Right Resident. The facility educator or designee will also conduct medication administration observations with licensed staff to ensure they are following the medication administration policy and procedure.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The ADON or designee will conduct medication administration audits/observations of 4 nurses per week, weekly x 4 weeks, monthly x 3 months, then quarterly x 2 quarters to ensure residents receive the correct medication and dose as prescribed by the physician.</p> <p>5. The results of these audits will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice</p>		

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F 759	<p>Continued From page 53</p> <p>At that time, the [U.S. FOIA (b)(6)] acknowledged that the Physician Order on the eMAR and the Artificial Tears she had obtained from the medication room were different.</p> <p>At that time, the [U.S. FOIA (b)(6)] stated she would contact the pharmacy to obtain the correct order and call to inform the physician that the eye drop was not available at that time.</p> <p>2. On 11/17/23 at 8:46 AM, the surveyor observed the [U.S. FOIA (b)(6)] prepare medications for Resident #55. The medications included a physician order of NJ Exec Order 26.4b1 [REDACTED]</p> <p>At 8:49 AM, the [U.S. FOIA (b)(6)] finished preparing the medication for Resident #55 that included, NJ Exec Order 26.4b1 and confirmed she was ready to administer the medications for Resident #55. The [U.S. FOIA (b)(6)] locked the cart and entered the threshold of the resident's room.</p> <p>At 8:50 AM, prior to the administration of Resident #55's medication, the surveyor asked the [U.S. FOIA (b)(6)] to step outside the resident's room.</p> <p>At 8:51 AM, the surveyor and the [U.S. FOIA (b)(6)] reviewed the eMAR together against the [U.S. FOIA (b)(6)] NJ Exec Order 26.4b1. The [U.S. FOIA (b)(6)] attempted to administer. The [U.S. FOIA (b)(6)] confirmed the medication she had attempted to administer was not the same as the physician's order since it did not contain the [U.S. FOIA (b)(6)] ingredient. The physician's order was for a NJ Exec Order 26.4b1 as part of the resident's [U.S. FOIA (b)(6)] NJ Exec Order 26.4b1</p>	F 759	will not recur.		

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F 759	<p>Continued From page 54</p> <p>A review of the U.S. FOIA (b) (6) Medication Pass Observation for the U.S. FOIA (b) (6) reflected the following:</p> <ul style="list-style-type: none"> -On 11/30/21, the U.S. FOIA (b) (6) had 0% error rate. -On 01/20/22, the U.S. FOIA (b) (6) had 7% error rate. -No further information was provided for 2023. <p>On 11/20/23 at 12:58 PM, in the presence of the survey team, the U.S. FOIA (b) (6), the U.S. FOIA (b) (6), the U.S. FOIA (b) (6) the surveyor discussed the concerns regarding the medication pass errors observed.</p> <p>On 11/21/23 at 12:04 PM, in the presence of the survey team, the U.S. FOIA (b) (6) stated that the U.S. FOIA (b) (6) should have informed the U.S. FOIA (b) (6), someone and called the physician to obtain a substitution and not assume it was the same item. The U.S. FOIA (b) (6) stated moving forward the pharmacist would conduct more medication pass observations. The U.S. FOIA (b) (6) also stated that during the medication pass, the U.S. FOIA (b) (6) should have followed the five steps to medication administration.</p> <p>A review of the facility provided policy, Medication Preparation and dispensing, revised on 02/16/22 included the following:</p> <p>Procedure:</p> <p>D. Medication Inspection</p> <ol style="list-style-type: none"> 1. Confirm that medication name and dose are correct. <p>G. Prior to Medication Administration</p> <ol style="list-style-type: none"> 1. Verify each medication preparation that the 	F 759			

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F 759	Continued From page 55 medication is the RIGHT DRUG, at the RIGHT DOSE, the RIGHT ROUTE, at the RIGHT RATE, at the RIGHT TIME, for the RIGHT CUSTOMER.	F 759			
F 812 SS=F	NJAC 8:39-11.2 (b), 29.2 (d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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 document review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 11/15/23 at 10:56 AM, the surveyor accompanied by the U.S. FOIA (b)(6)	F 812			1/3/24
			I. Corrective action(s)accomplished for resident(s)affected: 1. The 9 stacks of dessert tray cups were immediately removed and sanitized per facility policy. The metal dish racks, hanging utensil bar and all utensils that were hung on the bar were all cleaned and sanitized per facility		

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F 812	<p>Continued From page 56</p> <p>U.S. FOIA (b)(6) observed the following in the kitchen:</p> <ol style="list-style-type: none"> Upon entry to the kitchen, nine (9) stacks of dessert tray cups were observed with scattered white substances. The U.S. FOIA (b)(6) informed the surveyor that the white substances were dust. The U.S. FOIA (b)(6) stated that two (2) out of nine (9) stacks were empty. He further stated that they were considered clean but would not be used as of that time, the facility was using disposables for dessert because of the short staff "lately" for a month or so now. In the metal dish racks, there were clean pans and pots. The metal side part of the dish racks was noted with brownish discoloration. The U.S. FOIA (b)(6) stated that the brownish discoloration was not rust. He further stated that the metal dish racks should have been cleaned. In the hanging utensil bar, just above the hot food (with cover), there were scattered blackish substances all over the metal part of the hanging utensil bar. The U.S. FOIA (b)(6) wiped it with his bare hand and stated that the blackish substances were dust accumulation and should have been cleaned. There were six whisks, three spatulas, eight small serving spoons, one big serving spoon, and five tongs hung on the utensil bar that the U.S. FOIA (b)(6) indicated were considered clean. In the bread area, both the surveyor and U.S. FOIA (b)(6) observed the bread with one date with no specification if the date was "use by date," as follows: Two loaves of bread dated 11/10 12 loaves of bread dated 11/14 One loaf of rye bread dated 11/10 (not properly 	F 812	<p>policy. An order was placed on 11/20/2023 to replace the metal dish racks. The two loaves of bread dated 11/10, 12 loaves of bread dated 11/14, one loaf of rye bread that was dated 11/10 and not properly sealed, one bag of burger buns (12 buns) dated 11/10, one bag of burger buns dated 11/14, one bag of dinner rolls dated 11/10, one bag of dinner rolls dated 11/11, one bag of hotdog buns dated 11/11, two bags of hotdog buns dated 11/14 were removed and discarded. The pellet warmer and the plates inside the pellet warmer were cleaned and sanitized per facility policy. The tray line table and the area below the tray line table where the clean cereal bowl lids were stacked was cleaned and sanitized and the cereal bowl lids were also removed, cleaned and sanitized. The dietary staff was immediately educated on the correct policy of dating bread items when received and with a use by date of 5 days from the delivery date or the best buy date, whichever comes first and the cleaning of the dessert tray cups, metal dish racks, hanging utensil bar, pellet warmer and tray line table. No residents were affected by this deficient practice.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <ol style="list-style-type: none"> All residents residing in the facility have the potential to be affected by the deficient practice. <p>The Regional Food Service Director</p>		

