

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

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/03/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint NJ #'s: 163766, 165891, 167106, 168173, 168717, 169228, 169862, 169297, 171864, 171947, and 173833</p> <p>Survey Date: 9/26/24 to 10/3/24</p> <p>Census: 113</p> <p>Sample: 23 + 1 closed record</p> <p>A Recertification/LSC survey was conducted at Majestic Center for Rehabilitation and Sub-Acute Care from 9/26/24 through 10/3/24, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.</p> <p>During the survey a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.25(i) F 695 as the facility failed to (a) ensure there was NJ Ex Order 26.4(b)(1) equipment for a resident with a NJ Ex Order 26.4(b)(1), and (b) ensure staff were trained to use the emergency equipment in case of displacement of the NJ Ex Order 26.4(b)(1) for one (1) of one (1) resident (Resident #313) reviewed with a NJ Ex Order 26.4(b)(1).</p> <p>The IJ began on NJ Ex Order 26.4(b)(1) and was identified on 9/30/24.</p> <p>Resident #313 was admitted to the facility on NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). Diagnoses include but not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

10/28/2024

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

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F 000	<p>Continued From page 1</p> <p>A review of the physician orders (PO) for Resident #313 included the following:</p> <p>NJ Ex Order 26.4(b)(1) Care every shift for NJ Ex Order 26.4(b)(1) Care and as needed, NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26.4(b)(1) monitoring, NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26.4(b)(1) or to keep the NJ Ex Order 26.4(b)(1) and as needed for NJ Ex Order 26.4(b)(1) or to keep the NJ Ex Order 26.4(b)(1), physician orders: Give NJ Ex Order 26.4(b)(1) @ (specify) via NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26.4(b)(1) Care.</p> <p>A review of the Progress Notes revealed the resident was sent to the hospital on NJ Ex Order 26.4(b)(1) to replace the NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) and again on NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1).</p> <p>During an interview with the surveyor on 09/30/24 at 02:08 PM, the U.S. FOIA (b) (6) stated the resident was admitted to the facility without the proper NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and if the NJ Ex Order 26.4(b)(1) came out there was no replacement at the bedside and at the facility. The U.S. FOIA (b) (6) stated the reason she sent the resident to the emergency room (ER) on NJ Ex Order 26.4(b)(1) was because the facility did not have the supplies and the facility did not know when they would get the supplies. The U.S. FOIA (b) (6) saw the resident again on NJ Ex Order 26.4(b)(1) and there was still no NJ Ex Order 26.4(b)(1) at the bedside. She stated she had to call the hospital to obtain the NJ Ex Order 26.4(b)(1).</p> <p>During a telephone interview with the surveyor on 09/30/24 at 03:06 PM, the Licensed Practical Nurse (LPN #1) stated that she cared for Resident #313 but did not have any education for taking care of the resident with NJ Ex Order 26.4(b)(1). She</p>	F 000			

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F 000	<p>Continued From page 2</p> <p>further stated that there was no [NJ Ex Order 26.4(b)(1)] at the bedside or in the facility.</p> <p>During a telephone interview with the surveyor on 10/01/24 at 1:53 PM, LPN #6 stated the facility had [NJ Ex Order 26.4(b)(1)] in house but not the resident's [NJ Ex Order 26.4(b)(1)] and that was an issue. LPN #6 further stated "the facility was not prepared to take care of a [NJ Ex Order 26.4(b)(1)] patient; no one knew what to do" with him/her. LPN #6 stated she did not receive education regarding [NJ Ex Order 26.4(b)(1)] care at the facility but had worked previously with [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] at other facilities.</p> <p>The [U.S. FOIA (b) (6)] the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] were informed of the F695 IJ and were provided with the IJ template on 9/30/24 at 4:58 PM.</p> <p>An acceptable removal plan was received on 10/1/24 at 11:31 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: 1.) The [U.S. FOIA (b) (6)] conducted a house wide audit on 9/30/24 to resident physician orders and identified no additional residents with [NJ Ex Order 26.4(b)(1)] were at the facility; 2.) The [U.S. FOIA (b) (6)] completed education and in-servicing for all licensed staff on the location of [NJ Ex Order 26.4(b)(1)] at the bedside and in the facility and to communicate the need for additional supplies on [NJ Ex Order 26.4(b)(1)] and on [NJ Ex Order 26.4(b)(1)] emergencies.; 3.) the [U.S. FOIA (b) (6)] was re-educated to inform the [U.S. FOIA (b) (6)] for [U.S. FOIA (b) (6)] related concerns should they arise in the future.</p>	F 000			

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F 582 SS=D	<p>The survey team verified the removal plan on-site on 10/1/24 and determined the IJ for F 695 was removed as of 10/1/24 at 1:00 PM.</p> <p>Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)</p> <p>§483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the</p>	F 582			10/20/24

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F 582	<p>Continued From page 4</p> <p>facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of facility documentation, it was determined that the facility failed to issue the required Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and the Notice of Medicare Non-Coverage (NOMNC) for 1 of 3 residents (Resident #36) reviewed for Beneficiary Protection Notification.</p> <p>The deficient practice was evidenced by the following:</p> <p>The facility presented the surveyor with a list of residents who were discharged from the facility within six (6) months and should have received Beneficiary Notices.</p> <p>On 9/26/24 at 12:00 PM, the surveyor requested three (3) random residents', one (1) resident who</p>	F 582	<p>ELEMENT ONE: CORRECTIVE ACTION:</p> <p>An investigation was conducted, resident #36 was not affected by the practice. As a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) cannot be given once services have ended, no other actions were taken for this resident.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:</p> <p>All residents who have Medicare benefits have the potential to be affected by this practice: all residents whose Medicare benefits are ending, will receive the Skilled Nursing Facility Advanced</p>		

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F 582	<p>Continued From page 5</p> <p>went home and two (2) residents who remained in the facility, beneficiary notification forms from the U.S. FOIA (b) (6)).</p> <p>On 9/30/24 at 12:25 PM, the surveyor reviewed Resident #36's Beneficiary Notification list which indicated that the resident was discharged from a NJ Ex Order 26.4(b)(1) stay at the facility and was documented as having a discontinuation of their NJ Ex Order 26.4(b)(1) insurance payment to the facility.</p> <p>A review of the SNF Beneficiary Protection Notification Review (SNF BPNR) for Resident #36 indicated that the last covered day of NJ Ex Order 26.4(b)(1) Service was NJ Ex Order 26.4(b)(1). The SNF BPNR further revealed that a SNF ABN of non-coverage form NJ Ex Order 26.4(b)(1) and the NOMNC NJ Ex Order 26.4(b)(1) were provided to the resident.</p> <p>A review of the Advance Beneficiary Notice of Non-Coverage (ABN) form revealed Resident #36 did not sign the form.</p> <p>A review of the NOMNC revealed Resident #36 signed the form on NJ Ex Order 26.4(b)(1) which was after the last covered day of NJ Ex Order 26.4(b)(1) service.</p> <p>A review of the Progress Notes (PN) reflected on NJ Ex Order 26.4(b)(1) at 5:30 PM from Social Services that a NOMNC was issued with the last covered date on NJ Ex Order 26.4(b)(1), would revert back to NJ Ex Order 26.4(b)(1) and no appeal. There was no documented evidence that the forms were provided to the resident prior to NJ Ex Order 26.4(b)(1).</p> <p>During an interview with the surveyor on 9/30/24 at 12:36 PM, the U.S. FOIA (b) (6)</p>	F 582	<p>Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) in a timely manner.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The U.S. FOIA (b) (6) was re-educated on 10/2/24 regarding the proper time frame for when the Skilled Nursing Facility Advanced Beneficiary Notice and Notice of Medicare Non-Coverage should be presented to the residents.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that all Skilled Nursing Facility Advanced Beneficiary Notices (ABN) and Notice of Medicare Non-Coverage (NONMC) are being presented in a timely manner. The Social Worker/designee will audit all residents due for NOMNC/ABN weekly for three months or until substantial compliance is met. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 3 to Quality Assurance Performance Improvement team for review and action as necessary.</p> <p>ELEMENT FIVE: COMPLETION DATE: 10/20/2024</p>		

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F 582	<p>Continued From page 6</p> <p>U.S. FOIA (b) in the presence of the survey team stated that she had been working at the facility for NJ Ex Order 20.4(b)(1) but had seven (7) years of experience. The U.S. FOIA (b) stated that the SNF ABN and the NOMNC were given when therapy provide the last covered dates. She stated both forms should be given to the resident at least three (3) days prior to the last covered date. She further stated that if the resident could not sign the forms, then the resident's representative could sign it. The U.S. FOIA (b) explained the purpose of the forms were to inform the resident that their therapy was ending and if they would like to continue, the insurance would not pay and how much the resident would be responsible to pay. At that time, the surveyor and the U.S. FOIA (b) reviewed the provided NOMNC for Resident #36. She stated that the resident was admitted before she started at the facility. The U.S. FOIA (b) stated that the U.S. FOIA (b) was responsible for ensuring that the documents were signed. She stated that the previous U.S. FOIA (b) made a mistake because the NOMNC was signed after the last covered day. She stated that it should have been signed prior to the last covered date. Upon review of the SNF ABN, the U.S. FOIA (b) stated that the ABN was not signed and acknowledged that it should have been signed. She stated that since the NOMNC was signed, the ABN should have been signed. She concluded if both documents were not signed, they are "not aligned with what was told to the resident."</p> <p>On 9/30/24 at 1:37 PM, the U.S. FOIA (b) provided the guidelines the facility followed for the ABN and the NOMNC. At that time, the U.S. FOIA (b) stated that she followed up with the resident and that the SNF ABN form was not signed because prior to him/her signing anything the resident follows up</p>	F 582			

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F 582	<p>Continued From page 7</p> <p>with their [family representative]. The [U.S. FOIA (b) (6)] stated that the facility did not have a policy, she just followed the [NO EX ORD] guidance.</p> <p>On 10/3/24 at 9:36 AM, the [U.S. FOIA (b) (6)] stated in the presence of the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)] the [U.S. FOIA (b) (6)], and the survey team "even though it was presented timely" the resident does not sign anything until after the [family representative] reviewed it. At that time the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] acknowledged that the forms should have been signed prior to the last covered date. The [U.S. FOIA (b) (6)] stated they would review the medical records to see if the prior [U.S. FOIA (b) (6)] documented that the forms were presented in a timely manner, but the resident did not want to sign until after the [family representative] knowledge of it.</p> <p>On 10/3/24 at 9:53 AM, the [U.S. FOIA (b) (6)] stated that the facility did not have a policy related to SNF ABN and NOMNC and that they just followed the regulations.</p> <p>On 10/3/24 at 9:57 AM, the [U.S. FOIA (b) (6)] stated they could not find any documentation that the resident was notified prior to the last covered date and that the resident wanted to wait to sign the forms. The [U.S. FOIA (b) (6)] acknowledged both forms should have been signed prior and there should have been documentation.</p> <p>A review of the Social Services job description, updated October 2023, included, Main Duties: "C. Maintain appropriate departmental documentation: c. record all significant events in resident's life and social service contacts."</p>	F 582			

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F 607 SS=D	<p>NJAC 8:39-4.1(a)(8) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95,</p> <p>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.</p> <p>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, review of facility policy, and review of pertinent facility documents, it was</p>	F 607			10/20/24
			ELEMENT ONE: CORRECTIVE ACTION:		

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F 607	<p>Continued From page 9</p> <p>determined that the facility failed to implement their abuse policy to ensure a) licensed staff credentials were verified upon hire (Staff #2 and #9), and reference checks were completed. This deficient practice was identified for 8 of 10 employee files reviewed (Employee #4, #6, #7, #8, #9 and #10) and was evidenced by the following:</p> <p>1.) Staff #2, a Licensed Practical Nurse (LPN), with a date of hire [REDACTED], the employee file contained a copy of their licensure, however did not have a license verification printout in the employees file. There was no documented evidence that Staff #2's license was verified.</p> <p>Staff #9, an [REDACTED], with the hire date [REDACTED], the employee file did not contain a copy of the license. In addition, there was no documented evidence that Staff #9's license was verified.</p> <p>2.) A further review of the employee files for reference check reflected the following:</p> <p>Staff #4, a [REDACTED], with a date of hire of [REDACTED], did not have a reference check on file.</p> <p>Staff #6, a [REDACTED] with a date of hire of [REDACTED], did not have a reference check on file.</p> <p>Staff #7, [REDACTED] with a date of hire of [REDACTED], did not have a reference check on file.</p> <p>Staff #8, a [REDACTED], with a</p>	F 607	<p>Employee #2 license verification was immediately printed out and placed in the employee file.</p> <p>Employee #9 license verification was immediately printed out and placed in the employee file</p> <p>In addition, reference checks were located for staff members: L.P.N. #4, C.N.A #8, Occupational therapist #9, reference checks were completed for RN#6, L.P.N. #7, and #10.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the practice. The Licensed Nursing Home Administrator completed an audit on all new hires x6 months to ensure all have license verification (if applicable) and printed verification placed in employee file, as well as completed reference checks.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The [REDACTED] was re-educated on 10/2/24 regarding all items that are to be included in all licensed staff members' employee files, and an audit tool was created to confirm that all present licensed staff members employee files are complete, as well as for new hires.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: LNHA/designee will audit all new hire charts (prior to start date) weekly for three months or until substantial compliance is</p>		

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F 607	<p>Continued From page 10</p> <p>date of hire of [REDACTED] did not have a reference check on file.</p> <p>Staff #9, an [REDACTED] (US FOIA (b)(6)), with a date of hire [REDACTED] (NJ Ex Order 26.4(b)), did not have a reference check on file.</p> <p>Staff #10, [REDACTED] (US FOIA (b)(6)) with the hire date of [REDACTED] (NJ Ex Order 26.4(b)), did not have a reference check on file.</p> <p>On 10/1/24 at 2:34 PM, the [REDACTED] (U.S. FOIA (b) (6)) reviewed the copy of Staff #2's State of New Jersey license with the surveyor and stated, "I did not check this one because I have this here" (pointing to the nursing license). The [REDACTED] (U.S. FOIA (b)(6)) confirmed that it was not verified that Staff # 2 had an active license.</p> <p>The surveyor continued to interview the [REDACTED] (U.S. FOIA (b)(6)) who stated that a copy of the licensure and a printout of the verification should have been included in the employees file. The [REDACTED] (U.S. FOIA (b)(6)) acknowledged that reference checks should have been completed and included in the employee files.</p> <p>On 10/2/24 at 1:41 PM, the [REDACTED] (U.S. FOIA (b) (6)) stated that all reference checks should be completed pre-employment.</p> <p>A review of the facility's "Residents/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property" undated policy, included...Screening Procedures A. Screening of all employees are screened prior to employment2. Facility will be thorough in the investigation of past histories of individuals hired. This will be done through ...c. References will be checked. ..."</p>	F 607	<p>met. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 6 to Quality Assurance Performance Improvement team for review and revision as necessary.</p> <p>The Administrator is responsible for this plan of correction.</p> <p>ELEMENT FIVE: COMPLETION DATE: 10/20/2024</p>		

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F 607	Continued From page 11	F 607			
F 656 SS=D	<p>NJAC 8:39-4.1(a)5</p> <p>Develop/Implement Comprehensive Care Plan</p> <p>CFR(s): 483.21(b)(1)(3)</p> <p>§483.21(b) Comprehensive Care Plans</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</p>	F 656		10/20/24	

