

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

PRINTED: 08/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2025
NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint NJ #'s: 170517, 172426, 172794, and 183244 Survey Dates: 3/13/25 to 3/19/25 Census: 170 Sample size: 34 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561			5/1/25

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

TITLE

(X6) DATE

Electronically Signed

04/04/2025

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

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F 561	<p>Continued From page 1 facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to honor a resident's choice to a.) get out of bed at the resident's preferred time and b.) attend preferred activities for 1 of 1 resident (Resident #79) reviewed for choices.</p> <p>This deficient practice was evidence by the following:</p> <p>On 3/13/25 at 9:43 AM, the surveyor observed Resident #79 lying in bed. The resident stated he/she preferred to be out of bed by 9:30 AM every morning. The resident further stated that there was a [REDACTED] Social activity scheduled for 10:30 AM in the dining room that they wanted to attend. When asked about the resident's usual get up time, the resident stated that staff normally get them up around 11:00 AM which meant they missed their preferred activities.</p> <p>At 10:30 AM, the surveyor observed the [REDACTED] Social activity in the dining room and Resident #79 was not present.</p> <p>On 3/17/25 at 10:31 AM, the surveyor observed Resident #79 lying in bed. The resident stated he/she was [REDACTED] The</p>	F 561	<p>Resident #79s care plan has been updated to include preference to be out of bed daily by 9:30 AM so that they can attend activities of choice which include the [REDACTED] and the [REDACTED]. Resident #79 is now getting out of bed by 9:30 AM and is now attending the [REDACTED] activities per their preference.</p> <p>All residents who reside in the facility have the potential to be affected by the deficient practice. A comprehensive review of current residents who are cognitively intact has been conducted by the Activity Director (AD) to determine their activity preferences and their care plans have been updated if applicable.</p> <p>The [REDACTED] has been re-educated by the Director of Nursing (DON) to inform the nursing staff if residents are not ready to attend activities of choice and their preferences are not being met.</p> <p>Nursing staff have been re-educated by the DON or designee to ensure that they honor the preferences of the residents, and they are getting out bed and attending activities of choice according to their care plan.</p> <p>Resident preferences will be reviewed by the AD during the quarterly care plan</p>		

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F 561	<p>Continued From page 2</p> <p>surveyor observed a "Weekly Activity" schedule posted on the resident's door which indicated the [REDACTED] Club activity was scheduled for 10:30 AM in the dining room. The resident further stated that there was a US FOIA (b)(6) [REDACTED] in his/her room earlier that morning, but did not get the resident out of bed at that time.</p> <p>At 10:36 AM, the surveyor observed the [REDACTED] Club activity in the dining room and Resident #79 was not present.</p> <p>At 12:48 PM, the surveyor observed Resident #79 sitting in a wheelchair in their room. The resident stated his/her [REDACTED] was in the room around 9:30 AM that morning, but did not get him/her out of bed at that time. The resident further stated that the nurse had to get him/her out of bed around 11:00 AM.</p> <p>On 3/18/25 at 9:45 AM, the surveyor observed Resident #79 lying in bed. The resident stated they preferred to be out of bed by that time. The surveyor reviewed the "Weekly Activity" schedule posted on the resident's door and the resident stated they did not want to attend the 10:30 AM activity that day, but still preferred to be out of bed daily by 9:30 AM.</p> <p>The surveyor reviewed the medical record for Resident #79.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Exec Order 26.4b1 [REDACTED]</p> <p>A review of the comprehensive Minimum Data</p>	F 561	<p>review, and as needed to ensure that their preferences are met, and the care plan is up to date.</p> <p>The AD or designee will conduct weekly audits of 5 cognitively intact residents x 4 weeks, then monthly x 3 months to ensure their preference for getting out of bed and attending activities of choice are met.</p> <p>The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring</p>		

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F 561	<p>Continued From page 3</p> <p>Set (MDS), an assessment tool, dated [REDACTED] NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of 15, which indicated the resident's [REDACTED] NJ Exec Order 26.4b1. Further review of the MDS included the resident felt [REDACTED] NJ Exec Order 26.4b1.</p> <p>Additionally, the MDS revealed the resident required [REDACTED] NJ Exec Order 26.4b1 with [REDACTED] NJ Exec Order 26.4b1 and [REDACTED] NJ Exec Order 26.4b1 to and from a bed to wheelchair.</p> <p>A review of the individual comprehensive care plan (ICCP) included a focus, revised [REDACTED] NJ Exec Order 26.4b1 that the resident enjoyed playing [REDACTED] listening to [REDACTED] NJ Exec Order 26.4b1, [REDACTED] NJ Exec Order 26.4b1, and [REDACTED] NJ Exec Order 26.4b1. Interventions included: Encourage resident to exercise choice, encourage participation in activities of interest, and offer activities of interest daily.</p> <p>Further review of the ICCP included a focus that the resident had the potential for [REDACTED] NJ Ex Order 26.4b1. Interventions included: Assess resident's activities of choice, continue to involve resident in daily decision making to promote independence, provide facility activity calendar pointing out areas of possible interest, and continue to remind resident of upcoming activities that may be of interest.</p> <p>A review of the CNA Kardex, which provides instructions about the resident's care to the [REDACTED] US FOIA (b)(6) did not include the resident's preferred time to get up or preferred activities.</p> <p>A review of the Activity Assessment, dated [REDACTED] NJ Exec Order 26.4b1 included the resident's preferred bed and</p>	F 561			