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F 812	<p>Continued From page 57</p> <p>sealed, with hole)</p> <p>One bag of burger buns (12 buns) dated 11/10</p> <p>One bag of burger buns dated 11/14</p> <p>One bag of dinner rolls dated 11/10</p> <p>One bag of dinner rolls dated 11/11</p> <p>One bag of hotdog bun dated 11/11</p> <p>Two bags of hotdog bun dated 11/14</p> <p>At this time, the [REDACTED] stated that the dates on the bread were the delivery dates. The surveyor asked the [REDACTED] how they knew when to discard the bread and how long the shelf life was if it was stored at room temp. The [REDACTED] stated that as long as the bread was not stale (no longer fresh and pleasant to eat; hard, musty, or dry) and had no mold the bread was still good. The surveyor asked the [REDACTED] what's the facility policy about the bread and he stated that there's no specific date for how long the bread can be at room temp "probably 5 days."</p> <p>5. In the pellet warmer (an improved heating pellet for keeping serving plates warm in hospitals and other food-service operations), there were scattered areas inside with brownish substances. The [REDACTED] informed the surveyor that there were clean plates inside the pellet warmer. The [REDACTED] further stated that the brownish substances "looks like grease," and should have been cleaned.</p> <p>6. In the tray line table, below the tray line table there were dried white substances where the clean cereal bowl lids were stacked.</p> <p>On 11/20/23 at 11:36 AM, the surveyor reviewed the provided invoices of delivery receipts for bread as follows:</p>	F 812	<p>re-educated the FSD on the bread storage policy to include a received date and a use by date on all bread items as well as the proper way to store bread to maintain the freshness and quality of the bread. The Regional Food Service Director also re-educated the FSD on the facility policy and procedure of keeping the dessert tray cups, metal dish racks, hanging utensil bar and the tray line table clean and sanitized to prevent contamination of the items being stored on racks, tray line tables or pellet warmers.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The Regional Food Service Director or designee will re-educate the dietary staff on the bread storage policy to include a received date and a use by date on all bread items as well as the proper way to store bread to maintain the freshness and quality of the bread. A guide for dating bread with a received by date and a use by date no longer than 5 days from the date received or the best buy date whichever comes first will be posted in the bread storage area. The Regional Food Service Director or designee will re-educate the dietary staff FSD on the facility policy and procedure of keeping the dessert tray cups, metal dish racks, hanging utensil bar and areas under the tray line table clean and sanitized to prevent the contamination of</p>		

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F 812	<p>Continued From page 58</p> <p>11/10/23 invoice#37442454=quantity and description: four (4) packs hamb (hamburger) plain 12 pk (pack), six (6) each white LF (loaf) 28oz (28 ounces), 12 each wheat LF 280z, four (4) pk din (dinner) RL (roll) split top 16PK, four (4) EA (each) Texas TST (toast) wht (white)</p> <p>11/14/23 invoice#37445422=quantity and description: two (2) PK hotdog RL 12 PK, one (1) PK Hamb RL plain 12 PK, eight (8) EA white LF 280z, 10 EA wheat LF 280Z</p> <p>A review of the above provided invoices revealed that there was no delivery done on 11/11/23.</p> <p>On 11/20/23 at 12:57 PM, the survey team met with the U.S. FOIA (b)(6)</p> <p>The surveyor notified the facility management of the above findings and concerns.</p> <p>A review of the undated facility's General Sanitation in the Kitchen Policy that was provided by the U.S. FOIA (b)(6) included that the staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.</p> <p>A review of the facility's Bread Policy that was provided by the U.S. FOIA (b)(6) with an updated date on 7/06/23 included to assure all bread is being served in a safe manner and to maintain the freshness of the food product being served, the Food Service Department/designee will inspect all bread upon arrival to facility to assure proper freshness and food quality. All boxed bread will</p>	F 812	<p>items being stored on racks, tables or pellet warmers. The daily cleaning schedule was revised to specifically include the dessert cups, metal dish racks, hanging utensil bar, pellet warmer and tray line table will be followed to ensure proper cleaning and sanitizing of these items to prevent contamination of the items being stored on or in them.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The Dietician, LHNA or designee will conduct weekly audits x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters of bread in the bread storage area to ensure that no bread is kept past the discard date or use by date and that it is being stored properly to ensure it stays fresh until it is discarded.</p> <p>The Dietician or LHNA or designee will conduct weekly audits of all the areas that were not clean which were the dessert tray cups, metal dish racks, hanging utensil bar, pellet warmer and the tray line table weekly x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters to ensure all items remain clean and sanitized per facility policy and that the daily cleaning schedule is being followed including the dessert tray cups, metal dish racks, hanging utensil bar, pellet warmer and the tray line table</p> <p>5. The results of these audits will be reviewed at Quality Assurance Performance Improvement (QAPI)</p>		

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F 812	<p>Continued From page 59</p> <p>be date marked with a received date. Each individual package of bread will be date marked with a received date. No bread in the storage area and/or production area will exceed five days. If any bread in the storage area and/or production area exceeds five days, the product will be discarded at the end of day five or the best buy date, whichever comes first.</p> <p>A review of the provided In-service record/meetings by the [REDACTED] for the date of 11/16/23 with a topic(s) that included "All bread products must have a 'received on' and 'use by' date placed on them upon delivery. All bread products must be discarded after five days or by expiration date, whichever comes first. Ex (example) bread has a received date of 11/17, it must be discarded by end of day 11/21."</p> <p>On 11/21/23 at 12:04 PM, the survey team met with the [REDACTED] stated that there should be two dates in the bread, the delivery date and the discard date. The [REDACTED] further stated "I understand that was not the appropriate process," when the surveyor observed the bread.</p> <p>On that same date and time, the [REDACTED] stated that there were cleaning issues with the dessert cups, hanging utensils, and the pellet warmer and that they should have been cleaned.</p> <p>The surveyor reviewed the Order#WJ44831481 provided by the [REDACTED] It reflected that the five (5) tier rolling steel wire shelving unit for new dish racks was placed on order on 11/20/23.</p> <p>NJAC 8:39-17.2(g)</p>	F 812	<p>quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 882 SS=D	<p>Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)</p> <p>§483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must:</p> <p>§483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;</p> <p>§483.80(b)(2) Be qualified by education, training, experience or certification;</p> <p>§483.80(b)(3) Work at least part-time at the facility; and</p> <p>§483.80(b)(4) Have completed specialized training in infection prevention and control. 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 ensure that the [REDACTED] had completed specialized training in infection prevention and control per Centers for Medicare & Medicaid Services (CMS) guidance prior to assuming the [REDACTED] role for one (1) of one (1) employee reviewed for [REDACTED]</p> <p>This deficient practice was evidenced by the following:</p> <p>A review of CMS QSO-19-10-NH Memo, dated 3/11/19, included but was not limited to the following: Background: Effective November 28, 2019, the final requirement includes specialized</p>			F 882	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. The infection Control Preventionist did not complete the requirements per CMS guidance for the specialized training upon hire on January 1, 2023. The Infection Control Preventionist started the Centers for Disease Control (CDC) prevention training and continuing education online on 2/11/2023 and completed the Nursing home Infection Preventionist Training course (Web-based) awarded on 9/16/2023. No residents were affected by this deficient practice.</p>		1/3/24