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F 656	<p>Continued From page 12</p> <p>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 section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. 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 develop a comprehensive person-centered care plan for 1 of 24 residents (Resident #26) reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>A review of the Admission Record (an admission summary) revealed Resident #26 had diagnoses which included, but were not limited to, 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), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).</p> <p>Upon review of the Electronic Medical Record (EMR), there was no evidence that the Comprehensive Care Plan was completed.</p> <p>On 10/01/24 at 1:18 PM, during surveyor interview, the U.S. FOIA (b) (6) pulled up the EMR for Resident #26 and confirmed that the Comprehensive Care Plan was not completed.</p>	F 656	<p>ELEMENT ONE: CORRECTIVE ACTION: Resident #26's comprehensive person-centered care plan was developed.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: Interdisciplinary Care Planning Team (IDCP) was re-in serviced on initiating and completing a comprehensive person-centered care plan in a timely manner.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance, Director of Nursing/designee will audit all new admissions for comprehensive care plan developed upon admission with IDCP input weekly 4, then monthly x 6</p>		

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F 656	Continued From page 13 The U.S. FOI stated that the Comprehensive Care Plan should have been completed to ensure that staff knows how to better assist the resident. A review of the facility policy titled, INTERDISCIPLINARY CARE PLANNING PROTOCOL ...1. Social Services provides overview of social history and needs 2. Nursing provides overview of medical and nursing care regimens. Nursing assistants must provide input especially related to ADL (activities of daily living), skin, weights, and safety needs. 3. Activities and Dietary provide an overview of their assessment of residents needs and problems. 4. Other disciplines provide input as appropriate ...	F 656	Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 6 to Quality Assurance Performance Improvement team for review and revision as necessary. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
F 658 SS=D	NJAC 8:39-11.2(3)h Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of other pertinent documentation, it was determined that the facility failed to administer medications in accordance with physician's orders and professional standards of nursing clinical practice. This deficient practice was identified during the medication pass observation for 1 of 2 nurses on 1 of 2 nursing units (Two West). This deficient practice was evidenced by the following:	F 658	ELEMENT ONE: CORRECTIVE ACTION: Licensed Practical Nurse (LPN) #5 was immediately in-serviced on proper administration of medications requiring special instructions for use, specifically NJ Ex Order 26.4(b) requiring NJ Ex Order 26.4(b)(1) prior to taking additional medications by mouth. In addition, LPN #5 was in serviced on ensuring NJ Ex Ord management meets the resident's		10/20/24

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F 658	<p>Continued From page 14</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>On 09/27/24 at 8:49 AM, the surveyor observed Licensed Practical Nurse (LPN) #5 as she prepared and administered six oral medications and a NJ Ex Order 26.4(b)(1) [REDACTED] to Resident #92.</p> <p>At 8:59 AM, the surveyor observed LPN #5 provide Resident #92 with the NJ Ex Order 26.4(b)(1) [REDACTED] and NJ Ex Order 26.4(b)(1) [REDACTED], without instruction. The resident then proceeded to NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) LPN #5 then handed the resident a medication cup that contained the resident's scheduled medications and a cup of water. The surveyor observed the resident who took the medications with sips of water, but did not drink all of the water that was provided. LPN #5 stated "I gave the resident the NJ Ex Order 26.4(b)(1) first, then the oral medications were given with water, that way the resident NJ Ex Order 26.4(b)(1) after".</p> <p>At that time, LPN #5 asked Resident #92 if</p>	F 658	<p>acceptable level of NJ Ex Ord</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents receiving medication have the potential to be affected by the practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: LPN #5 was med passed and passed. All nursing staff were re-educated on 10/2/24 regarding special instructions for certain medications and ensuring pain management meets residents' acceptable level of pain.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that all nurses were re-educated regarding administering medication in accordance with physician's orders and professional standards of nursing clinical practice. Also, an audit tool was created to monitor that medication is being administered in accordance with physician's orders and professional standards of nursing clinical practice. The audit will be done weekly for three months or until substantial compliance is met. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Director of Nursing is responsible for this plan of correction.</p> <p>ELEMENT FIVE: COMPLETION DATE: 10/20/2024</p>		

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F 658	<p>Continued From page 15</p> <p>he/she had [REDACTED] NJ Ex Order 26.4(b)(1)? The resident stated, [REDACTED] NJ Ex Order 26.4(b)(1) LPN #5 asked the resident to rate [REDACTED] NJ Ex Order 26.4(b)(1) on a scale from [REDACTED] NJ Exec Order 26.4b1 being the [REDACTED] NJ Ex Order 26.4(b)(1). Resident #92 stated that their [REDACTED] NJ Ex Order 26.4(b)(1) was rated as [REDACTED] NJ Ex Order LPN #5 then proceeded to review the resident's [REDACTED] NJ Ex Order medication orders and stated that the resident had an order for [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b)(1). LPN #5 stated that the full dose was not available on her cart and then proceeded to go to the medication room, and then to another medication cart to obtain a stock medication bottle of the full dosage of [REDACTED] NJ Exec Order 26.4b1 NJ Ex Order [REDACTED]</p> <p>At 9:14 AM, LPN #5 administered [REDACTED] NJ Ex Order 26.4(b)(1) to Resident #92 and stated that the medication was given for [REDACTED] NJ Ex Order 26 level of [REDACTED] NJ Ex out of ten.</p> <p>A review of Resident # 92's Admission Record (an admission summary) which revealed that Resident #92 was admitted to the facility with diagnosis which included but were not limited to: [REDACTED] NJ Ex Order 26.4(b)(1), [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)</p> <p>A review of resident #92's Quarterly Minimum Data Set (MDS), an assessment tool, revealed that the resident had a Brief Interview for Mental Status Score (BIMS) score of [REDACTED] NJ Ex out of 15, which indicated that the resident was [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>A review of Resident #92's Order Summary Report (OSR) revealed an order dated [REDACTED] NJ Ex Order 26.4(b)(1),</p>	F 658			

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F 658	<p>Continued From page 16</p> <p>for NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>[REDACTED])... (NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>[REDACTED] two times a day for NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>[REDACTED] after use. A second order dated NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>was noted for NJ Ex Order 26.4(b)(1) [REDACTED] Give</p> <p>2 (two) tablets by mouth every 6 (six) hours as</p> <p>needed for NJ Ex Order 26.4(b)(1) [REDACTED]). Do not</p> <p>exceed NJ Ex Order 26.4(b)(1) [REDACTED])</p> <p>NJ Ex Order 26.4(b)(1) [REDACTED] in 24 hours form [sic.] all sources</p> <p>NJ Ex Order 26.4(b)(1) [REDACTED] Further review of the OSR</p> <p>revealed that there was not a second order in</p> <p>place to address the resident's NJ Ex Order 26.4(b)(1) [REDACTED] if it were</p> <p>greater than four.</p> <p>On 09/27/24 at 9:29 AM, during a later interview</p> <p>with LPN #5 she stated that the purpose of</p> <p>having a resident NJ Ex Order 26.4(b)(1) [REDACTED] after an</p> <p>NJ Ex Order 26.4(b)(1) [REDACTED] such as NJ Ex Order 26.4(b)(1) [REDACTED] were</p> <p>administered was to NJ Ex Order 26.4(b)(1) [REDACTED] .</p> <p>LPN #5 further stated that the resident was</p> <p>allowed to NJ Ex Order 26.4(b)(1) [REDACTED] after they NJ Ex Order 26.4(b)(1) [REDACTED],</p> <p>rather than NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>At 9:30 AM, the surveyor asked LPN #5 to review</p> <p>Resident #92's NJ Ex Order 26.4(b)(1) [REDACTED] order on the</p> <p>Medication Administration Record (MAR). LPN #5</p> <p>stated that the order was for NJ Ex Order 26.4(b)(1) [REDACTED] on a NJ</p> <p>[REDACTED] scale. LPN #5 stated that</p> <p>we normally give this one and use our judgement</p> <p>whether or not to call the doctor. LPN #5 further</p> <p>stated, "If NJ Ex Order 26.4(b)(1) [REDACTED], I call the doctor."</p> <p>During an interview with the surveyor on 09/30/24</p> <p>at 12:26 PM, the U.S. FOIA (b) (6) [REDACTED]</p> <p>[REDACTED] stated that for</p> <p>NJ Ex Order 26.4(b)(1) [REDACTED] she would have</p> <p>the resident NJ Ex Order 26.4(b)(1) [REDACTED] and NJ Ex Order 26.4(b)(1) [REDACTED] after</p>	F 658			

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F 658	Continued From page 18 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) you have to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to prevent NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1)). The U.S. FOIA (b) stated that the nurse should give directions. The U.S. FOIA (b) stated that you can not assume that drinking water would NJ Ex Order 26.4(b)(1). At that time, the U.S. FOIA (b) stated that the nurse should have contacted the doctor if the resident were NJ Ex Order 26.4(b)(1), to do something for the NJ Ex Order 26.4(b)(1) to get something supplemental. The U.S. FOIA (b) stated that the nurse could have contacted the doctor first, to inform him, and let the doctor know for further clarification. A review of the facility policy, "Medication Administration Policy" (02/24) revealed the following: The facility shall administer all resident medications according to physician orders. ...PRN medications should be given according to physicians order and documented on the MAR under date given, time noted and nurses initials. Reason for administration must be documented on the MAR, as well as result, where applicable.	F 658			
F 692 SS=D	NJAC 8:39-11.2(b), 29.4 (b) (2), 27.1(a) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692			10/20/24

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F 692	<p>Continued From page 19</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of other pertinent information, it was determined that the facility failed to ensure [NJ Ex Order 26.4(b)(1)] assessments were conducted in a timely manner for a resident with a [NJ Ex Order 26.4(b)(1)] who experienced [NJ Ex Order 26.4(b)(1)]. This deficient practice was identified for 1 of 1 resident (Resident #27) reviewed for [NJ Ex Order 26.4(b)(1)].</p> <p>This deficient practice was identified by the following:</p> <p>On 09/27/24 at 12:57 PM, the surveyor observed Resident #27 lying in bed awake. The resident had a [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] that [NJ Ex Order 26.4(b)(1)] on a [NJ Ex Order 26.4(b)(1)] beside the resident's bed that was not in use at the time of the observation.</p> <p>A review of Resident #27's Admission Record (an admission summary) revealed that the resident was admitted to the facility with a past medical history of [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)],</p>	F 692	<p>ELEMENT ONE: CORRECTIVE ACTION: Resident #27's had a [NJ Ex Order 26.4(b)(1)] assessment conducted immediately.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents requiring dietary assessments have the potential to be affected by the practice. The Regional Nurse Consultant (RNC) completed an audit on all residents due for nutritional assessment.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The [U.S. FOIA (b) (6)] was re-educated on 10/2/24 regarding the proper time frame for when dietary assessments need to be conducted.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that</p>		

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F 692	<p>Continued From page 20</p> <p>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) and NJ Ex Order 26.4(b)(1)</p> <p>A review of Resident #27's Quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26.4(b)(1) , revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15, which indicated that the resident was NJ Ex Order 26.4(b)(1) . Further review of the MDS indicated that the resident had a NJ Ex Order 26.4(b)(1) and had not experienced a NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(1) or a NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(1) .</p> <p>A review of Resident #27's Care Plan revealed an entry dated NJ Ex Order 26.4(b)(1) , with revision on NJ Ex Order 26.4(b)(1) with a Focus of: Resident #27 has a NJ Ex Order 26.4(b)(1) problem r/t (related to) NJ Ex Order 26.4(b)(1) .</p> <p>NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)) due to NJ Ex Order 26.4(b)(1) requiring NJ Ex Order 26.4(b)(1) to meet his/her needs, with NJ Ex Order 26.4(b)(1) of his/her NJ Ex Order 26.4(b)(1) . Goal: Resident #27 will not have a significant NJ Ex Order 26.4(b)(1) and Resident #27 will not experience NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) . Interventions included but were not limited to: ... NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) as ordered and NJ Ex Order 26.4(b)(1) as ordered.</p> <p>A review of Resident #27's Order Summary Report revealed an order dated NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) in the evening for NJ Ex Order 26.4(b)(1) up at 6 PM. A second order dated NJ Ex Order 26.4(b)(1) , was noted for a NJ Ex Order 26.4(b)(1) each</p>	F 692	<p>all dietary assessments are being conducted in a timely manner. RNC/designee will audit all residents due for nutritional assessment via MDS calendar, weekly for three months or until substantial compliance is met. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting for review and revision as necessary. The Director of Nursing is responsible for this plan of correction.</p> <p>ELEMENT FIVE: COMPLETION DATE: 10/20/2024</p>		

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F 692	<p>Continued From page 21 month.</p> <p>A review of Resident #27's ^{NJ Ex Order 26.4(b)(1)} Evaluation, dated ^{NJ Ex Order 26.4(b)(1)} at 18:19 (6:19 PM), indicated that the resident's most recent ^{NJ Ex Order 26.4(b)(1)} on ^{NJ Ex Order 26.4(b)(1)} was ^{NJ Ex Order 26.4(b)(1)}, and the resident's usual ^{NJ Ex Order 26.4(b)(1)} was ^{NJ Ex Order 26.4(b)(1)}. Further review of the resident's EHR revealed that there were no quarterly or annual ^{NJ Ex Order 26.4(b)(1)} evaluation completed thereafter.</p> <p>A review of Resident #27's EHR (electronic health record) revealed a ^{NJ Ex Order 26.4(b)(1)} Note dated ^{NJ Ex Order 26.4(b)(1)} at 21:31 (9:31 PM), which was documented by the former ^{U.S. FOIA (b) (6)} and indicated that the resident's ^{NJ Ex Order 26.4(b)(1)} on ^{NJ Ex Order 26.4(b)(1)} was ^{NJ Ex Order 26.4(b)(1)} and reflected a ^{NJ Ex Order 26.4(b)(1)} since ^{NJ Ex Order 26.4(b)(1)}...Further review of the entry revealed the following, "Spoke to nursing who reports resident has been ^{NJ Ex Order 26.4(b)(1)} his/her ^{NJ Ex Order 26.4(b)(1)} to be ^{NJ Ex Order 26.4(b)(1)} at his/her scheduled times, and ^{NJ Ex Order 26.4(b)(1)} may be related to resident's ^{NJ Ex Order 26.4(b)(1)} of his/her ^{NJ Ex Order 26.4(b)(1)}...Will increase ^{NJ Ex Order 26.4(b)(1)} to increase ^{NJ Ex Order 26.4(b)(1)} due to ^{NJ Ex Order 26.4(b)(1)} and start ^{NJ Ex Order 26.4(b)(1)} at a later time in the day. Will order ^{NJ Ex Order 26.4(b)(1)}, up at 6 PM, for ^{NJ Ex Order 26.4(b)(1)}...Will follow-up. Further review of the Progress Notes revealed that there was no further documentation to reflect that the ^{U.S. FOIA (b) (6)} followed up on the resident's ^{NJ Ex Order 26.4(b)(1)} as indicated.</p> <p>A review of Resident #27's last recorded weight under the ^{NJ Ex Order 26.4(b)(1)} tab in the EHR revealed that on ^{NJ Ex Order 26.4(b)(1)}, the resident ^{NJ Ex Order 26.4(b)(1)}</p> <p>During an interview with the surveyor on 10/01/24 at 10:19 AM, the ^{U.S. FOIA (b) (6)} stated that she had worked at the facility since ^{NJ Ex Order 26.4(b)(1)}. The</p>	F 692			