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F 882	<p>Continued From page 61</p> <p>training in infection prevention and control for the individual(s) responsible for the facility's IPCP (infection prevention and control program). ...Specialized Training for Infection Prevention and Control: In order to receive ... a certificate of completion, learners must complete all modules and pass a post-course exam ... The "Nursing Home Infection Preventionist Training Course" is available on CDC's (Centers for Disease Control and Prevention) TRAIN website ...Completion of this course will provide specialized training in infection prevention and control.</p> <p>A review of the CMS QSO-22-19-NH Memo dated 6/29/22 included but was not limited to the following: Infection Control: Revisions include guidance for implementing Phase 3 regulations which require nursing homes to have an U.S. FOIA (b)(6) U.S. FOIA (b)(6) who has specialized training onsite at least part-time to effectively oversee the facility's infection prevention and control program (IPCP). This revision will strengthen our general infection control guidance to address frequently cited issues such as hand hygiene, transmission-based precautions, and surveillance of infectious diseases. While the requirement is to have an U.S. FOIA (b)(6) at least part-time, facilities are responsible for an effective IPCP and should ensure the role of the U.S. FOIA (b)(6) is tailored to meet the facility's needs. With emerging infectious disease such as COVID-19, CMS believes the role of the U.S. FOIA (b)(6) is critical in the facility's efforts to mitigate the onset and spread of infections. Additionally, CDC and CMS developed specialized U.S. FOIA (b)(6) training to include topics such as Transmission Based Precautions and Antibiotic Stewardship programs (ASP).</p>	F 882	<p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The DON was re-educated by the Regional Nurse Consultant (RNC) regarding requesting/reviewing the completed certificate for specialized IP training prior to interviewing for the position. The DON will review any candidate(s) resume(s) for the Infection Control Preventionist position to ensure the completion of specialized training in infection prevention and control per CMS guidance was met prior to hire, including review of the completed certificate(s).</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The Licensed Nursing Home Administrator (LHNA) or designee will review any potential candidate for the Infection Control Preventionist role prior to hire to review the completed certificate for the specialized IP training requirements each time a candidate applies monthly x 3 months, then quarterly x 2 quarters.</p> <p>5. The results of these audits will be</p>		

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F 882	<p>Continued From page 62</p> <p>On 11/16/23 at 11:10 AM, the surveyor interviewed the facility [redacted]. The [redacted] stated that she assumed the role of [redacted] in [redacted] NJ Ex Order 26.4(b)(1). She added that she took the CDC course. The surveyor requested a copy of the CDC course certificate and her signed job description.</p> <p>A review of the designated IP CDC Nursing Home Infection Preventionist Training Course (web-based) required training for [redacted] revealed that it was completed on [redacted] NJ Ex Order 26.4(b)(1).</p> <p>A review of the Job Description Acknowledgment for the position of an [redacted] showed that the [redacted] signed the acknowledgement on 01/09/23 and assumed the role of [redacted]. The [redacted] did not have the required specialized training prior to assuming the role of [redacted] U.S. F.</p> <p>On 11/20/23 at 01:12 PM, in the presence of the survey team, the surveyor notified the [redacted] NJ Ex Order 26.4(b)(1).</p> <p>[redacted] the concern that the [redacted] U.S. F. did not have specialized training prior to assuming the role as [redacted] U.S. F.</p> <p>On 11/21/23 at 12:41 PM, in the presence of the survey team, [redacted] U.S. FOIA (b)(6) stated that the [redacted] U.S. F. was hired [redacted] U.S. FOIA (b)(6) and took the CDC training course in the beginning of April 2023 but that she did not take the test and get the certificate at that time. She added that the [redacted] U.S. F. did not complete it [the course] until September when it was recognized. The [redacted] U.S. FOIA (b)(6) stated that the [redacted] U.S. F. was a new role that came about since Covid and that we needed someone in the role</p>	F 882	<p>reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 882	Continued From page 63 and get them trained. He added that they chose to fill the role with someone that was already employed at the facility. A review of the [REDACTED] Job Description included the following: Qualifications: ... MUST become a Certified NJ Ex Order 26.4(b)(1) as per CDC Guidelines (will be informed of required trainings) The job description did not include any information regarding CMS guidance.	F 882			
F 922 SS=F	N.J.A.C. 8:39-19.1(b) Procedures to Ensure Water Availability CFR(s): 483.90(i)(1) The facility must-- §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility provided documents, it was determined that the facility failed to maintain the designated emergency supply of water needed for residents in the event of a loss of normal water supply in accordance with the facility's emergency disaster plan. This failure had the potential to affect all 62 residents who currently live in the facility. This deficient practice was evidenced by the following: On 11/16/23 at 12:45 PM, the surveyor observed the emergency water storage area in the presence of the U.S. FOIA (b)(6)	F 922	I. Corrective action(s) accomplished for resident(s) affected: 1. The facility immediately obtained a fresh emergency supply of water sufficient to provide 1 gallon of water per day per resident and staff x 3 days. The expired water was discarded. II. II. Residents identified having the potential to be affected and corrective action taken: 2. All residents residing have the potential to be affected by the deficient practice. The U.S. FOIA (b)(6) and the U.S. FOIA (b)		1/3/24

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F 922	<p>Continued From page 64</p> <p>U.S. FOIA (b)(6) The resident census on the day of observation was 62 (based on the Matrix [used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents currently in the facility] provided by the U.S. FOIA (b)(6)). The surveyor observed 27 cases that contained three (3) 1-gallon bottles each, for a total of 81 gallons. The expiration date of the water gallons was 3/23/22.</p> <p>On that same date and time, the U.S. FOIA (b)(6) stated that they should have three (3) gallons of water per resident for three days in storage. He further stated it was important to have the water in storage in case of emergency the facility will have water to use. The U.S. FOIA (b)(6) then confirmed that this was the only water stored for the facility and that the water was all expired.</p> <p>At that same time, the surveyor asked the facility management why the Emergency Stock Inventory dated February 2023 (where the emergency water supply was listed) was computed only for residents and the staff was not included. The facility management had no response. The U.S. FOIA (b)(6) informed the surveyor that they (facility management) would get back to the surveyor for the facility policy and procedure regarding emergency water supply and computation that included the facility staff. The U.S. FOIA (b)(6) stated that he acknowledged that the facility did not have enough emergency water supply and that they are all expired the one that they have in stock.</p> <p>Furthermore, the U.S. FOIA (b)(6) stated that there should be</p>	F 922	<p>U.S. FOIA (b)(6) were re-educated by the Regional Food Service Director on the policy of storing and maintaining a fresh, adequate supply of water for all residents and staff in the facility x 3 days.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur: 3. The FSD will re-educate the dietary staff on the emergency water supply policy and procedure and that they need permission from the FSD or the Administrator to remove water from the supply. The FSD or designee will count the number of gallons and expiration dates for the emergency water supply weekly and record on a log to be maintained by the FSD.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur: 4. The LNHA or designee will conduct weekly audits x 4 weeks, monthly x 3 months, then quarterly x 2 quarters to ensure and adequate fresh emergency water supply is maintained and available for all residents and staff in the facility. 5. The results of these audits will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		

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F 922	<p>Continued From page 65</p> <p>201 gallons of water for a total of 67 residents (licensed beds=67 residents x 3 gallons=201 gallons).</p> <p>On 11/16/23 at 01:35 PM, the [U.S. FOIA (b)(6)] informed the surveyor that he was not happy about the emergency water supply. The surveyor asked the [U.S. FOIA (b)(6)] who was responsible for the emergency water supply and the [U.S. FOIA (b)(6)] stated that he and the [U.S. FOIA (b)(6)] were responsible.</p> <p>At that same time, the surveyor asked the [U.S. FOIA (b)(6)] what happened and why the facility's emergency water supply was not in accordance with the facility's requirement and all expired, the [U.S. FOIA (b)(6)] stated "Out of sight, out of mind." He further stated that he would make sure that delivery would be done today for emergency water supply to comply with the requirement. The surveyor followed up with the [U.S. FOIA (b)(6)] on the requested documents that included policy and procedure and the [U.S. FOIA (b)(6)] stated that they were still working on it.</p> <p>On 11/20/23 at 12:57 PM, the survey team met with the [U.S. FOIA (b)(6)] [REDACTED].</p> <p>The surveyor notified the facility management of the above findings and concerns.</p> <p>On 11/21/23 at 12:04 PM, the survey team met with the [U.S. FOIA (b)(6)] [REDACTED] informed the survey team that the emergency water was now available. The [U.S. FOIA (b)(6)] stated that the facility should be able to provide water for three days in case of disaster. The surveyor asked the facility management why the initial</p>	F 922			

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F 922	<p>Continued From page 66</p> <p>provided document for emergency water was computed only for the residents and the facility staff were not included. The [REDACTED] stated that he did not have an answer and I was not aware of it.</p> <p>A review of the undated facility's Emergency Disaster Plan Policy that was provided by the [REDACTED] included that the [REDACTED] will coordinate the function of the food service department during an emergency. The Procedure: the following will be available during an emergency or disaster: emergency food, water, and supplies for the planned menu pattern for three days.</p> <p>On 11/22/23 at 02:25 PM, the survey team met with the [REDACTED] for an Exit Conference. There was no additional information provided by the facility.</p> <p>NJAC 8:39-31.6(n)</p>	F 922			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROLLING HILLS CARE CENTER

**16 CRATETOWN ROAD
LEBANON, NJ 08833**

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for residents on 13 of 14 day shifts the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	I. Corrective action(s) accomplished for resident(s) affected: 1. Corrective action accomplished for resident affected: No residents were identified to be affected by the deficient practice. A review of the care that residents received on day shift on 10/29/23, 10/30/23, 10/31/23, 11/01/23, 11/02/23, 11/03/23, 11/04/23, 11/05/23, 11/06/23, 11/07/23, 11/08/23, 11/09/23 and 11/11/23 revealed no adverse events or grievances related to resident care were reported on these dates on the day shift. All Certified Nurse Aide (CNA) assignments including Central Unit were	1/3/24

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

TITLE

(X6) DATE

Electronically Signed

12/15/23

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S 560	<p>Continued From page 1</p> <p>established minimum staffing requirements in nursing homes.</p> <p>The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/29/23 to 11/11/23, the staffing to resident ratios that did not meet the minimum requirement of one (1) CNA to eight (8) residents for the day shift as documented below:</p> <p>For the 2 weeks of staffing prior to survey from 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows:</p> <p>-10/29/23 had 5 CNAs for 63 residents on the day shift, required at least 8 CNAs.</p> <p>-10/30/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs.</p> <p>-10/31/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs.</p> <p>-11/01/23 had 7 CNAs for 63 residents on the</p>	S 560	<p>revised to ensure the staff to resident ratios for all shifts are being met as mandated by The State of New Jersey which are one CNA to every eight residents for the day shift, one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be assigned to work as a CAN and shall perform nurse aide duties; and one direct care staff member to every 14 residents for the night shift, provided that each direct staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. Residents identified having the potential to be affected and corrective action taken:</p> <p>All residents that reside in the facility have the potential to be affected by the deficient practice.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The Facility Educator (FE) re-educated the Administrative Nursing staff and Staffing Coordinator on the Call Out Policy. When a call out(s) occurs and the minimum resident to C.N.A. ratio is not met, the DON or designee will be notified. All facility and contracted agency staff that is not on the schedule will be contacted to come in and assist with direct patient care to ensure staff to resident ratios for the</p>	