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F 692	<p>Continued From page 22</p> <p>U.S. FOIA (b) (6) stated that she saw Resident #27, but sometimes started something, then went onto something else and failed to complete the task. The U.S. FOIA (b) (6) stated that the resident was due for a NJ Ex Order 26.4(b)(1) Assessment on NJ Ex Order 26.4(b)(1), and she did not get to do it. The U.S. FOIA (b) (6) stated that she reviewed the resident's NJ Ex Order 26.4(b)(1) but did not document that she reviewed them. The U.S. FOIA (b) (6) stated that she "worked at the facility 24 hours per week, which was not enough time to get all of my work done". The U.S. FOIA (b) (6) stated that she reported to the U.S. FOIA (b) (6) that she was not able to get her work done in the time allotted and he stated that the position was only for 24 hours per week. The U.S. FOIA (b) (6) stated, "that was the reason why the resident had not received a formal assessment". The U.S. FOIA (b) (6) then stated, "I just did a note now." The U.S. FOIA (b) (6) stated that there were 113 residents in the facility, and she received a lot of admissions and had to do their admission assessments. The U.S. FOIA (b) (6) stated that the resident had a significant change assessment (completed when a change in status was observed to drive care) completed on NJ Ex Order 26.4(b)(1) by U.S. FOIA (b) (6) and a quarterly NJ Ex Order 26.4(b)(1) assessment was not done and was not completed on schedule. The U.S. FOIA (b) (6) stated that the importance of doing a quarterly assessment after a significant change was to follow up on the resident's significant change and write a follow-up note. The NJ Ex Order 26.4(b)(1) further stated, "The resident's NJ Ex Order 26.4(b)(1)".</p> <p>During an interview with the surveyor on 10/01/24 at 11:25 AM, the U.S. FOIA (b) (6) stated that weekly weight meetings were held with the U.S. FOIA (b) (6) and the Interdisciplinary Team. The U.S. FOIA (b) (6) stated that they notified the doctor and the</p>	F 692			

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F 692	<p>Continued From page 23</p> <p>resident's family. The [U.S. FOIA (b) (6)] stated, "There are notes in there." The [U.S. FOIA (b) (6)] stated that she thought the [U.S. FOIA (b) (6)] was required to complete quarterly [NJ Ex Order 26.4(b)(1)] assessments, but was not sure.</p> <p>During an interview with the surveyor on 10/01/24 at 11:30 AM, the [U.S. FOIA (b) (6)] stated that he had worked at the facility since [NJ Ex Order 26.4(b)(1)] and this was his first position as an [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated that he initiated a [NJ Exec Order 26.4b1] assessment for Resident #27 on [NJ Ex Order 26.4(b)(1)], after the resident had a decline in their [NJ Ex Order 26.4(b)(1)] post-hospitalization. The [U.S. FOIA (b) (6)] stated the resident's last quarterly MDS was completed on [NJ Ex Order 26.4(b)(1)], and the [U.S. FOIA (b) (6)] note that was included in the [NJ Ex Order 26.4(b)(1)] portion of the MDS was written by the current [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated, "sometimes there were no notes in the EHR by the [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated that he reviewed the [U.S. FOIA (b) (6)] notes and conferred with the [U.S. FOIA (b) (6)] when there were no notes seen. The [U.S. FOIA (b) (6)] further stated, "There should be [U.S. FOIA (b) (6)] documentation, but I do not see anything there."</p> <p>During an interview with the surveyor on 10/01/24 at 12:13 PM, the [U.S. FOIA (b) (6)] stated that the [U.S. FOIA (b) (6)] was hired for 24 hours per week, and if she needed more time, she may request more time. The [U.S. FOIA (b) (6)] stated that the [U.S. FOIA (b) (6)] completed an admission assessment, quarterly assessments, and as needed. The [U.S. FOIA (b) (6)] stated, "Yes, naturally there should be documentation on a [NJ Exec Order 26.4b] resident." He stated, "There was always enough time." The [U.S. FOIA (b) (6)] further stated, "The previous [U.S. FOIA (b) (6)] were able to do it in time." The surveyor requested a copy of the facility policy related to the [U.S. FOIA (b) (6)] required documentation and the facility was unable to provide the policy</p>	F 692			

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F 692	Continued From page 24 when requested. A review of the "Job Description" (Revised 11/26/10) of the Dietician revealed the following: Position: Dietician Reports to: administrator Job Responsibilities: Develop preliminary and comprehensive assessments of the dietary needs of each resident throughout their stay. Review and revise care plans and assessments as necessary, but at least quarterly. NJAC 8:39-17.1(c), 17.2(c), (d)			F 692			
F 695 SS=J	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: PART A: NJ Complaint #: 163766 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to (a) ensure there was emergency NJ Ex Order 26.4(b)(1) equipment for a			F 695	ELEMENT ONE: CORRECTIVE ACTION: Resident #313 discharged on NJ Ex Order 26.4(b)(1) . The facility has not had a NJ Ex Order resident since this resident was discharged. Emergency equipment is always in place in the crash cart which is checked daily.		10/20/24

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F 695	<p>Continued From page 25</p> <p>resident with NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) [REDACTED]), and (b) ensure staff were trained to use the emergency equipment in case of displacement of the NJ Ex Order 26.4(b)(1) for one (1) of 1 resident (Resident #313) reviewed with a NJ Ex Order 26.4(b)(1)</p> <p>Resident #313 was admitted to the facility with a NJ Ex Order 26.4(b)(1). A review of the Progress Notes revealed that the resident was sent to the hospital on two occasions, on NJ Ex Order 26.4(b)(1) for not having NJ Ex Order 26.4(b)(1) supplies, and on NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1). During an interview with the surveyor, the U.S. FOIA (b) (6) stated that the resident was admitted to the facility without the proper NJ Ex Order 26.4(b)(1) and if the NJ Ex Order 26.4(b)(1) came out, there was no replacement, and that the facility did not know when the supplies would arrive. The U.S. FOIA (b) (6) sent the resident to the hospital twice on NJ Ex Order 26.4(b)(1) and on NJ Ex Order 26.4(b)(1) because there were no supplies for the resident. The surveyor interviewed LPN #1 who stated she cared for Resident # 313 but did not have education for taking care of a resident with NJ Ex Order 26.4(b)(1). She further stated that there were no NJ Ex Order 26.4(b)(1) supplies at the bedside or at the facility.</p> <p>The facility's failure to ensure there was emergency equipment in the resident's room and failure to ensure staff were trained to use the emergency equipment in case of the displacement of the NJ Ex Order 26.4(b)(1) placed the resident at risk for serious harm, serious impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation.</p>	F 695	<p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents receiving tracheostomy care have the potential to be affected by the practice: the facility will ensure that there are adequate emergency tracheostomy equipment for residents with a tracheostomy, ensure staff are trained to use the emergency equipment in case of displacement of the tracheostomy tube, ensure consistent documentation in the Medication Administration Record (MAR) and Treatment Administration Record (TAR) that oxygen and respiratory related treatments are administered as ordered, ensure staff are clarifying physician orders for a resident with a tracheostomy, and ensuring that physician orders are accurately transcribed and followed.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The U.S. FOIA (b) (6) was re-educated on 9/30/24 regarding ordering emergency tracheostomy equipment. All nurses were re-educated on 9/30/24 regarding the use of emergency equipment in case of displacement of the tracheostomy tube. All nurses were re-educated on 9/30/24 regarding consistently documenting in the Medication Administration Record and Treatment Administration Record that oxygen and respiratory related treatments are being administered as ordered. All nurses were re-educated on 9/30/24 regarding clarifying physician orders for a resident with a tracheostomy. All nurses were re-educated on 9/30/24 to ensure</p>		

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F 695	<p>Continued From page 26</p> <p>The IJ began on [REDACTED] when the resident was admitted to the facility and was transferred to the hospital on [REDACTED] and [REDACTED] because there were no [REDACTED] supplies at the bedside or in the facility in addition to ensuring that all staff caring for Resident #313 were trained. The [REDACTED] U.S. FOIA (b) (6) the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6)) were informed of the IJ on 09/30/24 at 4:58 PM. The facility submitted an acceptable Removal Plan (RP) on 10/1/24 at 1:00 PM. The survey team verified the implementation of the (RP) during the continuation of the on-site survey on 10/1/24.</p> <p>The evidence was as follows:</p> <p>A review of the facility's undated "Tracheostomy Care" policy revealed "Tracheostomy care and suctioning shall be performed as necessary to maintain a clear airway and to prevent infection. The purpose of tracheostomy care is to maintain a patent airway; to keep the tracheostomy area clean and free of irritation and infection; and to prevent the tracheostomy tube from being coughed or pulled out. Equipment needed included but not limited to a. oxygen set up including oxygen concentrator, oxygen humidifier bottle, oxygen flow meter, oxygen tubing/trach collar, b. Suctioning set up including portable suction machine, sterile tracheostomy care tray, suction gauge, sterile Sodium Chloride irrigation and c. Other: stethoscope, sterile disposable suction catheter kits for PRN (as needed) suctioning and replacement inner cannulas. The policy further indicated under SPECIAL NOTE: 1. Never remove outer cannula: this is changed only</p>	F 695	<p>that physician orders are accurately transcribed and followed.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: Audit tools were created to monitor that all nurses were re-educated on the use of emergency equipment in case of displacement of the tracheostomy tube, consistently documenting in the Medication Administration Record and Treatment Administration Record that oxygen and respiratory related treatments are being administered as ordered, clarifying physician orders for a resident with a tracheostomy, ensuring that physician orders are accurately transcribed and followed. Also, audit tools were created to monitor the facility has adequate emergency tracheostomy equipment, documentation in the Medication Administration Record and Treatment Administration Record that oxygen and respiratory related treatments are being administered as ordered, clarifying physician orders for a resident with a tracheostomy, and physician orders are accurately transcribed and followed. Director of nursing/designee will complete these audits weekly for three months or until substantial compliance is met. Needed corrections will be addressed as they are discovered. The results of these audits will be reviewed at our QAPI meeting. The Director of Nursing is responsible for this plan of correction.</p> <p>ELEMENT FIVE: COMPLETION DATE:</p>		

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F 695	<p>Continued From page 27</p> <p>by a Physician and 2. Be careful not to dislodge the Tracheostomy Tube."</p> <p>On 09/30/24, the surveyor reviewed the closed record of Resident #313.</p> <p>A review of the Admission Record documented that Resident #313 had diagnoses which included, but were not limited to, NJ Ex Order 26.4(b)(1) [REDACTED], NJ Ex Order 26.4(b)(1) [REDACTED], NJ Ex Order 26.4(b)(1) [REDACTED], NJ Ex Order 26.4(b)(1) [REDACTED], and NJ Ex Order 26.4(b)(1) [REDACTED].</p> <p>The admission Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26.4(b)(1) [REDACTED], reflected the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex [REDACTED] out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1) [REDACTED]. The MDS further indicated that the resident had NJ Ex Order 26.4(b)(1) [REDACTED] and received NJ Ex Order 26.4(b)(1) [REDACTED] and NJ Ex Order 26.4(b)(1) [REDACTED].</p> <p>A review of Resident #313's Care Plan, initiated on NJ Ex Order 26.4(b)(1) [REDACTED] and revised on NJ Ex Order 26.4(b)(1) [REDACTED], included a focus for NJ Ex Order 26.4(b)(1) [REDACTED] related to NJ Ex Order 26.4(b)(1) [REDACTED] with interventions that included to ensure NJ Ex Order 26.4(b)(1) [REDACTED] were secured at all times, monitor/document for NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] and NJ Ex Order 26.4(b)(1) [REDACTED], good NJ Ex Order 26.4(b)(1) [REDACTED] and NJ Ex Order 26.4(b)(1) [REDACTED] as necessary.</p> <p>The surveyor reviewed Resident #313's physicians orders (PO) dated NJ Ex Order 26.4(b)(1) [REDACTED] with a discontinued date of NJ Ex Order 26.4(b)(1) [REDACTED], which included the following:</p> <p>Give NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] with NJ Ex Order 26.4(b)(1) [REDACTED] every</p>	F 695	10/20/2024		

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F 695	<p>Continued From page 28 shift for [NJ Ex Order 26.4(b)(1)] care.</p> <p>NJ Ex Order 26.4(b)(1) as needed for [NJ Ex Order 26.4(b)(1)] or to keep the [NJ Ex Order 26.4(b)(1)].</p> <p>NJ Ex Order 26.4(b)(1) every shift for [NJ Ex Order 26.4(b)(1)] or to keep the [NJ Ex Order 26.4(b)(1)] AND as needed for [NJ Ex Order 26.4(b)(1)] or to keep the [NJ Ex Order 26.4(b)(1)].</p> <p>NJ Ex Order 26.4(b)(1) Care every shift every shift for [NJ Ex Order 26.4(b)(1)] Care.</p> <p>NJ Ex Order 26.4(b)(1) care every shift as needed.</p> <p>NJ Ex Order 26.4(b)(1) every shift for [NJ Ex Order 26.4(b)(1)] Monitoring.</p> <p>A review of the Admit/Readmit Evaluation Assessment, dated [NJ Ex Order 26.4(b)(1)] at 22:20 (10:20 PM), revealed that Resident #313 had an [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] and a NJ Ex Order 26.4(b)(1). The nurse did not document if the resident was [NJ Ex [NJ Ex Order 26.4(b)(1)]], or if the resident had a NJ Ex Order 26.4(b)(1) [NJ Ex Order 26.4(b)(1)]) or [NJ Ex Order 26.4(b)(1)]</p> <p>A review of the admitting nurse (LPN #6) admission summary dated [NJ Ex Order 26.4(b)(1)] at 22:40 (10:40 PM), revealed that Resident #313 was "admitted to the facility with a NJ Ex Order 26.4(b)(1) ...able to make needs known by NJ Ex Order 26.4(b)(1) [NJ Ex Order 26.4(b)(1)]", and call bell within reach and uses it frequently."</p> <p>A review of the NJ Ex Order 26.4(b)(1) Advanced Practice Nurse (APN #2) PN, dated [NJ Ex Order 26.4(b)(1)] at 14:00 (2:00 PM), revealed that the resident was sent to the Emergency Room (ER) as "the facility did not</p>	F 695			

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F 695	<p>Continued From page 31</p> <p>NJ Ex Order 26.4(b)(1) has been employed as the U.S. FOIA The U.S. FOIA stated that when a resident was admitted to the facility with NJ Ex Order 26.4(b)(1), the external liaison would provide the U.S. FOIA (b) (6) with the NJ Ex Order of the NJ Ex Order and any NJ Ex Order 26.4(b)(1) requirements, then admissions would notify the unit and make sure the facility had all the necessary equipment needed prior to admission which would include NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and an NJ Ex Order 26.4(b)(1) at the bedside. The U.S. FOIA added, "I am not sure if NJ Ex Order 26.4(b)(1) or nursing would set up the room."</p> <p>On 09/30/24 at 1:33 PM, the surveyor conducted a telephone interview with the attending physician (U.S. FOIA) who reviewed the progress notes written by APN #1. The U.S. FOIA then reviewed the APN #2's note from NJ Ex Order 26.4(b)(1) and stated he was not aware that APN #2 documented that the NJ Ex Order 26.4(b)(1), or NJ Ex Order 26.4(b)(1) were not at the bedside. The U.S. FOIA further stated that the facility usually would have supplies and equipment at the bedside for emergencies. The U.S. FOIA stated he would further review the medical records and call the surveyor back with any further information. The surveyor did not receive a return call from the U.S. FOIA.</p> <p>On 09/30/24 at 2:08 PM, the surveyor conducted a telephone interview with APN#2 who stated that Resident #313 was admitted to the facility without the proper NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) and if the NJ Ex Order came out there would be no replacement at the bedside and at the facility. APN#2 stated the reason she sent Resident #313 to the ER on NJ Ex Order 26.4(b)(1) was because the facility did not have the supplies at the facility and did not know when they would get the supplies. APN #2 stated she saw the resident</p>	F 695			