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S 560	<p>Continued From page 2</p> <p>day shift, required at least 8 CNAs. -11/02/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -11/03/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -11/04/23 had 5 CNAs for 61 residents on the day shift, required at least 8 CNAs.</p> <p>-11/05/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs. -11/06/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. -11/07/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. -11/08/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs. -11/09/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. -11/11/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs.</p> <p>On 11/21/23 at 10:21 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding staffing. The LNHA acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs. He stated, "it is very difficult for us to hire new employees because we are in a rural area and no one wants to travel here."</p> <p>On 11/21/23 at 11:18 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding staffing. The SC acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs. She stated the coordinate CNA staff according to the census total not by acuity on the floor. The SC further stated that she was</p>	S 560	<p>The facility currently utilizes 5 contracted nursing staffing agencies for licensed and certified nursing staff. Daily Bonus for agency and in house staff is offered for double shifts, weekends and for staff recognition. Referral and sign on bonuses are offered for both licensed and certified nursing staff. Advertisement lawn signs are in place on the front of the building and near the entrance of the facility. Use of multiple search engines and multiple media platforms to advertise our job ads Staffing needs are assessed daily and in the event, there is a CNA shortage and the ratio of one CNA to eight residents on day shift is not being met, nursing managers (Charge Nurses, ADON, FE) will assist with resident care if unable to find CNA replacements immediately. Other shift staff for that given day are asked to come in earlier and work the current shift and their assigned shift Other staff from other shifts are offered to switch shifts or pick up overtime to assist when running short</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur: 4. Other staff from other days are asked to switch shift or pick up overtime to assist when running short. The DON or designee will conduct weekly CNA staffing schedule audits x 4 weeks, monthly x 3 months then quarterly x 2 quarters to ensure that the CNA to resident staffing ratios are being met as mandated by The</p>	

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S 560	Continued From page 3 aware of the assignment on the long-term care "Central" unit not being staffed appropriately on day shift. The CNA assignment was for 10 residents on the unit and only one (1) CNA was ever staffed on that unit. She was not sure if the LNHA was aware or realizes it. According to the updated Facility Assessment November 2022 to November 2023 that was provided by the LNHA on 11/22/23 at 02:25 PM included on page 22, Staffing Ratio: per state regulations, 7 AM to 3 PM shift 1 CNA to 8 residents, 3 PM to 11 PM 1 CNA to 10 residents, and 11 PM to 7 AM 1 CNA to 14 residents.	S 560	State of New Jersey. 5. The LHNA or designee will analyze trend findings and report outcomes at the quarterly QAPI committee meeting.	
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to provide residents two evening activity programs per week. This deficient practice was identified for two (2) of three (3) months reviewed, September 2023, October 2023 and November 2023, as evidenced by the following: On 11/16/23 at 11:10 AM, the surveyor observed the facility's November 2023 activity calendar in hallway. Review of the calendar indicated the last activity scheduled was for 4 PM. There were no	S 720	I. Corrective action(s) accomplished for resident(s) affected: 1. Resident #12 NJ Ex Order 26.4(b)(1) by this practice. Evening activities are now being offered at least twice a week during evening hours for residents interested in evening activities. II. Residents identified having the potential to be affected and corrective action taken: 2. The deficient practice has the	1/3/24

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S 720	<p>Continued From page 4</p> <p>evening activities listed.</p> <p>On 11/16/23 at 11:23 AM, the surveyor interviewed an Activity Aid (AA) regarding the facilities activity program. The AA stated that the activity aides worked till 5 PM or 6 PM.</p> <p>On 11/16/23 at 11:43 AM, the surveyor observed Resident #12 seated in a [REDACTED] wheelchair participating in an activity in the activity room.</p> <p>On 11/16/23 at 11:48 AM, the surveyor interviewed Resident #12 regarding the facility's activity program. Resident #12 stated that the program was good. The surveyor asked Resident #12 if the facility provided an activity in the evening two times a week. Resident #12 stated that the question was not a good question for him/her because the resident was [REDACTED] at that time. The surveyor then asked Resident #12 if there was an activity after the 4 PM activity that was listed on the calendar. Resident #12 stated that he/she [REDACTED] but that he/she did not think that the facility had anything after 4 PM.</p> <p>On 11/17/23 at 8:48 AM, the surveyor interviewed the Director of Activities (DoA) regarding activities. The DoA stated that the facility had two fulltime aids and one per diem aid who just worked on the weekends. She added that they just hired someone to do one on one visits. The DoA stated that they have activities throughout the day and that sometimes we go until 6 or 7 at night. She added that we just had someone leave and someone was just hired to cover Tuesdays and Thursdays in the evening. The surveyor requested a copy of the last three months of activity calendars and staff schedules.</p>	S 720	<p>potential to affect all residents residing in the facility.</p> <p>Schedules of current activity employees have been adjusted to ensure there is activity staff in the building twice a week during evenings for evening activities. The activity calendar has been updated to reflect what days evening activities are being offered.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The Activities director was re-educated by the LHNA on the requirement of offering evening activities twice weekly. Referral and sign-on bonuses are now being offered. The facility is recruiting on multiple employment search engines and multiple social media platforms. The Director of Activities has switched schedules to accommodate in person evening activities at least twice a week if evening staff are unavailable.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>4. The Activity Director or designee will audit the activity calendar and activity staff schedule weekly x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters to ensure evening activities are offered twice per week.</p> <p>5. The results of these audits will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice</p>	

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S 720	<p>Continued From page 5</p> <p>Review of the September 2023 activity calendar provided by the DoA indicated the last activity scheduled was 5:45 PM two evenings a week during that month. Review of the staff schedule included a staff member that was scheduled to work until 7 PM for the first two weeks of September 2023. The last two weeks had a staff member scheduled to work until 6 PM.</p> <p>Review of the October 2023 activity calendar provided by the DoA indicated the last activity scheduled was 4:30 PM. There were no evening activities scheduled. Review of the staff schedule included a staff member that was scheduled to work until 6 PM.</p> <p>Review of the November 2023 activity calendar provided by the DoA indicated the last activity scheduled was 4:00 PM. There were no evening activities scheduled. Review of the staff schedule included a staff member that was scheduled to work until 6 PM.</p> <p>On 11/17/23 at 11:30 AM, the surveyor interviewed the DoA and asked if the month of October and November had evening activities. The DoA stated that the two months did not have evening activities. She added that the evening staff member left in August or September. The DoA stated that she was in the process of finding someone.</p> <p>On 11/20/23 at 01:12 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse Consultant (RNC), Assistant DON (ADON) and Vice President of Skilled Nursing Division (VPoSND) the concern that the facility did not have evening</p>	S 720	will not recur.	

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S 720	Continued From page 6 activities two times a week. On 11/21/23 at 12:11 PM, in the presence of the survey team, DON and RNC, the LNHA stated that the facility had a staffing situation and that the staff member had left. The LNHA stated that a staff person stayed until 6 PM and that evening activity had been scheduled on the calendar in the past. The LNHA confirmed that the facility did not have evening activities for the last two (2) months. A review of the facility provided policy titled "General Activities Policy" dated 6/15/23, included the following: Policy: The activities program at [facility name redacted] will be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activity professional to manage the Activities Department providing quality programming for the residents we service. The policy did not include any information regarding evening activities.	S 720		
S2340	8:39-31.6(n) Mandatory Physical Environment (n) The facility shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a review of pertinent facility documentation, it was determined that the facility failed to maintain a three-day minimum emergency food supply. This	S2340	I. Corrective action(s) accomplished for resident(s) affected: 1. On 11/16/23 all the emergency food supply and water noted to be expired was	1/3/24

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S2340	<p>Continued From page 7</p> <p>failure had the potential to affect all 62 residents who currently live in the facility.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 11/16/23 at 12:45 PM, the surveyor observed the emergency water storage area in the presence of the Food Service Director (FSD), Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON). The resident census on the day of observation was 62 (based on the Matrix [used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents] provided by the DON).</p> <p>On that same date and time, the surveyor requested a copy of the facility's three-day emergency food supply menu. At this time, the FSD provided a copy of the facility's Emergency Stock Inventory list dated February 2023 and proceeded for emergency food supply inspection. The surveyor and the facility management observed the following items listed on the Emergency Stock Inventory were not in storage:</p> <ol style="list-style-type: none"> 1. Two cases of cream of mushroom soup (12 cans) 2. One case of tuna (total of six cans) 3. Three cases of dry cereal 4. Two cases of apple juice (no refrigeration needed) 5. Two cases of vanilla pudding (for med [medication] pass) 6. Two cases of applesauce (for med pass) 7. One case each of salt, pepper, sugar, and artificial sweetener 	S2340	<p>immediately removed and discarded from the stock room.</p> <p>The three-day disaster menu guide was calculated for residents and staff and the emergency food was immediately purchased and replaced in the stock room on 11/17/23.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <ol style="list-style-type: none"> 2. All residents residing in the facility have the potential to be affected by the deficient practice if the facility does not maintain at least a three-day supply of food and water in case of an emergency. <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 3. The Corporate Food Service Director re-in serviced the Licensed Nursing home Administrator (LHNA) and Food Service Director (FSD) on the emergency food stock supply computation for residents and facility staff three-day emergency food and water supply and the Facility Emergency and Disaster Plan policy which includes the availability during an emergency or disaster food and water supplies need for a planned menu pattern for three days. <p>The FSD or designee is to audit the ER food stock weekly to validate the three-day supply of food and water is readily available and not expired.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 4. The LHNA or designee will conduct 	

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S2340	<p>Continued From page 8</p> <p>Furthermore, the surveyor and the facility management observed the following items listed on the Emergency Stock Inventory were in storage and with expired dates:</p> <ol style="list-style-type: none"> 1. Two cases of beef stew (total of 12 cans)=available were 10 cans with an expiration date of 12/05/2020 2. Two cases of chili with beans (total of 12 cans)=available were 12 cans with an expiration date of 02/28/21 3. Two cases of beef ravioli (total of 12 cans)=available were 12 cans with an expiration date of 01/04/22 4. Two cases of corned beef hash (total of 12 cans)=available 12 cans with a use by date of 5/04/22 5. Two cases of green beans (total of 12 cans)=available 10 cans with an expiration date of 12/2022 6. Two cases of of mixed vegetables (total of 12 cans)=available 12 cans with a use by date of 5/04/22 7. Two cases of pudding (chocolate) (total of 12 cans)=available one can with a use by date of 5/04/22 8. Two cases of powdered milk=with a use by date of 02/23/22 (expiration date) 9. Two cases of orange juice (no refrigeration needed)=one case available with an expiration date of 12/20/20 <p>At the time of observation, the surveyor asked the facility management why the Emergency Stock Inventory dated February 2023 was computed only for residents and the staff was not included. The facility management had no response.</p>	S2340	<p>weekly audits x 4 weeks, then monthly audits x 3 months, then quarterly audits x 2 quarters to ensure there is and adequate three-day emergency food and water supply that is not expired and is stored and maintained in the facility for residents and facility staff.</p> <p>5. The results of these audits will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>	

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S2340	<p>Continued From page 9</p> <p>On that same date and time, the LNHA informed the surveyor that they would get back to the surveyor regarding the facility policy and procedure regarding Emergency food supply and computation that included the facility staff. The LNHA stated that he acknowledged that the facility did not have emergency food supplies because all emergency food supplies were expired the ones that they had in stock.</p> <p>On 11/16/23 at 01:35 PM, the LNHA informed the surveyor that he was not happy about the emergency food and water supply. The surveyor asked the LNHA who was responsible for the emergency food and water supply and the LNHA stated that he and the FSD were responsible.</p> <p>At that same time, the surveyor asked the LNHA what happened and why the facility's emergency food and water supply was not in accordance with the facility's requirement and all expired, the LNHA stated "Out of sight, out of mind." He further stated that he would make sure that delivery would be done today for emergency food and water supply to comply with the requirement. The surveyor followed up with the LNHA on the requested documents that included policy and procedure and the LNHA stated that they were still working on it.</p> <p>On 11/20/23 at 12:57 PM, the survey team met with the LNHA, DON, Regional Nurse Consultant (RNC), Assistant Director of Nursing (ADON), and Vice President of Skilled Nursing Division. The surveyor notified the facility management of the above findings and concerns.</p> <p>On 11/20/23 at 02:07 PM, the surveyor reviewed the provided Emergency Food Supply</p>	S2340		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
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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S2340	<p>Continued From page 10</p> <p>Performance Improvement Plan that was provided by the LNHA that included the Route Cause Analysis: "It was discovered on 11/16/23 that we were out of compliance with regard to our emergency food supply. Most of the emergency supply had expired, which meant that the food was not being check regularly."</p> <p>On 11/21/23 at 12:04 PM, the survey team met with the RNC, DON, and LNHA. The LNHA informed the survey team that emergency food and water were now available. The LNHA stated that the facility should be able to provide food and water for three days in case of disaster for both residents and staff. The surveyor asked the facility management why the initial provided document for emergency water was computed only for the residents and the facility staff were not included. The LNHA stated that he did not have an answer and I was not aware of it.</p> <p>On 11/22/23 at 9:13 AM, the surveyor in the presence of the DON and FSD inspected the basement area for emergency food and water supply. The surveyor and the facility management observed that the Three Day Disaster Menu Order Guide (updated emergency food and water supply lists) was available in stock except for the beef stew 12 servings x 12 cans equals 144 servings (two cases). Both the FSD and the DON stated that they could not believe it was not there because they both confirmed that it was delivered with the rest of the emergency food supplies. Both the FSD and the DON stated that they will get back to the surveyor on what had happened and why the beef stew was missing as part of the emergency food supply.</p>	S2340			