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F 695	<p>Continued From page 33</p> <p>that she was an agency nurse who worked the 11 PM to 7 AM shift when Resident #313 was admitted to the facility. LPN #1 further stated that she had not received education for [REDACTED] care through her agency or the facility. LPN #1 stated, "I remember that situation, because it was crazy." LPN #1 stated that when the resident was admitted to the facility, the room was not set up with supplies for a resident with [REDACTED]. LPN #1 stated the first night the resident came in "we did not have anything, and I did not have a key to get anything." LPN #1 stated that the resident needed a [REDACTED], the [REDACTED] for the resident 's [REDACTED] but there wasn't anything. LPN #1 stated that she was "scrambling for supplies". LPN #1 stated, "I remember [the resident 's] [REDACTED] but I did not have any extra [REDACTED] or [REDACTED]." LPN #1 stated that she had to set up the [REDACTED] and use an [REDACTED] because "we did not have a [REDACTED]." LPN #1 stated, "This was my first [REDACTED] patient ever, and we did not have the [REDACTED]" LPN #1 further stated the next morning she stayed and told Central Supply (CS) that the supplies were needed.</p> <p>LPN #1 further stated that the second night on the 11 PM to 7 AM shift, she called a nurse from the second floor (LPN #2) who came to the unit and helped her to get all the supplies that were needed and set up the resident's room. LPN #1 stated, "We had everything except the extra [REDACTED] and [REDACTED]." She further stated, "We needed the [REDACTED] to take them in and out and we never got them. I remember the resident was [REDACTED] and I took out the [REDACTED] and it was [REDACTED] I had to [REDACTED] and put the [REDACTED]. We had to keep [REDACTED] the [REDACTED] we</p>	F 695			

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F 695	<p>Continued From page 35</p> <p>education regarding [NJ Ex Order 26.4(b)(1)] care at the facility but had worked previously with [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] at other facilities. LPN #6 concluded "I feel the staff were afraid to take care of [NJ Ex Order 26.4(b)(1)]."</p> <p>On 10/01/24 at 2:23 PM, the surveyor conducted a telephone interview with Resident #313's family representative (FR). The FR stated that when the resident was admitted to the facility, the facility had very little supplies and they were trying to get all the supplies that was needed. The FR further stated the facility did not have any [NJ Ex Order 26.4(b)(1)] and that they did not have the staff to do what needed to be done.</p> <p>The facility provided copies of [NJ Ex Order 26.4(b)(1)] Care Competency skills list for LPN #1 and LPN #2. LPN #1 [NJ Ex Order 26.4(b)(1)] Care Competency Skills Checklist was signed and dated as completed on [NJ Ex Order 26.4(b)(1)]. LPN #2's [NJ Ex Order 26.4(b)(1)] Care Competency Skills Checklist was signed as completed on [NJ Ex Order 26.4(b)(1)], after the resident was discharged. The surveyor requested to review the original, not copies, of the competencies for both LPNs but the facility was unable to provide the original checklists.</p> <p>An acceptable RP was received on 10/01/24 at 11:31 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: 1.) The [U.S. FOIA (b)(6)] conducted a house wide audit on 09/30/24 to resident physician orders and identified no additional residents with a trach were at the facility; 2.) The [U.S. FOIA (b)(6)] completed education and in-servicing for all licensed staff on the location of [NJ Ex Order 26.4(b)(1)] supplies at the bedside and in the facility and to</p>	F 695			

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F 695	<p>Continued From page 36</p> <p>communicate the need for additional supplies on trach care and on trach care emergencies; 3.) the U.S. FOIA (b) (6) was re-educated to inform the U.S. FOIA (b) (6) for trach supply related concerns should they arise in the future.</p> <p>The survey team verified the implementation of the removal plan during the continuation of the on-site survey on 10/01/24.</p> <p>The surveyor had requested the following information from [NJ Ex Order 26.4(b)(1)] through 10/3/24:</p> <p>Staffing and assignments for the dates of [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)]; tracheostomy education or competencies for all staff who worked with Resident #313 from [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)]; timeclock/time sheets for the dates of [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)]; paper medical records that were not scanned into the electronic medical record, including after visit summaries from Resident #313's ER visits.</p> <p>On 10/03/24 at 10:45 AM, and the facility confirmed they were unable to provide the requested information.</p> <p>F695 remains a deficiency at a scope and severity of a D based on the following:</p> <p>PART B</p> <p>The facility further failed to (c) consistently document in the Medication Administration Record (MAR) and Treatment Administration Record (TAR) that [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] related treatments were administered as ordered, (d) clarify physician orders for a resident with a [NJ Ex Order 26.4(b)(1)] and (e) ensure that physician</p>	F 695			

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F 695	<p>Continued From page 37</p> <p>orders were accurately transcribed and followed for 1 of 4 residents (Resident #313) reviewed for respiratory care.</p> <p>A review of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) Order Summary Report and the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) MARs and TARs for Resident #313 revealed that there was no documentation to indicate that the medications and treatments were administered as ordered on the following dates and times:</p> <p>1. NJ Ex Order 26.4(b)(1) [redacted] via NJ Ex Order 26.4(b)(1) two times a day for NJ Ex Order 26.4(b)(1) -Ordered [redacted]</p> <p>0900 NJ Ex Order 26.4(b)(1) [redacted]</p> <p>2100 - NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted]</p> <p>2. NJ Ex Order 26.4(b)(1) [redacted] every 12 hours for NJ Ex Order 26.4(b)(1) -Ordered NJ Ex Order 26.4(b)(1) [redacted]</p> <p>0900- NJ Ex Order 26.4(b)(1) [redacted]</p> <p>2100 NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted]</p> <p>3. Give NJ Ex Order 26.4(b)(1) [redacted] with NJ Ex Order 26.4(b)(1) [redacted] every shift for NJ Ex Order 26.4(b)(1) -Ordered NJ Ex Order 26.4(b)(1) [redacted]</p> <p>Day shift- NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted]</p> <p>Evening shift- NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted]</p>	F 695			

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F 695	<p>Continued From page 38</p> <p>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) , NJ Ex Order 26.4(b)(1) ,</p> <p>Night shift NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) ,</p> <p>4. NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26.4(b)(1) or to keep the NJ Ex Order 26.4(b)(1) -Ordered NJ Ex Order 26.4(b)(1) ,</p> <p>Day shift 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) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) ,</p> <p>Evening shift 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) , 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>Night shift NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) ,</p> <p>5. NJ Ex Order 26.4(b)(1) Care every shift. every shift for NJ Ex Order 26.4(b)(1) Care-Ordered NJ Ex Order 26.4(b)(1) .</p> <p>Day shift 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) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) ,</p> <p>Evening shift 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) , 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>Night shift NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) ,</p> <p>A review of the Advanced Practice Nurse (APN #1) Progress Note (PN), dated NJ Ex Order 26.4(b)(1) at 12:35 PM, revealed documentation of NJ Ex Order 26.4(b)(1) and to continue NJ Ex Order 26.4(b)(1) . There was no documentation of the NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) method, or amount of NJ Ex Order 26.4(b)(1) . This note was signed by the attending US FOIA (b)(6)) on NJ Ex Order 26.4(b)(1) at 11:19 PM.</p>	F 695			

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F 695	<p>Continued From page 39</p> <p>A review of the Pulmonary Advanced Practice Nurse (APN #2) PN, dated [REDACTED] at 14:00 (2:00 PM), revealed under the assessment and plan section, APN #2 documented to continue [REDACTED] monitor [REDACTED] NJ Ex Order 26.4(b)(1)); avoid [REDACTED] NJ Ex Order 26.4(b)(1)); [REDACTED] NJ Ex Order 26.4(b)(1) present [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b)(1) BID (twice a day), change [REDACTED] NJ Ex Order 26.4(b)(1) every 8 weeks-next due on [REDACTED] and [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED]. The progress notes also revealed that the case was discussed with nursing, and the primary care team were aware of the plan.</p> <p>A review of the [REDACTED] NJ Ex Order 26.4(b)(1) active physician's orders did not reflect a change in the PO to a [REDACTED] NJ Ex Order 26.4(b)(1) or the recommended [REDACTED] NJ Ex Order 26.4(b)(1) and [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>A PN that was written by the APN #2, dated [REDACTED] NJ Ex Order 26.4(b)(1) (late entry), reflected to continue [REDACTED] NJ Ex Order 26.4(b)(1) monitor [REDACTED] NJ Ex Order 26.4(b)(1)); avoid [REDACTED] NJ Ex Order 26.4(b)(1)); [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b)(1) care BID (twice a day), [REDACTED] NJ Ex Order 26.4(b)(1) every 8 (eight) weeks-next due on [REDACTED] NJ Ex Order 26.4(b)(1) and [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED]. The progress notes also revealed that the case was discussed with nursing and primary care team aware of plan.</p> <p>A review of APN #2's PO, dated [REDACTED] NJ Ex Order 26.4(b)(1) reflected the following: Please put patient on a [REDACTED] NJ Ex Order 26.4(b)(1) TODAY. Please have 3 (three) [REDACTED] NJ Ex Order 26.4(b)(1) at bedside. Please place 1 (one) box of [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] at bedside. [REDACTED] NJ Ex Order 26.4(b)(1) care BID and as needed.</p>	F 695			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 695	<p>Continued From page 40</p> <p>Weekly ^{NJ Ex Order 26.4(b)} changes. I will change the ^{NJ Ex Order} every 8 weeks while the patient is admitted. ^{NJ Ex Order 26.4(b)(1)} two times a day for ^{NJ Ex Order} care BID.</p> <p>A review of the ^{NJ Ex Order 26.4(b)(1)} active physician's orders did not reflect a change in the PO to a ^{NJ Ex Order} size of ^{NJ Ex Order 26.4(b)(1)} or the recommended ^{NJ Ex Order 26.4} and ^{NJ Ex Order 26.4(b)(1)}</p> <p>A nurses note, dated ^{NJ Ex Order 26.4(b)(1)} at 13:49 (1:49 PM), revealed that Resident #313 returned from the acute hospital with no new orders or discharge paperwork. The nurse called the hospital to see if the paperwork could be forwarded.</p> <p>A review of the sending hospital after visit summary and medical records from Resident's #313's acute hospitalization from ^{NJ Ex Order 26.4(b)(1)} through ^{NJ Ex Order 26.4(b)(1)} did not reveal any documentation of the ^{NJ Ex Order 26.4(b)(1)}, ^{NJ Ex Order 26.4} or if ^{NJ Ex Order 26.4(b)(1)} was recommended.</p> <p>The following physicians order for oxygen were not clarified or transcribed during Resident#313's admission to the facility from ^{NJ Ex Order 26.4(b)(1)} to ^{NJ Ex Order 26.4(b)(1)}:</p> <p>1. Give ^{NJ Ex Order 26.4(b)(1)} with ^{NJ Ex Order 26.4(b)(1)} every shift for ^{NJ Ex Order 26.4(b)(1)} Care- Start Date ^{NJ Ex Order 26.4(b)(1)} 0700-Hold Date from ^{NJ Ex Order 26.4(b)(1)} 2135 to ^{NJ Ex Order 26.4(b)(1)} 1347-Hold Date from ^{NJ Ex Order 26.4(b)(1)} 1439 to ^{NJ Ex Order 26.4(b)(1)} 2213-D/C Date ^{NJ Ex Order 26.4(b)(1)} 0112.</p> <p>2. [Name redacted] ^{NJ Ex Order 26.4(b)(1)} Routine ^{NJ Ex Order} care daily and as needed, change ^{NJ Ex Order 26.4(b)}</p>	F 695			

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F 695	<p>Continued From page 41</p> <p>weekly, and please order 3 appropriately sized NJ Ex Order 26.4(b)(1) to keep at the bedside, I will change the NJ Ex Order at my next visit. Please also order a box of NJ Ex Order 26.4(b)(1) to keep at the bedside. TY one time a day for NJ Ex Order care. Ordered NJ Ex Order 26.4(b)(1)</p> <p>3. Please put patient on NJ Ex Order 26.4(b)(1) TODAY Please have 3 NJ Ex Order 26.4(b)(1) at bedside Please place 1 box of NJ Ex Order 26.4(b)(1) at bedside NJ Ex Order 26.4(b)(1) card BID an as needed Weekly NJ Ex Order 26.4(b)(1) I will change the NJ Ex Order every 8 weeks while the patient is admitted NJ Ex Order 26.4(b)(1) PRN two times a day for NJ Ex Order care BID. Ordered NJ Ex Order 26.4(b)(1)</p> <p>On 10/01/24 at 10:18 AM, the surveyor interviewed LPN #3 who stated that when administering medications or treatments, the nurse should sign out the medications after they were given or completed and there should not be any blanks (not initialed as given) on the MAR or TAR. If there were blanks on the MAR or TAR it could mean that the nurse forgot to sign it out or forgot to do it. LPN #3 further stated "If it wasn't documented, it wasn't done." LPN #3, in the presence of the surveyor, reviewed the NJ Ex Order 26.4(b)(1) Physician Order (PO), dated NJ Ex Order 26.4(b)(1), and stated that the PO should have a specific number of liters of NJ Ex Order 26.4(b)(1) to be given and how the NJ Ex Order 26.4(b)(1) should be given. It was important to have a PO for NJ Ex Order 26.4(b)(1) because NJ Ex Order 26.4(b)(1) was a medication that needed to be prescribed by the doctor. When asked how the nurse would know how much NJ Ex Order 26.4(b)(1) to provide to Resident #313 with the PO as written, LPN #3 stated "the nurses wouldn't know by that order."</p> <p>On 10/01/24 at 10:36 AM, the surveyor</p>	F 695			

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F 695	<p>Continued From page 42</p> <p>interviewed the [U.S. FOIA (b) (6)] who stated that all medication and treatment should be signed out as soon as they were administered. If there are blanks on the MARs and TARs, it was not done. The [U.S. FOIA (b) (6)] stated, "If it's not documented, then it is not done." The [U.S. FOIA (b) (6)] further stated that if the resident was in the hospital, out of the facility or refused, there was a space to document why the medication or treatment was not given and there should not be any blanks in the MARs and TARs. At that time, the [U.S. FOIA (b) (6)] and the surveyor reviewed the above [NJ Ex Order 26.4(b)(1)] order dated [NJ Ex Order 26.4(b)(1)] and the [U.S. FOIA (b) (6)] stated that the order was an incomplete PO because it did not include how many [NJ Ex Order 26.4(b)(1)] and the [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4(b)(1)] to administer to the resident. She further stated that the nurse should have called the doctor and clarified the [NJ Ex Order 26.4(b)(1)] order because [NJ Ex Order 26.4(b)(1)] was a medication.</p> <p>The [U.S. FOIA (b) (6)], in the presence of the surveyor, reviewed the PO's as written below:</p> <p>1. Please put patient on [NJ Ex Order 26.4(b)(1)] TODAY Please have 3 [NJ Ex Order 26.4(b)(1)] at bedside Please place 1 box of [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] at bedside [NJ Ex Order 26.4(b)(1)] BID an as needed Weekly [NJ Ex Order 26.4(b)(1)] changes I will change the [NJ Ex Order 26.4(b)(1)] every 8 weeks while the patient is admitted [NJ Ex Order 26.4(b)(1)] PRN two times a day for [NJ Ex Order 26.4(b)(1)] care BID. Ordered [NJ Ex Order 26.4(b)(1)]</p> <p>2 [NJ Ex Order 26.4(b)(1)] Type: [Name redacted] [NJ Ex Order 26.4(b)(1)] Routine [NJ Ex Order 26.4(b)(1)] care daily and as needed, change [NJ Ex Order 26.4(b)(1)] weekly, and please order 3 [NJ Ex Order 26.4(b)(1)] to keep at the bedside, I will change [NJ Ex Order 26.4(b)(1)] at my next visit. Please also order a box of [NJ Ex Order 26.4(b)(1)]</p>	F 695			