New Jersey Department of Health

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S2340	<p>Continued From page 11</p> <p>A review of the provided Customer Copy [name of food company] with invoice#F45418-00, purchase order#ROL430992, and an email of an added food order showed that beef stew was not part of the order.</p> <p>On 11/22/23 at 10:09 AM, the surveyor in the presence of another surveyor notified the LNHA that after inspecting the basement area for emergency food and water supply, the two cases of beef stew was missing. The surveyor also notified the LNHA that according to the facility provided copy of delivery receipts beef stew was not included in the list.</p> <p>At this time, the surveyor showed the LNHA copy of the delivery receipts that were previously provided to the surveyor. The LNHA confirmed the beef stew was not part of the delivery.</p> <p>A review of the undated facility's Emergency Disaster Plan Policy that was provided by the LNHA included that the FSD will coordinate the function of the food service department during an emergency. The Procedure: the following will be available during an emergency or disaster: emergency food, water, and supplies for the planned menu pattern for three days.</p> <p>On 11/22/23 at 02:25 PM, the survey team met with the LNHA, DON, RNC, and ADON for an Exit Conference. There was no additional information provided by the facility.</p>	S2340			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315302	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/17/2024
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 F0656	Correction	ID Prefix F0684	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25	Completed
LSC	01/03/2024	LSC	01/03/2024	LSC	01/03/2024
ID Prefix F0686	Correction	ID Prefix F0695	Correction	ID Prefix F0728	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.35(d)(1)-(3)	Completed
LSC	01/03/2024	LSC	01/03/2024	LSC	01/03/2024
ID Prefix F0755	Correction	ID Prefix F0759	Correction	ID Prefix F0812	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	01/03/2024	LSC	01/03/2024	LSC	01/03/2024
ID Prefix F0882	Correction	ID Prefix F0922	Correction	ID Prefix	Correction
Reg. # 483.80(b)(1)-(4)	Completed	Reg. # 483.90(i)(1)	Completed	Reg. #	Completed
LSC	01/03/2024	LSC	01/03/2024	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 11/22/2023		<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 1/17/2024
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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0720	Correction	ID Prefix S2340	Correction	ID Prefix	Correction
Reg. # 8:39-7.3(d)	Completed	Reg. # 8:39-31.6(n)	Completed	Reg. #	Completed
LSC	01/03/2024	LSC	01/03/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
REVIEWED BY CMS RO <input type="checkbox"/>		REVIEWED BY (INITIALS)		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 11/22/2023		<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: 07/10/2024
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 11/22/2023
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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/21/23, 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 Rolling Hills Care Center is a 2- building that was built in 90's. It is composed of Type II construction. The facility is divided into 7- smoke zones. The generator does approximately 80% of the building and the fuel source is propane The building utilizes propane as a fuel source for heating and cooking The fire sprinkler system is provided water from an under ground water pump to a water storage tank. The facility has 67 licensed beds currently at 62. The facility was informed that due to the ongoing K-252 that a new updated FSES must be completed.	K 000			
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 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	K 252			1/3/24

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

TITLE

(X6) DATE

Electronically Signed

12/15/2023

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	<p>Continued From page 1 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 11/21/23, with the facility's U.S. FOIA (b)(6), it was determined that the facility's partial basement was not provided with two (2) acceptable and remote exits as evidenced by the following:</p> <p>During a tour of the building from 9:00 AM to 01:00 PM, the surveyor observed 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 facility's U.S. FOIA (b)(6) confirmed in an interview at 01:00 PM, that the building's basement was only provided with the exits noted above. The surveyor noted that residents were prevented access to the basement by a locked door that required a restricted keycode to open.</p> <p>The U.S. FOIA (b)(6) was informed that a new updated FSES (Fire Safety Evaluation System) must be completed. The U.S. FOIA (b)(6) confirmed he was aware of the FSES needing to be annually updated.</p> <p>The U.S. FOIA (b)(6) were informed of the ongoing issue at the Life Safety Code exit conference on 11/21/23.</p> <p>NJAC 8:39-31.2(e)</p>	K 252	<p>1.The facility completed a new updated FSES (Fire Safety Evaluation System) as required to address this concern related to the basement having less than the minimum of two exits leading to the outside. The LHNA was notified via email on 12/27/23 that the facility passed the updated FSES. No residents have access to the basement area which requires the use of a restricted keycode to open. The staff that utilize the basement are aware of the location of the exit doors to the exterior and to the stairway leading to the first floor. There have not been any events that have affected the safety of the staff accessing that area.</p> <p>2.Since the residents do not have access to this area as it is restricted to only staff (requires a code to gain access) this does not cause a safety concern for the residents. With regard to the Maintenance Director (MD) who accesses this area frequently, there is one exit that leads outside and one exit that leads back into the facility. The basement is used exclusively for storage and mechanical equipment. Residents are completely restricted from the basement area and are</p>		

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K 252	Continued From page 2	K 252	<p>unable to gain access.</p> <p>3. Should it be required to correct this issue further, it would require extensive demolition, major reconstruction and reconfiguration of the building's first floor layout which would negatively impact the residents living in the facility. The LHNA or designee will update the FSES on an annual basis. All staff are in-serviced at orientation and each year thereafter, as well as annual fire drills for each of these areas by the MD or designee.</p> <p>4. Since the residents do not have access to this area as it is restricted to only staff (requires a code to gain access) this does not cause a safety concern for the residents. With regard to the Maintenance Director (MD) who accesses this area frequently, there is one exit that leads outside and one exit that leads back into the facility. Pending on the results of the FSES, another means of egress will be considered to ensure ongoing safety of our staff.</p> <p>5. The results of the FSES will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will prevent this issue from recurring.</p>		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345			1/3/24

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K 345	<p>Continued From page 3</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interview on 11/21/23, in the presence of the U.S. FOIA (b)(6), it was determined that the facility failed to maintain the fire alarm system in accordance with NFPA 72.</p> <p>This deficient practice was evidenced by the following:</p> <p>At 10:42 AM, the surveyor and U.S. FOIA (b)(6) observed in the supply room by resident room U.S. FOIA (b)(6) that one (1) of one (1) smoke detector was covered with an orange cone type protective cover over the smoke detector activation chamber. The orange cone type protective cover applied to the smoke detector will cause the smoke detector not to work in the event of a smoke or fire condition.</p> <p>An interview was conducted with the U.S. FOIA (b)(6) at the time of the observation. The U.S. FOIA (b)(6) acknowledged that he was not sure why the smoke detector was covered and he removed the cover immediately.</p> <p>The U.S. FOIA (b)(6) was notified of the finding at the Life Safety Code exit conference on 11/21/23.</p> <p>NJAC 8:39-31.1(c) NJAC 8:39-31.2(e)</p>	K 345	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. 1. The orange cap that was observed covering the smoke detector in the supply room by resident room U.S. FOIA (b)(6) was immediately removed by the Maintenance Director (MD).</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>2. All residents in the facility have the potential to be affected by the deficient practice.</p> <p>A complete inspection of all smoke detectors was done by the MD and no other smoke detectors were found with coverings on them.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>3. The U.S. FOIA (b)(6) was re-educated by the LHNA to inspect all smoke detectors after any outside vendors are doing maintenance or renovations to any areas of the facility.</p> <p>The vendors will also be requested to inform the MD of the necessity to place a</p>		

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K 345	Continued From page 4 NFPA 70, 72	K 345	<p>cap or covering over a smoke detector in any area of the facility so the MD can inspect the area after the vendor leaves to ensure the cap or covering has been removed to allow proper function of the smoke detector. Sprinklers are checked quarterly for proper function by the facility vendor and visually inspected monthly by the MD. Smoke detectors will be visually inspected monthly by the MD to ensure no caps or coverings are on the smoke detectors that would interfere with functioning.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur: 4. The LHNA or designee will visually inspect all the sprinklers/smoke detectors in the facility including supply rooms weekly x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters to ensure no caps or coverings were inadvertently left on smoke detectors that may interfere with functioning.</p> <p>5. The results of these audits will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.</p>		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363			1/3/24

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K 363	<p>Continued From page 5</p> <p>hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview on 11/21/23, in the presence of the U.S. FOIA (b) (6)</p>	K 363	<p>I. Corrective action(s) accomplished for resident(s) affected:</p> <p>1. The compromised resident room door</p>		

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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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K 363	<p>Continued From page 6</p> <p>it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.</p> <p>This deficient practice of not ensuring complete bedroom door closure for confinement of smoke/fire products was identified in four (4) of 25 resident room (RR) doors observed and was evidenced by the following:</p> <p>During the building tour on 11/21/23 from 9:15 AM to 01:45 PM, the surveyor in the presence of the U.S. FOIA (b)(6) toured the facility and observed the following compromised RR doors:</p> <p>RR S23 door will not close into its frame. RR S14 door is warped at top not smoke resistant RR S15 door is warped at top not smoke resistant RR S16 door is warped at top not smoke resistant</p> <p>At the time of observations, the surveyor interviewed the U.S. FOIA (b)(6) who both confirmed the above findings.</p> <p>The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 11/21/23.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.</p>	K 363	<p>S23 that was noted to not close into its frame was repaired immediately by the Regional Maintenance Director. Resident room doors C14, C15 and S16 that were noted warped at the top (not smoke resistant) were all repaired immediately by the Regional Maintenance Director. Pictures as proof of repairs have been submitted for your records.</p> <p>II. Residents identified having the potential to be affected and corrective action taken: 2. All residents residing in the facility have the potential to be affected by the deficient practice. All the resident doors in the facility have been inspected and found to be functioning properly and no other doors were found to be warped.</p> <p>III. Measures will be put into place to ensure the deficient practice will not recur: 3. The LHNA re-educated the U.S. FOIA (b)(6) to routinely inspect all resident room doors every month to ensure they are closing into the frame properly and are not warped causing them not to be smoke resistant. The MD will visually inspect all resident doors monthly to ensure that they are not warped and close properly.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur: 4. The LHNA or designee will inspect all resident room doors in the facility weekly x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters to ensure that resident room doors are not warped and</p>		

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

PRINTED: 07/10/2024
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 11/22/2023
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 363	Continued From page 7	K 363	close properly. 5. The results of these audits will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility's corrective action for the deficient practice is preventing any reoccurrences.		

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

PRINTED: 06/18/2025
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 02 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/17/2024	
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 000}	INITIAL COMMENTS The facility remains 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, specifically K252. The facility conducted an FSES but the report is inaccurate and therefore unacceptable. Rolling Hills Care Center is a 2- building that was built in 90's. It is composed of Type V protected construction. The facility is divided into 6-smoke zones. The generator does approximately 80% of the building and the fuel source is propane The building utilizes propane as a fuel source for heating and cooking The fire sprinkler system is provided water from an under ground water pump to a water storage tank.			{K 000}			
{K 252} SS=F	The facility has 67 licensed beds. Number of Exits - Corridors CFR(s): NFPA 101 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			{K 252}			2/2/24

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

TITLE

(X6) DATE

Electronically Signed

01/31/2024

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

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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) COMPLETION DATE
{K 252}	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: The facility remains in non-compliance of the partial basement for not providing two (2) acceptable and remote exits.</p> <p>The facility conducted an FSES but the report is inaccurate and therefore unacceptable.</p> <p>During a tour of the building from 9:00 AM to 01:00 PM, the surveyor observed 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 facility's confirmed in an interview at 01:00 PM, that the building's basement was only provided with the exits noted above. The surveyor noted that residents were prevented access to the basement by a locked door that required a restricted keycode to open.</p> <p>NJAC 8:39-31.2(e)</p>	{K 252}	<p>1.The facility completed an updated FSES (Fire Safety Evaluation System) as required to address this concern related to the basement having less than the minimum of two exits leading to the outside. The LHNA was notified via email on 1-25-24 that the facility passed the updated FSES. No residents have access to the basement area which requires the use of a restricted keycode to open. The staff that utilize the basement are aware of the location of the exit doors to the exterior and to the stairway leading to the first floor. There have not been any events that have affected the safety of the staff accessing this area.</p> <p>2.Since the residents do not have access to this area as it is restricted to only staff (requires a code to gain access) this does not cause a safety concern for the residents. With regard to the Maintenance Director (MD) who accesses this area frequently, there is one exit that leads outside and one exit that leads back into the facility. The basement is used exclusively for storage and mechanical equipment. Residents are completely restricted from the basement area and are unable to gain access.</p> <p>3.The LHNA or designee will update the FSES on an annual basis or as needed. All staff are in-serviced at orientation and</p>		

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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) COMPLETION DATE
{K 252}	Continued From page 2	{K 252}	<p>each year thereafter, as well as annual fire drills for each of these areas by the MD or designee.</p> <p>4. Since the residents do not have access to this area as it is restricted to only staff (requires a code to gain access) this does not cause a safety concern for the residents. With regard to the Maintenance Director (MD) who accesses this area frequently, there is one exit that leads outside and one exit that leads back into the facility.</p> <p>5. The results of the FSES will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meetings to ensure the facility's corrective action for the deficient practice will ensure the ongoing safety of any staff entering the basement</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315302	MULTIPLE CONSTRUCTION A. Building 02 - BUILDING B. Wing	DATE OF REVISIT 1/17/2024
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. #	Completed
LSC K0345	01/03/2024	LSC K0363	01/03/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 11/22/2023		<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			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315302	MULTIPLE CONSTRUCTION A. Building 02 - BUILDING B. Wing	DATE OF REVISIT 2/5/2024
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. #	Completed	Reg. #	Completed
LSC K0252	02/02/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 11/22/2023		<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			