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F 695	<p>Continued From page 43</p> <p>NJ Ex Order 26.4(b)(1) to keep at the bedside. TY one time a day for NJ Ex Order 26.4(b)(1) care. Ordered NJ Ex Order 26.4(b)(1).</p> <p>The U.S. FOIA (b) (6) stated that the above orders should have been clarified because it had too many orders in one PO, and they were not transcribed onto the TAR. The U.S. FOIA (b) (6) further stated, the nurse should have called the doctor and clarified the order when the nurse acknowledged the PO in the electronic MAR or during the 24-hour chart check.</p> <p>On 10/01/24 at 12:03 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that all medication and treatments were to be signed out upon rendering the treatment or medication and there should not be any blanks on the MARs and TARs. The U.S. FOIA (b) (6) in the presence of the surveyor, reviewed the above NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) orders and the U.S. FOIA (b) (6) stated that the PO's should have been clarified either when the nurse acknowledged the order or during the 24-hour chart check. When a nurse acknowledged a PO, they would review the order to make sure it was a complete order and if they had any questions, they would call the doctor to get the order clarified. The U.S. FOIA (b) (6) confirmed that the physician orders were not ordered correctly and were not transcribed onto the MARs and TARs. The U.S. FOIA (b) (6) further stated the above POs should have been clarified because it was important to prevent NJ Ex Order 26.4(b)(1) in a resident with a NJ Ex Order 26.4(b)(1).</p> <p>A review of the facility's "Oxygen Administration" policy, undated, indicated to verify that there is a physician order and to review the physician's orders or facility's procedure for oxygen administration.</p>	F 695			

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F 695	<p>Continued From page 44</p> <p>A review of the facility's "Medication Orders" policy undated, revealed that for Oxygen Orders to specify the rate of flow, route, and rationale (i.e., O2 (Oxygen) 2/3 L/min per nasal cannula prn SOB).</p> <p>A review of the facility's "Physicians Orders" policy undated, reflected that orders for medications must include a. Name and strength of the drug; b. Quantity and specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration if other than oral; and e. Reason or problem for which given.</p> <p>A review of the facility's "Charting/Documenting Policy" undated, reflected that the purpose of these guidelines is to ensure complete comprehensive and timely documentation of the residents'/patient 'care, treatment, response to care, signs, symptoms, change in condition as well as the progress of the resident/patient. Under Medication Administration: the date and time medication administered on the Medical Administration Record. Document reason for refusal of medication on the nurses note. Initial of person in appropriate body on Medex. Under treatments: All treatments requiring a physician's order, or nursing intervention must be documented on Treatment Record. The Nurse completing the treatment must initial in the appropriate section on the record.</p> <p>A review the facility's "Physician Order Chart check Policy",undated, included: is to ensure that physicians orders are correctly carried over from the (POS) Physician Order Summary to MAR/TAR. The 11pm -7am Nurse will:</p>	F 695			

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F 695	Continued From page 45 " Review each chart checking for medication orders, lab orders, consultation sheets against the MAR/TAR and Lab book. " if the order has been missed, the 11-7 nurse will transcribe the order sign that it was noted on the TAR/MAR/Lab sheet and sign the POS and fax it to the pharmacy. At the bottom of the POS the nurse will write 24-hour chart check and sign it. " The nurse will review all newly admitted resident's medication orders and check that they were processed correctly as above and write 24-hour chart check on the admission POS and sign it. " 4.The nurse will report any missed orders to the unit manager to educate staff members on the importance of accuracy in health care.	F 695			
F 729 SS=D	NJAC 8:39 25.2(b), (c)4, 27.1(a) Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.	F 729			10/20/24

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F 729	<p>Continued From page 46</p> <p>§483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.</p> <p>§483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that all certified nursing staff hired by the facility had certifications in good standing. This deficient practice occurred to 2 of 10 newly hired CNAs (certified nurse aides), (Employees #3 and #8) that were newly hired.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 10/1/24 at 1:32 PM, the surveyor reviewed the employee files of 10 randomly selected CNAs that was recently hired. The following was revealed:</p> <p>A review of the employee file for Employee #3 with a hire date of 10/1/24, did not contain evidence that her certification was verified prior to employment.</p>	F 729	<p>ELEMENT ONE: CORRECTIVE ACTION: Employees #3 and #8 were immediately verified via Nurse Aide Registry.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The U.S. FOIA (b) (6) was re-educated 10/2/24 regarding verifying certifications prior to employment.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to confirm that all current certified nursing staff</p>		

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F 729	Continued From page 47 A review of the employee file for Employee #8 with a hire date of [REDACTED], did not contain evidence that her certification was verified prior to employment. On 10/1/24 at 2:34 PM, during an interview with the surveyor, the U.S. FOIA (b) (6) [REDACTED] confirmed that Employee #3 and Employee #8's employment files did not contain verification. She continued by stating that the state registry should be checked for verification. After the CNA was verified, the verification was printed out and kept in the employee's employment file. A review of the facility's "Residents/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property" undated policy, included...Screening Procedures A. Screening of all employees are screened prior to employment2. Facility will be thorough in the investigation of past histories of individuals hired. This will be done through: a. Inquiry of State Nurse Aide Registry.	F 729	certifications are in good standing. Also, an audit tool was created to ensure that all new certified nursing staff certifications were verified prior to hire. The audit will be done weekly for three months or until substantial compliance is met. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Administrator is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
F 755 SS=E	NJAC 8:39-43.15 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755			10/20/24

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F 755	<p>Continued From page 48</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: Complaint #: NJ169862</p> <p>Based on observations, interviews, record review, and review of other pertinent documentation, it was determined that the facility failed to: 1) develop and implement a comprehensive policy to maintain a system of accountability for the back up storage of controlled medications (drugs that are tightly controlled by the government because of the risk of abuse and addiction) 2) store ^{NJ Ex Order 26.4(b)(1)} (NJ Ex Order 26.4(b)(1) ^{NJ Ex Order 26.4(b)(1)} in a safe and sanitary manner to prevent the spread of infection, and 3) administer</p>	F 755	<p>ELEMENT ONE: CORRECTIVE ACTION: Medication Dispensary Machine technician was disbursed to facility and printer re-booted and is currently functioning for cycle count. An investigation was conducted, resident #314 was ^{NJ Ex Order 26.4(b)(1)} by the practice. Resident #314 ^{NJ Ex Order 26.4(b)(1)} at the facility. ^{NJ Ex Order 26.4(b)(1)} were immediately stored in a safe and sanitary manner. The facility immediately made sure that medication used to treat ^{NJ Ex Order 26.4(b)(1)} ^{NJ Ex Order 26.4(b)(1)} were being given in a timely</p>		

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F 755	<p>Continued From page 49</p> <p>a medication used to treat NJ Ex Order 26.4(b)(1) in a timely manner in accordance with the facility policy and professional standards of nursing practice. This deficient practice was identified for 1 of 1 automated medication dispensing systems reviewed in 1 of 2 medication rooms (Third Floor Medication Room), and for 4 of 4 medications carts reviewed for NJ Ex Order 26.4(b)(1) storage, and for 1 of 1 closed record (Resident #314) reviewed for medication administration.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 9/30/24 at 8:23 AM, the surveyor met with the U.S. FOIA (b) (6) who agreed to demonstrate the cycle count (system to count the inventory of controlled medications in the automated medication dispensing unit) with a required second nurse, the U.S. FOIA (b) (6), during the inspection of the third floor medication room. When the surveyor asked to review the shift to shift sign in book to verify that two nurses performed the count in accordance with the facility policy, the U.S. FOIA (b) (6) stated that we had issues with the log book previously during survey and there was a recommendation to get rid of it. The U.S. FOIA (b) (6) stated that she would print out a log from the automated medication system which kept a record of when the cycle count was performed. The U.S. FOIA (b) (6) failed to print the report of accountability at that time and indicated that she required assistance to perform that function. The U.S. FOIA (b) (6) stated that she did not know how to print a discrepancy report to show the surveyor that there were no discrepancies identified since the last cycle count.</p>	F 755	<p>manner.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the practice. An audit was completed by Assistant director of Nursing noting blood pressure medication timing via Electronic Medical Record, chart audits completed to note any medications not packaged.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: A comprehensive policy to maintain a system of accountability for the backup storage of controlled medications was developed by the facility. The computer to back up system has been re-booted and is currently functioning. All nurses were re-educated on 10/2/24 regarding storing insulin pens in plastic bag, all nurses were re-educated on 10/2/24 regarding administering medication used to treat high blood pressure in a timely manner in accordance with the facility policy and professional standards of nursing practice.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: Nursing staff were re-educated on 10/2/24 storing insulin pens in a safe and sanitary manner and re-educated 10/2/24 on administering a medication used to treat high blood pressure in a timely manner in accordance with the facility policy and professional standards of nursing practice. Audit tools were created to</p>		

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F 755	<p>Continued From page 50</p> <p>At that time, during the cycle count, the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] noted that there was a discrepancy for Roxicodone (a controlled medication used to treat moderate to severe pain) 20 mg (milligrams) and stated that 94 tablets were counted, that the count was different and they were resolving it from yesterday. The [U.S. FOIA (b) (6)] stated that two nursing staff who were identified documented that there were 96 tablets that remained, and pulled two tablets, and miscounted by one and entered 93, when the count should have been 94. The [U.S. FOIA (b) (6)] stated, "I will print the discrepancy for you." The [U.S. FOIA (b) (6)] stated, "That was not the count (correct count). We are resolving a discrepancy from yesterday." The [U.S. FOIA (b) (6)] stated that when there was a discrepancy nursing should let me know and the automated dispensing system picks it up and sends a notification to me. The [U.S. FOIA (b) (6)] denied receipt of any notification of a discrepancy and further stated, "I have to check my texts".</p> <p>On 9/30/24 at 10:21 AM, the surveyor requested policies regarding the Shift to Shift Narcotic (controlled medications) Count for the automated medication system, and the Process for resolving discrepancies for the automated medication dispensing system.</p> <p>On 9/30/24 at 11:52 AM, the [U.S. FOIA (b) (6)] provided the surveyor with a policy titled, "Controlled Substances" dated 02/24, and stated that the facility did not have a policy that specifically addressed the automated medication dispensing system. The surveyor reviewed the policy and noted that the policy only pertained to the count of controlled drugs on each medication cart at the end of each shift by the nurse coming on duty and the nurse going off</p>	F 755	<p>monitor that insulin pens are being stored in an appropriate manner, and medication used to treat high blood pressure is being given in a timely manner in accordance with the facility policy and professional standards of nursing practice. ADON/designee will audit medication carts for proper storage of medication, will audit MAR via EMR for timely medication administration and q shift narcotic cycle shift count weekly for three months or until substantial compliance is met. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Director of Nursing is responsible for this plan of correction.</p> <p>ELEMENT FIVE: COMPLETION DATE: 10/20/2024</p>		

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F 755	<p>Continued From page 51</p> <p>duty. A review of the policy revealed that they (nursing) must document and report any discrepancies to the U.S. FOIA (b) (6) Services. The policy failed to specify and detail the process for nursing to maintain accountability of controlled medications and discrepancies when identified in the automated dispensing medication system.</p> <p>On 9/30/24 at 12:54 PM, the U.S. FOIA (b) (6) provided the surveyor with a document titled, "3rd floor automated medication dispensing system count [sic]" for September 2024. A review of the document revealed that the form was paper based, and was not printed out of the automated medication dispensing system as previously described by the U.S. FOIA (b) (6). The surveyor reviewed the document which indicated that the count was completed every shift by two nurses who printed their initials only and whether the count was correct by filling in a Y (yes) or N (no). On 9/29/24 on the 3PM to 11 PM shift the U.S. FOIA (b) (6) documented that he performed the cycle count with another nurse and indicated that there were no discrepancies noted during the count. On 9/30/24 during the 11 PM to 7 AM shift the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) documented N, to indicate the count was not correct and in the field allotted for F/U (follow up) Actions Taken documented "report error by Sup (Oxy 20) resolved Oxy 20 mg count on 9/30/24) and the entry was initialed by the U.S. FOIA (b) (6) and U.S. FOIA (b) (6).</p> <p>During an interview with the surveyor on 9/30/24 at 12:26 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that she did not know the process for counting the automated medication system, but she guessed that it should have been counted</p>	F 755			

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F 755	<p>Continued From page 52</p> <p>every shift like the medication cart. The [U.S. FOIA (b) (6)] stated that she only counted the contents of the automated medication system when we put narcs (narcotics) in, when they were received from the pharmacy and was not involved in the day to day process.</p> <p>During an interview with the surveyor on 9/30/24 at 1:02 PM, the [U.S. FOIA (b) (6)] was asked where the "3rd floor automated medication dispensing system count" was for September 2024 when it was requested by the surveyor during the inspection of the controlled medication inventory? The [U.S. FOIA (b) (6)] stated that she "got rid of the shift to shift narcotic accountability book in 2021, because there was too much discrepancy with the book." The [U.S. FOIA (b) (6)] stated that we just got the new automated medication dispensing machine two to three months ago. The [U.S. FOIA (b) (6)] stated that the Office of Resiliency (a state agency) was here and the representative asked me if there was a way to retrieve the information from it. The [U.S. FOIA (b) (6)] stated that the representative made a recommendation for us to have documentation because I do not know how to retrieve cloud information. The [U.S. FOIA (b) (6)] stated that we were not documenting shift to shift accountability for the controlled medication dispensing system prior to August, so I have provided you with written documentation now for September of 2024. The surveyor asked why the documentation were not available to view when initially requested and why only the Month of September were provided as she indicated that documentation was also recorded in August of 2024. The [U.S. FOIA (b) (6)] stated that it was a miscommunication and she agreed to provide it. The [U.S. FOIA (b) (6)] stated that the [U.S. FOIA (b) (6)] texted her and made her aware of the discrepancy that was created in the automated medication dispensing</p>	F 755			

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F 755	<p>Continued From page 53</p> <p>system on 9/20/24 during the 3-11 shift . The surveyor requested to see the text at that time and the [U.S. FOIA (b)] stated, "I do not have the text."</p> <p>On 9/30/24 at 2:10 PM, the [U.S. FOIA (b)] provided the surveyor with a copy of the "3rd floor Automated Medication System Count" for August 2024.</p> <p>During a telephone interview with the surveyor on 10/1/24 at 10:00 AM, the [U.S. FOIA (b)] stated that the facility was supposed to maintain a shift to shift accountability log for the automated medication dispensing system to ensure the counts were accurate and there was no diversion (theft) between shift to shift. The [U.S. FOIA (b)] further explained that she was not responsible for the oversight of the automated medication dispensing machine, the provider pharmacy was. The surveyor obtained contact information from the facility and attempted to reach the provider pharmacy representative and their designee, who were not available for interview.</p> <p>During a telephone interview with the surveyor on 10/1/24 at 3:01 PM, the [U.S. FOIA (b)] stated that he worked at the facility for [NJ Exec Order 26.4b]. He stated that the automated medication dispensing system was counted by two nurses and was only counted when it was being filled or when a narcotic was removed. The [U.S. FOIA (b)] stated, "The automated medication dispensing system was not counted on a routine basis." The [U.S. FOIA (b)] stated that he worked full-time and that when there was a discrepancy because the count was not correct, the drawer will not open, it will not let you go ahead. He stated, one time I was told there was a discrepancy and the count on the screen was not the count. The [U.S. FOIA (b)] stated I called the [U.S. FOIA (b)] right away when it happened.</p>	F 755			

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F 755	<p>Continued From page 54</p> <p>During an interview with the surveyor on 10/2/24 at 10:02 AM, when the surveyor asked the [U.S. FOIA (b) (6)] if the documentation for the automated medication dispensing system was in place prior to the observation on 9/30/24, the [U.S. FOIA (b) (6)] stated, "I do not want to put my foot in my mouth." The [U.S. FOIA (b) (6)] further stated, "I have no explanation at all for this.</p> <p>2. On 9/30/24 at 9:10 AM, during the Medication Storage Task, the surveyor inspected the Three West Medication Cart in the presence of Licensed Practical Nurse (LPN) #4. In the top left drawer, the surveyor observed three [NJ Ex Order 26.4(b)(1)] that were stored together within a single compartment of the drawer and were not kept in a [NJ Ex Order 26.4(b)(1)]. LPN #4 stated that the [NJ Ex Order 26.4(b)(1)] belonged to Resident #5, Resident #41 and Resident #103. When the surveyor asked what the policy was regarding [NJ Ex Order 26.4(b)(1)] storage, LPN #4 stated that she was unsure and further stated, "Is it supposed to be in [NJ Ex Order 26.4(b)(1)]</p> <p>During an interview with the surveyor on 9/30/24 at 9:30 AM, the [U.S. FOIA (b) (6)] stated that [NJ Ex Order 26.4(b)(1)] were stored in the top drawer of the medication cart with the rest of the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)] stated that she was used to keeping them in [NJ] at the previous facility that she worked at. The [U.S. FOIA (b) (6)] stated that the [U.S. FOIA (b) (6)] inspected the medication carts and had not said anything about the [NJ Ex Order 26.4(b)(1)] not being stored in [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)] stated that there was no policy related to the storage of [NJ Ex Order 26.4(b)(1)] that she was aware of. The [U.S. FOIA (b) (6)] stated that she had been in the role of [U.S.] since [NJ Ex Order 26.4(b)(1)], and got her certification on [NJ Ex Order 26.4(b)(1)], and infection control was a broad topic.</p>	F 755			

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F 755	<p>Continued From page 55</p> <p>On 9/30/24 at 9:37 AM, the surveyor inspected the Two West Medication Cart in the presence of LPN #5. In the top left drawer, the surveyor observed two [redacted] that were stored together. LPN #5 stated that the [redacted] belonged to Resident #38 and Resident #16. LPN #5 stated that the [redacted] were always stored in the drawer. When the surveyor asked if the pharmacy dispensed the [redacted] in a [redacted] LPN #5 stated, "We always throw [redacted] away."</p> <p>On 9/30/24 at 10:04 AM, the surveyor inspected the Three West Medication Cart in the presence of LPN #8. In the top left drawer, the surveyor noted three [redacted] were stored together and were not kept in [redacted]. LPN #8 stated that the [redacted] all belonged to Resident #77. LPN #8 stated that the [redacted] were kept in [redacted] but sometimes we replaced it.</p> <p>During an interview with the surveyor on 9/30/24 at 12:26 PM, the [redacted] U.S. FOIA (b) (6) stated that [redacted] usually came in [redacted] which was labeled with the resident's name on it. The [redacted] U.S. FOIA (b) (6) stated that she would leave the [redacted] in the [redacted] and write the date that the [redacted] were [redacted] because it was good for 28 days. The [redacted] U.S. FOIA (b) (6) stated there was a potential to pick up the wrong one if it were not in [redacted]. The [redacted] U.S. FOIA (b) (6) further stated that it would also need to be wiped off after use if it were not stored in [redacted] to prevent the spread of infection.</p> <p>During an interview with the surveyor on 10/1/24 at 9:46 AM, the [redacted] U.S. FOIA (b) (6) stated that she worked at the facility for four to five years. The [redacted] U.S. FOIA (b) (6) stated that</p>	F 755			

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F 755	<p>Continued From page 56</p> <p>once [NJ Ex Order 26.4(b)(1)] were opened they needed to be dated and put right back into [NJ Ex Order 26.4(b)(1)] for infection control purposes. The [U.S. FOIA (b) (6)] further stated, "It should be in the [NJ Ex Order 26.4(b)(1)]. When the surveyor asked the [U.S. FOIA (b) (6)] if she noted the storage of multiple insulin pens belonging to different residents being without [NJ Ex Order 26.4(b)(1)] during the medication cart inspections that she performed she stated, "I could not say that I have seen that, as the pharmacy sends them in [NJ Ex Order 26.4(b)(1)]."</p> <p>On 10/1/24 at 10:45 AM, the surveyor inspected the Three North Medication Cart in the presence of LPN #7. In the top left drawer, the surveyor noted that there were three [NJ Ex Order 26.4(b)(1)] stored together in the same compartment. LPN #7 stated that multiple [NJ Ex Order 26.4(b)(1)] were delivered for a single resident and were stored in a bag in the refrigerator. LPN #7 further stated that a single [NJ Ex Order 26.4(b)(1)] was then pulled from [NJ Ex Order 26.4(b)(1)] and placed into the medication cart without [NJ Ex Order 26.4(b)(1)] to cover it. LPN #7 stated that the [NJ Ex Order 26.4(b)(1)] belonged to Resident #219 and Resident #26. LPN #7 further stated that Resident #26 was discharged yesterday and then proceeded to remove the resident's [NJ Ex Order 26.4(b)(1)] from the medication cart.</p> <p>During an interview with the surveyor on 10/1/24 at 10:54 AM, the [U.S. FOIA (b) (6)] stated that after surveyor inquiry, she asked the [U.S. FOIA (b) (6)] what the purpose was for storing [NJ Ex Order 26.4(b)(1)] in [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)] stated that she was informed that the [NJ Ex Order 26.4(b)(1)] was used for infection control reasons. The [U.S. FOIA (b) (6)] further stated, "Now we are aware of a need to store the [NJ Ex Order 26.4(b)(1)] in the bag."</p> <p>3. A review Resident #314's closed record</p>	F 755			

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F 755	<p>Continued From page 58</p> <p>tablet by mouth every 12 hours for [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>[REDACTED]. The</p> <p>surveyor reviewed the resident's [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>and [REDACTED] NJ Ex Order 26.4(b)(1) that were documented in the</p> <p>EHR (electronic health record) from [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>through [REDACTED] NJ Ex Order 26.4(b)(1) and all recorded entries</p> <p>indicated that the resident's [REDACTED] NJ Ex Order 26.4(b)(1) and [REDACTED] NJ Ex Order 26.4(b)(1) met</p> <p>the conditions of the physician's order to</p> <p>administer [REDACTED] NJ Ex Order 26.4(b)(1) to</p> <p>the resident.</p> <p>A review of Resident #314's [REDACTED] NJ Ex Order 26.4(b)(1) Medication</p> <p>Administration Record (MAR) revealed an entry</p> <p>for [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>[REDACTED] Give 1 (one) tablet by mouth every 12 hours</p> <p>for [REDACTED] NJ Ex Order 26.4(b)(1) Hold if [REDACTED] NJ Ex Order 26.4(b)(1) or</p> <p>[REDACTED] NJ Ex Order 26.4(b)(1). The entry was scheduled to</p> <p>be administered at 0900 (9:00 AM) and 2100</p> <p>(9:00 PM). A review of the MAR revealed that the</p> <p>entry appeared to be given as scheduled daily at</p> <p>both 9:00 AM and 9:00 PM throughout the month</p> <p>of [REDACTED] NJ Ex Order 26.4(b)(1).</p> <p>On 09/30/24, the surveyor requested to view</p> <p>Resident #314's Medication Admin Audit Report</p> <p>(MAAR, a document that detailed the time exact</p> <p>time of medication administration not detailed on</p> <p>the MAR) for [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>administration as ordered. Review of the MAAR</p> <p>revealed that the scheduled 9 AM dose of</p> <p>[REDACTED] NJ Ex Order 26.4(b)(1) was</p> <p>administered late to the resident on the following</p> <p>dates and times: On [REDACTED] NJ Ex Order 26.4(b)(1) at 10:14 AM, on</p> <p>[REDACTED] NJ Ex Order 26.4(b)(1) at 12:11 PM, on [REDACTED] NJ Ex Order 26.4(b)(1) at 10:51 AM,</p> <p>on [REDACTED] NJ Ex Order 26.4(b)(1) at 10:26 AM, on [REDACTED] NJ Ex Order 26.4(b)(1) at 12:46</p> <p>PM, on [REDACTED] NJ Ex Order 26.4(b)(1) at 12:06 PM, on [REDACTED] NJ Ex Order 26.4(b)(1) at</p> <p>10:43 AM, on [REDACTED] NJ Ex Order 26.4(b)(1) at 11:42 AM, on [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>at 10:06 AM, on [REDACTED] NJ Ex Order 26.4(b)(1) at 1:04 PM and on</p>	F 755			

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

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/03/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 755	<p>Continued From page 59</p> <p>[REDACTED] at 12:36 PM.</p> <p>Further review of Resident #314's MAAR revealed that scheduled 9 PM dose of [REDACTED] was administered late to the resident on the following dates and times: On [REDACTED] at 10:43 PM, on [REDACTED] the entry was not charted as administered until [REDACTED] at 1:56 AM, on [REDACTED] at 11:19 PM, on [REDACTED] at 10:21 PM, on [REDACTED] at 11:49 PM, on [REDACTED] the entry was not charted as administered until [REDACTED] at 4:27 AM, on [REDACTED] at 11:04 PM, on [REDACTED] the entry was not charted as administered until [REDACTED] at 1:21 AM, on [REDACTED] the entry was not charted as administered until [REDACTED] at 12:01 AM, on [REDACTED] the entry was not charted as administered until [REDACTED] at 12:07 AM, on [REDACTED] the entry was not charted as administered until [REDACTED] at 12:08 AM, on [REDACTED] at 11:44 PM, on [REDACTED] at 10:38 PM, on [REDACTED] at 11:03 PM, and on [REDACTED] at 11:48 PM.</p> <p>A review of Resident #314's Progress Notes failed to contain documented evidence that the resident's physician was notified that the resident received their scheduled dosages of [REDACTED] beyond the scheduled administration time. There was also no documented rationale within the resident's EHR to explain why the medication was not administered timely as required.</p> <p>During an interview with the surveyor on 10/1/24 at 10:41 AM, Licensed Practical Nurse (LPN) #7 stated that if a medication were not available for administration, she went to the back up medication system or called the physician. LPN #7 stated that she was permitted to administer</p>	F 755			

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 755	<p>Continued From page 60</p> <p>medications one hour before or one hour after the scheduled administration time per facility policy. LPN #7 stated that she had enough time to administer her medications on time during her shift.</p> <p>During an interview with the surveyor on 10/1/24 at 11:20 AM, the U.S. FOIA (b) (6) who stated that medications should be given one hour before or an hour after the scheduled administration time. The U.S. FOIA (b) (6) stated that nursing should document if a resident refused their medication. The U.S. FOIA (b) (6) stated that the nurse needed to be educated if the medications were not administered on time because it was not acceptable.</p> <p>During an interview with the surveyor on 10/2/24 at 11:58 AM, the U.S. FOIA (b) (6) stated that the facility may have lost the Internet and was not able to sign his medications out on time when he administered medications to Resident #314. The U.S. FOIA (b) (6) stated that medications should be given one hour before or one hour after the scheduled time. U.S. FOIA (b) (6) further stated, "we always give medications on time."</p> <p>During an interview with the surveyor on 10/2/24 at 1:29 PM, the U.S. FOIA (b) (6) stated that the facility had a back up electronic medication administration record if the Internet were to go out. The U.S. FOIA (b) (6) explained that it was hooked up to a computer with a generator back up. The U.S. FOIA (b) (6) stated that if the Internet went out we used a hot spot for computer access and staff were able to use the computer. The U.S. FOIA (b) (6) stated that if paper emar were used, it could be scanned into the EHR. The U.S. FOIA (b) (6) was not aware of any Internet outages in</p>	F 755			

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 755	<p>Continued From page 61</p> <p>NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) was present at that time, and did not report any circumstances that could have contributed to delayed medications administration for Resident #314.</p> <p>A review of the facility policy, "Controlled Substances" (02/24) revealed the following: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances.</p> <p>...The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify responsible parties.</p> <p>The Director of Nursing Services shall maintain a list of individuals/personnel who have access to drug storage areas and controlled substance containers.</p> <p>A review of the facility policy, "Storage of Medications" (02/24) revealed the following: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received...</p> <p>The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</p> <p>...Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be</p>	F 755			

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 755	<p>Continued From page 62</p> <p>assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.</p> <p>A review of the facility policy, "Medication Administration Policy" (02/24) revealed the following: The facility shall administer all resident medications according to physician's orders.</p> <p>...Licensed nursing professionals will administer medications [sic.] according to times of administration determined by the facility.</p> <p>...Medication administration pass may begin sixty (60) minutes before the scheduled times of administration buy [sic.] may not exceed sixty (60) minutes after the scheduled times of administration.</p> <p>...Medications administered outside the prescribed timeframe requires physician notification and documentation in the medical record in the Interdisciplinary Progress Notes and/or on the MAR, stating reason for change of time and physician response...</p> <p>A review of an undated facility policy, "Charting/Documentation Policy" revealed the following:</p> <p>...Medication Administration: The date and time medication administered on the Medication Administration Record...Pulse and blood pressure when appropriate...</p> <p>NJAC 8:39-29.2(a), 29.4 (11) (1), 29.4 (d) (3), 29.7 (c), 27.1 (a)</p>	F 755			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/03/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUT		STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 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		
S2345	8:39-31.6(o) Mandatory Physical Environment (o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 10/01/24, in the presence of the Director of Maintenance (DM) it was determined the facility failed to invite state, county and municipal Emergency Management Officials (EMOs) at least 10 days in advance to attend one Emergency Preparedness (EP) evacuation drill annually in accordance with NJAC 8:39-31.6(o). This deficient practice had the potential to affect 113 residents and was evidenced by: During record review at 10:15 AM the facility provided a copies of the last EP drills. In the last	S2345	ELEMENT ONE: CORRECTIVE ACTION: An investigation was conducted, no residents were affected by the practice. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the practice: the facility sent out invites on 10/24/24 to state, county, and municipal Emergency Management Officials (EMOs) for our planned annual disaster drill to take place on 12/19/24.	10/20/24

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

Electronically Signed

TITLE

(X6) DATE

10/28/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/03/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUT		STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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S2345	Continued From page 1 12 months there was one full scale evacuation exercise dated 11/16/23 and there was no invitations to state, county or municipal EMOs to attend the annual exercise. In an interview at the time, the MD confirmed the findings and stated he was not at this facility for the previous drills and does not know what they did. The Regional Administrator was informed of the deficient practice during the Life Safety Code exit conference on 10/03/24 at 2:30 PM.	S2345	ELEMENT THREE: SYSTEMIC CHANGES: The Director of Maintenance was re-educated on 10/2/24 regarding to invite state, county, and municipal Emergency Management Officials at least 10 days in advance to attend one Emergency Preparedness evacuation drill annually. ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that state, county, and municipal Emergency Management Officials are invited at least 10 days in advance to attend one Emergency Preparedness evacuation drill annually. The audit will be done weekly for three months or until substantial compliance is met. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Administrator is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024	
S2460	8:39-31.8(c)(8) Mandatory Physical Environment (c) All residents shall have, in their rooms: 8. Night lights;	S2460		10/20/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/03/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUT		STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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S2460	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/02/24 in the presence of the Director of Maintenance, it was determined that the facility failed to provide working night lights in 11 of 13 resident rooms in accordance with NJAC 8:39-31.8(c)(8). This deficient practice had the potential to affect 113 residents and was evidenced by the following:</p> <p>An observation of the residents rooms from 10:29 AM to 2:25 PM revealed there were no working night lights present in rooms: 204, 207, 208, 214, 221, 230, 313, 318, 319, 323, and 330.</p> <p>In an interview at the time, the DM confirmed the observations.</p> <p>The Regional Administrator was informed of the findings at the Life Safety Code exit conference at 2:30 PM.</p>	S2460	<p>ELEMENT ONE: CORRECTIVE ACTION: An investigation was conducted, night lights were placed in every resident room requiring a new light including rooms 204, 207, 208, 214, 221, 230, 313, 318, 319, 323, and 330.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: Residents without night lights have the potential to be affected: all rooms were checked for any missing or non-functional night lights.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The Director of Maintenance was re-educated 10/2/24 regarding all resident rooms need to have working night lights.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that all resident rooms have a working night light. The audit will be done weekly for three months or until substantial compliance is met. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Administrator is responsible for this plan of correction.</p> <p>ELEMENT FIVE: COMPLETION DATE: 10/20/2024</p>	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315205	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/27/2024
NAME OF FACILITY MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103	

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 F0582	Correction	ID Prefix F0607	Correction	ID Prefix F0656	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	10/20/2024	LSC	10/20/2024	LSC	10/20/2024
ID Prefix F0658	Correction	ID Prefix F0692	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	10/20/2024	LSC	10/20/2024	LSC	10/20/2024
ID Prefix F0729	Correction	ID Prefix F0755	Correction	ID Prefix	Correction
Reg. # 483.35(d)(4)-(6)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. #	Completed
LSC	10/20/2024	LSC	10/20/2024	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	
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 10/3/2024		<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 060412	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/27/2024
NAME OF FACILITY MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103	

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 S2345	Correction	ID Prefix S2460	Correction	ID Prefix	Correction
Reg. # 8:39-31.6(o)	Completed	Reg. # 8:39-31.8(c)(8)	Completed	Reg. #	Completed
LSC	10/20/2024	LSC	10/20/2024	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	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/3/2024		<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			

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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E 000	Initial Comments	E 000			
K 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>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/01/2024, 10/02/2024 and 10/03/2024 and Majestic Center Rehab. and Sub-Acute Care 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>Majestic Center Rehab. and Sub-Acute Care is a Three-story, Type I Fire Resistant building that was built in January 1980. The facility is divided into 8 smoke zones. The facility has one internal 365 KW Diesel emergency power generator. The facility has piped oxygen to the 3rd floor rooms with the piped oxygen system outside in the back of the building. There is a oxygen storage room for portable E- cylinders inside.</p>	K 000			
K 222 SS=F	<p>Egress Doors</p> <p>CFR(s): NFPA 101</p> <p>Egress Doors</p> <p>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:</p>	K 222			10/20/24

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

TITLE

(X6) DATE

Electronically Signed

10/28/2024

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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K 222	<p>Continued From page 1</p> <p>CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p>	K 222			

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K 222	<p>Continued From page 2</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/02/24 in the presence of the U.S. FOIA (b) (6), it was determined the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA 101: 2012 Edition, Sections 7.1.10.1, 7.2.1.5.3, 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. The deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>An observation at 10:29 AM revealed the exterior exit from the boiler room had a double door with the left door leaf manually fixed in place and the right door leaf had panic hardware to open the right leaf and exit the building. The panic hardware was broken and did not function. The facility had installed a bolt lock on the door leaves to prevent entrance from the outside creating an impediment to egress.</p> <p>In an interview at the time, the U.S. FOIA (b) (6) confirmed the</p>	K 222	<p>ELEMENT ONE: CORRECTIVE ACTION: An investigation was conducted, no residents were affected by the deficient practice. The facility Maintenance Director checked all exit doors with means of egress to ensure they are readily accessible and free of all obstructions or impediments in the case of emergencies.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice. All doors were checked, and no other exit doors were affected</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The U.S. FOIA (b) (6) was reeducated on 10/19/24 regarding all exit doors in the means of egress are readily accessible and free of all obstructions or impediments to full instant use in the case</p>		

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K 222	Continued From page 3 observation. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 10/03/24 at 2:30 PM. NJAC 8:39-31.2(e)	K 222	of fire or other emergencies in accordance with NFPA101. The slide lock that was on the doors of the exterior exit from the boiler room was removed, and new panic hardware was installed on 10/6/24. ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created for Maintenance staff to use to monitor that all exit doors have a means of egress readily accessible and free of all obstructions or impediments. The monitoring of exit doors is conducted as part of weekly maintenance rounds. The results of weekly audits will be reported monthly for three months at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches	K 321		10/20/24	

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K 321	<p>Continued From page 4 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/02/24 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that hazardous areas were protected with self-closing doors in accordance with NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.5.9 and 8.4. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>An observation at 11:17 AM, revealed the door to the fire pump room did not close to the frame from the fully open position, it remained open 5 inches from the door frame, measured with a standard tape measure. This test was repeated 2 additional times with the same results.</p> <p>In an interview at the time, the U.S. FOIA confirmed the observation.</p>	K 321	<p>ELEMENT ONE: CORRECTIVE ACTION: An investigation was conducted, no residents were affected by the deficient practice. For the door to the fire pump, door hinges were replaced which allows them to be self-closing. For the first-floor business office door, a new door closer was installed.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The U.S. FOIA (b) (6) was reeducated on 10/19/24 regarding ensuring that all hazardous areas are</p>		

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K 321	Continued From page 5 An observation at 01:53 PM, revealed the first floor business office used to store combustible boxes and papers had a door closer that was missing the closer arm and not operational. In an interview at the time, the [U.S. FOIA] confirmed the observation. The facility's [U.S. FOIA (b) (6)] was informed of the deficient practice at the Life Safety Code exit conference at 2:30 PM. NJAC 8:39-31.2(e)	K 321	protected with self-closing doors in accordance with NFPA 101. An audit of all doors was completed to ensure that all hazardous areas are protected with self-closing doors. ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that all doors in hazardous areas are protected with self-closing doors. Monitoring doors to hazardous areas is conducted as part of weekly maintenance rounds. The results of weekly audits will be reported monthly for three months at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as	K 351		10/20/24	

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K 351	<p>Continued From page 6</p> <p>required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interview on 10/02/24 in the presence of the U.S. FOIA (b) (6), it was determined the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>An observation at 2:07 PM of the stairwell #3 First floor landing revealed there was no fire sprinklers coverage under the First floor and Second floor accessible landings. The stairwell #3 First floor landing was the ground level exterior exit for the First, Second, and Third floors and Basement areas served by those means of egress. The First floor landing would require fire sprinkler coverage.</p> <p>In an interview at the time, the U.S. FOIA confirmed the observations.</p> <p>The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit on 10/03/24 at 2:30 PM.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25</p>	K 351	<p>ELEMENT ONE: CORRECTIVE ACTION: An investigation was conducted, no residents were affected by the deficient practice. The sprinkler contractor is installing a sprinkler head in stairwell #3 first floor landing.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The U.S. FOIA (b) (6) was reeducated on 10/19/24 regarding ensuring that there is automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101. The contracted sprinkler company conducted a facility audit with the maintenance director/designee to ensure all areas are properly protected with sprinkler coverage in the event of an emergency.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that all areas of the facility have automatic fire sprinkler protection. Monitoring of sprinkler heads is conducted as part of</p>		

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K 351	Continued From page 7	K 351	weekly maintenance rounds. The results of weekly audits will be reported monthly for three months at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction.		
K 353 SS=F	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/02/24 in the presence of the U.S. FOIA (b) (6), it was determined the facility failed ensure fire sprinkler system sprinkler heads were maintained in accordance with NFPA 101: 2012</p>	K 353	<p>ELEMENT FIVE: COMPLETION DATE: 10/20/24</p> <p>ELEMENT ONE: CORRECTIVE ACTION: An investigation was conducted, no residents were affected by the deficient practice.</p>	10/20/24	

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K 353	<p>Continued From page 8</p> <p>edition, Sections 9.7.5, 19.3.5.1 and, NFPA 25: 2011 edition. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>Observations during a tour of the facility between 10:29 AM and 2:25 PM, revealed the following:</p> <ol style="list-style-type: none"> 1. In the basement record storage room protected by pendant sprinklers, five 2-foot by 4-foot and two 2-foot by 2-foot ceiling tiles were missing preventing proper operation. 2. In the 3rd floor trash chute room, there was a 5-inch by 5-inch penetration in the sheetrock ceiling with wires going through. 3. In the 3rd floor AC room, there was a 8-inch by 23-inch ceiling tile missing in the drop ceiling. 4. In the 3rd floor U.S. FOIA (b) (6) office doorless closet, the ceiling sprinkler escutcheon was missing. 5. In the 3rd floor stairwell #3 top landing's ceiling, there was a pipe with a 1-inch space through the sheetrock fire barrier around the pipe. 6. In the 3rd floor stairwell #1 top landing's ceiling, there was a pipe with a 1-inch space through the sheetrock fire barrier around the pipe. 7. In the 2nd floor soiled utility room ceiling, the sprinkler escutcheon was missing from the sprinkler head. 8. In the 2nd floor shower toilet room, the escutcheon was missing from the sprinkler head. 9. In the 2nd floor janitors closet, a 2-inch by 	K 353	<ol style="list-style-type: none"> 1) New ceiling tiles were installed in the record storage room located in the basement. 2) The 5-inch by 5-inch penetration in the sheetrock ceiling located in the 3rd floor trash chute room was replaced with 5/8 sheetrock. 3) The missing ceiling tile in the 3rd floor AC room was replaced. 4) The missing ceiling sprinkler escutcheon located in the ADONs office doorless closet was installed. 5) In the 3rd floor stairwell #3 top landing's ceiling, the pipe with a 1-inch space through the sheetrock fire barrier around the pipe was filled with fire rated caulk. 6) In the 3rd floor stairwell #1 top landing's ceiling, there was a pipe with a 1-inch space through the sheetrock fire barrier around the pipe. 7) In the 2nd floor soiled utility room ceiling, the sprinkler escutcheon that was missing from the sprinkler head was installed 8) In the 2nd floor shower toilet room, the escutcheon that was missing from the sprinkler head was installed. 9) In the 2nd floor janitors' closet, a 2-inch by 2- inch ceiling tile that was missing was installed. 10) In the stairwell #1 second floor landing, the pipe with a 1-inch space through the sheetrock fire barrier around the pipe was filled with fire rated caulk. 11) In the 2nd floor staff lounge bathroom and closet, the missing ceiling tiles were installed. 12) In the 1st floor trash room, where 		

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K 353	<p>Continued From page 9</p> <p>2-inch ceiling tile was missing.</p> <p>10. In the stairwell #1 second floor landing, there was a pipe with a 1-inch space through the sheetrock fire barrier around the pipe.</p> <p>11. In the 2nd floor staff lounge bathroom and closet, there were ceiling tiles missing in the drop ceiling.</p> <p>12. In the 1st floor trash room, there were penetrations in the drop ceiling in the following locations:</p> <ul style="list-style-type: none"> -In the corner, 7-inch by 12-inch around pipes and wires. -By the entrance door 7-inch by 12-inch around pipes and wires. -Around the trash chute. <p>13. In the 1st floor housekeeping closet, there was a 2-inch by 15-inch penetration around 2 pipes and the sprinkler escutcheon was missing.</p> <p>14. In the kitchen ceiling by the entrance from the hallway, the sprinkler escutcheon was missing.</p> <p>15. In the 1st floor dry storage room, 1 of the 2 sprinkler escutcheons was missing.</p> <p>16. In the kitchen freezer, the sprinkler escutcheon was missing.</p> <p>17. In the first floor storage room, the sprinkler escutcheon was missing.</p> <p>In interviews at the times of the observations, the U.S. FOIA confirmed the findings.</p>	K 353	<p>there were penetrations in the drop ceiling reinstalled new ceiling tiles with proper cuts and filled with fire rated caulk.</p> <p>13) In the 1st floor housekeeping closet, the 2-inch by 15-inch penetration around 2 pipes new ceiling tiles with proper cuts were installed and filled with fire rated caulk and the missing sprinkler escutcheon was installed.</p> <p>14) In the kitchen ceiling by the entrance from the hallway, the missing sprinkler escutcheon was installed.</p> <p>15) In the 1st floor dry storage room, the missing sprinkler escutcheon was installed.</p> <p>16) In the kitchen freezer, the missing sprinkler escutcheon was installed.</p> <p>17) In the first-floor storage room, the missing sprinkler escutcheon was installed.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The U.S. FOIA (b) (6) was reeducated on 10/19/24 regarding ensuring that the fire sprinkler system sprinkler heads are maintained in accordance with NFPA 101. The facility administrator and maintenance director/designee make weekly rounds to check the fire sprinkler system sprinkler</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 353	Continued From page 10 The U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 10/03/24 at 2:30 PM. NJAC 8:39-31.2(e) NFPA 13, 25	K 353	heads are being maintained in accordance with NFPA 101. The Sprinkler contractor monitors sprinkler heads during quarterly scheduled visits and repairs or replaces the sprinkler heads and/or equipment as needed. ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created for maintenance staff to monitor the fire sprinkler system to ensure sprinkler heads are being maintained in accordance with NFPA 10. The audit will be done weekly for three months. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or 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	K 363			10/20/24

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K 363	<p>Continued From page 11</p> <p>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 10/02/24 in the presence of the U.S. FOIA (b) (6) (), it was determined that the facility failed to ensure corridor doors closed and latched into their frame in accordance with NFPA 101: 2012 edition, Section 19.3.6.3, 19.3.2.1, 19.3.2.1.3, 19.3.5.9, 19.3.7.6, 19.3.7.8, 19.3.7.9 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p>	K 363	<p>ELEMENT ONE: CORRECTIVE ACTION:</p> <p>An investigation was conducted, no residents were affected by the deficient practice. New hardware was installed for rooms #312 and #222 to ensure the corridor doors close and latch into the frame.</p> <p>ELEMENT TWO: IDENTIFICATION OF</p>		

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K 363	Continued From page 12 An observation of the facility between 10:29 AM and 2:25 PM, revealed 2 of 25 resident room corridor doors observed (rooms 312 and 222) did not close into their frames and latch. In an interview at the time, the [U.S. FOIA (b) (6)] confirmed the observations. The [U.S. FOIA (b) (6)] was informed of the deficient practice during the Life Safety Code exit conference on 10/03/24 at 2:30 PM. NJAC 8:39-31.2 (e) NFPA 80	K 363	AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice. ELEMENT THREE: SYSTEMIC CHANGES: An audit was conducted to check all corridor doors to ensure they properly close and latch into their frame. The [U.S. FOIA (b) (6)] was reeducated on 10/19/24 to check corridor doors for proper functioning during weekly rounds to ensure they close and latch into the frames. ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that all corridor doors close and latch into their frame. The audit will be done weekly for three months. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and	K 531		10/20/24	

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K 531	<p>Continued From page 13</p> <p>Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview on 10/01/24 and 10/02/24 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to conform with Firefighter's Service Requirements of ASME/ANSI A17.3 and NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. This included firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation for 1 of 1 devices. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>A record review on 10/01/24 revealed there was no record of the monthly fire fighters service tests being performed for the facilities 2 elevators that serve 3 floors and a basement.</p> <p>In an interview on 10/02/24 at 9:00 AM, the surveyor asked the U.S. FOIA for the Phase I and Phase II firefighters monthly recall documentation for the two passenger elevators. The U.S. FOIA stated</p>	K 531	<p>ELEMENT ONE: CORRECTIVE ACTION:</p> <p>All residents have the potential to be affected by the deficient practice. An outside vendor conducted the fire fighters service tests for the facilities 2 elevators that serve 3 floors and the basement on 10/4/2024.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES:</p> <p>Fire fighter service tests of the two elevators have been scheduled to be conducted monthly to meet Firefighter's Service Requirements of ASME/ANSI A17.3 and NFPA 101.</p>		

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K 531	Continued From page 14 that the contracted elevator service company did not perform the required monthly firefighters service testing they were supposed to do. The U.S. FOIA (b) (6) was informed of the finding at the Life Safety Code exit conference on 10/03/24 at 2:30 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	The U.S. FOIA (b) (6) was reeducated on 10/19/24 to ensure the monthly tests are properly conducted and results placed in the maintenance logbooks. ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that the fire fighters service tests are being conducted monthly. These audits will be done monthly for three months and as directed by the QAPI committee thereafter. The results of these audits will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash	K 541		10/20/24	

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K 541	<p>Continued From page 15</p> <p>collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)</p> <p>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.</p> <p>19.5.4, 9.5, 8.4, NFPA 82</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interview on 10/02/24, in the presence of the U.S. FOIA (b) (6) it was determined that the facility failed to maintain the 1-hour fire protection rating of laundry chute door assemblies by the doors latching into their frame in accordance with NFPA 101: 2012 Edition, Section 9.5 and NFPA 82: 2009 Edition. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>An observation at 11:32 AM revealed the laundry chute door located in the main laundry on the basement level failed to latch securely in its assembly frame when tested. When stationary, the door was hovering an inch from closed into its frame. Further observation revealed that the door was not equipped with positive latching hardware and the automatic closing mechanism was not operational to drive the door into its frame when the fire alarm was activated. The door was unable to prevent transferring of fire, fumes and smoke to or from floors above.</p> <p>In an interview at the time, the U.S. FOIA confirmed the observation.</p> <p>An observation at 2:20 PM for a section of the</p>	K 541	<p>ELEMENT ONE: CORRECTIVE ACTION:</p> <p>All residents have the potential to be affected by the deficient practice. A release device was installed to the laundry chute door to release when the fire alarm is activated. Also, a new latching mechanism was installed on the face of the laundry chute door.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES:</p> <p>The U.S. FOIA (b) (6) was reeducated on 10/19/24 to ensure they continue to monitor compliance with the 1-hour fire protection rating of laundry chute door assemblies by the doors latching into their frame in accordance with NFPA 101</p> <p>ELEMENT FOUR: QUALITY ASSURANCE:</p> <p>An audit tool was created to monitor that</p>		

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K 541	Continued From page 16 laundry chute located in a 1st. floor closet revealed the laundry chute door failed to latch securely in its assembly frame when tested by the surveyor and MD. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 10/03/24 at 2:30 PM. NJAC 8:39-31.2(e)	K 541	the new release device and new lock hardware are working properly. The audit will be done weekly for three months. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024	10/20/24	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 10/01/24 and 10/02/24 in the presence of the U.S. FOIA (b) (6) , it was determined that the facility failed to ensure that the fire barrier doors including corridor doors to patient rooms and smoke barrier doors were inspected annually with written record by an	K 761	ELEMENT ONE: CORRECTIVE ACTION: All residents have the potential to be affected by the deficient practice. The maintenance director/designee immediately conducted and documented inspections of fire and smoke doors and		

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K 761	<p>Continued From page 17</p> <p>individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101: 2012 Edition, Section 7.2.1.15, 7.2.1.15.1 to 7.2.1.15.8, 8.3.3.1, 19.7.6 and NFPA 80: 2010 Edition, Section 5.2.1, 5.2.3. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>A documents review on 10/01/24, revealed there were no documented annual fire or smoke door inspections provided by the facility.</p> <p>In an interview on 10/01/24 at approximately 11:15 AM, the U.S. FOIA (b) (6) stated that the facility checked the smoke doors with the local fire inspector during the quarterly inspections but did not document inspections of the fire and smoke doors in the last 12 months.</p> <p>Observations during a facility tour on 10/02/24 between 11:30 AM and 2:25 PM in the presence of the U.S. FOIA (b) (6) revealed there were 7 smoke door assemblies, 11 fire door assemblies and corridor doors to resident rooms equip with hold open devices released by the fire alarm system.</p> <p>The facility's U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 10/03/24 at 02:30 PM.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 80</p>	K 761	<p>all released as required when activating the fire alarm system. The fire barrier doors including corridor doors to patient rooms and smoke barrier doors are inspected annually with written record by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice:</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: All fire barrier doors including corridor doors to patient rooms and smoke barrier doors are scheduled to be inspected per life safety regulations by the maintenance director who will also document inspection results in the maintenance logs.</p> <p>The U.S. FOIA (b) (6) was reeducated on 10/19/24 about the proper means to inspect corridor and doors to patient rooms and smoke barrier doors during maintenance rounds.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that the fire barrier doors including corridor doors to patient rooms and smoke barrier doors are inspected to ensure proper function. The audit will be done monthly for three months. The results of this audit will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for</p>		

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K 761	Continued From page 18	K 761	this plan of correction.		
K 911 SS=F	<p>Electrical Systems - Other CFR(s): NFPA 101</p> <p>Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/02/24, in the presence of the U.S. FOIA (b) (6) (), it was determined that the facility did not maintain the required clearance around electrical panels in accordance with NFPA 101, 2012 Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>An observation at 10:47 AM of the electrical room off the boiler room revealed the following:</p> <ol style="list-style-type: none"> 1. The main electrical panel was obstructed by stored construction supplies on the floor including: three 44 lbs bags of mortar mix, an 8-foot long, 4-inch by 6-inch beam and boxes. 2. Two electrical wall panels and the emergency 	K 911	<p>ELEMENT FIVE: COMPLETION DATE: 10/20/2024</p> <p>ELEMENT ONE: CORRECTIVE ACTION: All residents have the potential to be affected by the deficient practice. Obstructions were removed from the electrical room off the boiler room including the following: 1. 3 bags of mortar mix, the 8 foot long 4 inch by 6 inch beam and all boxes were removed. 2. All construction supplies including paint cans, boxes, signposts and cardboard tubes were removed by the emergency power transfer switch.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES:</p>	10/20/24	

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K 911	Continued From page 19 power transfer switch were obstructed by stored construction supplies on the floor including: boxes, paint cans, 8-foot sign posts and a 4-inch diameter, 8-foot long cardboard tube. In an interview at the time the [U.S. FOIA (b) (6)] confirmed the observations. The [U.S. FOIA (b) (6)] was informed of the deficient practice at the Life Safety Code exit conference on 10/03/24 at 2:30 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	The [U.S. FOIA (b) (6)] was reeducated on 10/19/24 to ensure the required clearance around electrical panels which includes emergency power switch is monitored and maintained in accordance with NFPA 101. ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor that the electrical panels are free of obstruction. The audit will be done weekly for three months. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		10/20/24	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 918	<p>Continued From page 20</p> <p>months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on documentation review and interviews on 10/01/2024 and in the presence of the [REDACTED] U.S. FOIA (b) (6), it was determined that the facility failed to a) exercise the emergency generator under full load 12 times per year on a 20 to 40 day interval for 3 of 12 months, b) conduct a load bank test on the emergency generator annually where the generator uses less than 30% of the rating, and c) ensure the emergency generator assumed the building load within 10 seconds of a power failure in accordance with NFPA 101: 2012 Edition, NFPA 99: 2012 Edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 8.4, 8.4.1, 8.4.2, and 8.4.2.3. These deficient practices had the potential to affect all 113 residents and were evidenced by the following:</p>	K 918	<p>ELEMENT ONE: CORRECTIVE ACTION:</p> <p>All residents have the potential to be affected by the deficient practice. The Director of Maintenance performed the monthly load and weekly generator tests. Also, the generator log sheet has been updated to include the load rating and transfer time. Maintenance staff were educated about proper completion of the log sheet.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:</p> <p>All residents have the potential to be affected by the deficient practice.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 918	Continued From page 21 a) A review of the the facility's emergency generator log at 10:30 AM revealed the facility failed to document full load tests were performed for 3 of the 12 previous months. The missing months were December, November and October 2023. b) A continued review of the emergency generator log revealed the facility had no documentation of the percent of the nameplate rating the generator was exercised at during the monthly load tests to ensure it is exercised at 30 % or greater of its nameplate rating. There was no documentation of the required 90 minute load bank test performed if the generator does not run at 30% or greater of its nameplate rating. c) A continued review of the emergency generator log revealed the facility failed to record the time to transfer power from the primary source to the secondary emergency source during the monthly full load tests to ensure the time is 10 seconds or less. In an interview at 11:14 AM the U.S. FOIA (b) (6) confirmed the findings. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 10/03/2024 at 2:30 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	ELEMENT THREE: SYSTEMIC CHANGES: The U.S. FOIA (b) (6) was reeducated on 10/19/24 to ensure a) exercising of the emergency generator under full load is conducted and documented 12 times per year on a 20 to 40 day interval for 3 of 12 months, b) a load bank test is conducted on the emergency generator annually where the generator uses less than 30% of the rating, and c) to ensure the emergency generator assumed the building load within 10 seconds of a power failure in accordance with NFPA 101 ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to monitor the monthly and weekly generator test was completed. The audit will be done weekly for three months. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		
K 921 SS=F	Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance	K 921		10/20/24	

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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K 921	<p>Continued From page 22</p> <p>Requirements</p> <p>The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.</p> <p>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on documentation review and interview on 10/01/24, 10/02/24 and 10/3/24 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) intervals were established with policies and protocols for Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA</p>	K 921	<p>ELEMENT ONE: CORRECTIVE ACTION:</p> <p>All residents have the potential to be affected by the deficient practice. The Director of Maintenance inspected all rehab equipment and tested patient beds, air mattresses, oxygen concentrators, nebulizer and similar items being used for</p>		

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K 921	<p>Continued From page 23</p> <p>99: 2012 Edition, Sections 10.3, 10.5.2.1 and 10.3.5.4. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>A review of the facility's maintenance records on 10/01/24, revealed there was no documentation regarding ITM for PCREE.</p> <p>A review of a document provided on 10/02/24 for rehab equipment inspections revealed only two NJ Ex Order 26.4(b)(1), an NJ Exec Order 26.4b1 and Parallel Bars were inspected.</p> <p>In an interview on 10/03/2024 at 11:25 AM, the DM stated there was no ITM documentation for PCREE that included patient beds, air mattresses, oxygen concentrators, nebulizer and similar items that were used for patient care.</p> <p>The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 10/03/24 at 02:30 PM.</p> <p>NJAC 8:39-31.2(e) NFPA 99</p>	K 921	<p>patient care and documented findings in compliance with Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA 99.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: Inspection, Testing, and Maintenance (ITM) intervals are established with policies and protocols for Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA 99. The Director of Maintenance was reeducated on 10/19/24 regarding implementation of the testing policies and protocols.</p> <p>ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to ensure that the inspection and testing were performed for the patient's beds, air mattresses, oxygen concentrators, nebulizer and similar items that are being used for patient care. The audit will be conducted monthly for the next three months and yearly thereafter. The results of this audit will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction.</p> <p>ELEMENT FIVE: COMPLETION DATE: 10/20/2024</p>		
K 924 SS=F	Gas Equipment - Testing and Maintenance Requi	K 924			10/20/24

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K 924	<p>Continued From page 24 CFR(s): NFPA 101</p> <p>Gas Equipment - Testing and Maintenance Requirements Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 10/03/24 in the presence of the U.S. FOIA (b) (6) [REDACTED], it was determined that the facility failed to inspect, maintain, and test the piped-in Oxygen system as part of a maintenance program in accordance with NFPA 99. This deficient practice had the potential to affect all 113 residents and was evidenced by the following:</p> <p>A documentation review of the facility's last annual medical gas system inspection assessment report dated 04/03/23 revealed that the medical gas system had not been inspected in 18 months.</p> <p>Further review of the inspection report revealed failures that required repairs. There were no repair records provided by the facility that the work had been performed.</p>	K 924	<p>ELEMENT ONE: CORRECTIVE ACTION: All residents have the potential to be affected by the deficient practice. An outside vendor inspected, and the piped-in Oxygen system tested on 10/20/2024 with results documented in the maintenance log. All required repairs were completed. Repair records were completed to ensure all repairs were properly logged.</p> <p>ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice.</p> <p>ELEMENT THREE: SYSTEMIC CHANGES: The facility will ensure that the piped-in</p>		

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K 924	Continued From page 25 In an interview at 10:25 AM, the U.S. FOIA (b) (6) confirmed that 04/03/23 was the last annual piped-in oxygen system inspection and that the deficiencies identified on the inspection report by the service provider had not been repaired. The U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 10/03/2024 at 2:30 PM. NJAC 8:39-31.2(e) NFPA 99	K 924	Oxygen system will be inspected, maintained, and tested as part of a maintenance program in accordance with NFPA 99. The U.S. FOIA (b) (6) was reeducated on 10/19/24 regarding proper inspection and testing of the medical gas system. ELEMENT FOUR: QUALITY ASSURANCE: An audit tool was created to ensure that the inspection and testing were performed for the piped-in Oxygen system. The audit will be done annually or more often if required. Needed corrections will be addressed as they are discovered. The results of this audit will be reviewed at our QAPI meeting. The Director of Maintenance is responsible for this plan of correction. ELEMENT FIVE: COMPLETION DATE: 10/20/2024		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315205	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 11/27/2024
NAME OF FACILITY MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103	

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	10/20/2024	LSC K0321	10/20/2024	LSC K0351	10/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	10/20/2024	LSC K0363	10/20/2024	LSC K0531	10/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0541	10/20/2024	LSC K0761	10/20/2024	LSC K0911	10/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0918	10/20/2024	LSC K0921	10/20/2024	LSC K0924	10/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/3/2024		<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			