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F 561	<p>Continued From page 4</p> <p>waking times were: NJ Exec Order 26.4b1</p> <p>Further review of the Activity Assessment included that the resident's favorite activities included NJ Exec Order 26.4b1 and that the resident's preferred setting for activities was the main activity room.</p> <p>A review of the Activity Notes (AN) included a note dated NJ Exec Order 26.4b1 which revealed the resident enjoyed programs in the main dining room throughout the week.</p> <p>Further review of the AN included a note dated NJ Exec Order 26.4b1, which revealed the resident attended programs in the main dining room of choice and participated in NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p> <p>On 3/18/25 at 10:00 AM, the surveyor interviewed CNA #1 who stated she asked her residents at the beginning of the shift what time they preferred to get up and would get the residents up accordingly. The CNA further stated that every resident had a weekly activity schedule posted in their rooms and that staff would ask residents which activities they wanted to attend. The CNA then explained that staff should get residents up and take them to activities if that was the resident's preference. When asked about Resident #79, the CNA stated the resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b1 with care. The CNA added that the resident preferred to be out of bed depending on what activities were scheduled and that the resident would tell staff when he/she wanted to get up. The CNA explained that the resident preferred activities such as the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and that staff should be honoring the resident's preference to get up and attend activities.</p>	F 561			

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F 561	<p>Continued From page 5</p> <p>On 3/18/25 at 10:12 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that residents would tell the staff what time they wanted to be out of bed depending on the activities for that day. The LPN further stated that staff would remind residents of the scheduled activities and then assist the resident to the main dining room if needed. The LPN explained that it was important to honor a resident's preference to get out of bed for activities because it promoted and improved the residents' lives. When asked about Resident #79, the LPN stated the resident was [REDACTED] and [REDACTED] and would tell staff what time they wanted to get out of bed and what activities they wanted to attend. The LPN further stated that the resident preferred activities such as the [REDACTED] and that staff should be honoring the resident's preference to get up and attend activities.</p> <p>On 3/18/25 at 10:20 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that staff got residents out of bed depending on the residents' preferences and that the CNAs would ask the residents their preference during morning rounds. The LPN/UM further stated that staff would inform residents of the activities scheduled and would assist the residents to the main dining room. The LPN/UM explained that it was important to honor a resident's preference to get out of bed for activities because it "keeps the residents active and well." When asked about Resident #79, the LPN/UM was unsure what time the resident preferred to be out of bed, but stated if there was a morning activity that the resident enjoyed, the resident would tell staff to get him/her up at a certain time to attend the activity. The LPN/UM</p>	F 561			

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F 561	<p>Continued From page 6</p> <p>further stated that the resident preferred activities such as the [US FOIA (b)(6)] and that staff should be honoring the resident's preference to get up and attend activities.</p> <p>On 3/18/25 at 10:28 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated the activities in the main dining room were typically for higher functioning residents and included programs such as the [NJ Exec Order 26.4b1] and the [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] explained that there was a monthly activity calendar posted on the nursing units and a weekly activity schedule posted in each resident's room. The [US FOIA (b)(6)] further stated that it was important to honor a resident's preference for activities because if there was an activity that a resident loved, then allowing them to do that activity connected the resident to who they were and gave them a reason to get up in the morning. When asked about Resident #79, the [US FOIA (b)(6)] stated the resident came out to do a lot of the activities as he/she enjoyed [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] further stated that staff should be getting Resident #79 up and taking him/her to the activities of his/her choice.</p> <p>On 3/18/25 at 11:11 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated staff get residents out of bed depending on the resident's preference. The [US FOIA (b)(6)] further stated that the activities staff would inform residents of the activities schedule and assist residents to the main dining room as needed. The [US FOIA (b)(6)] then explained that it was important to honor residents' preferences and to get them up for activities. At that time, the surveyor informed the [US FOIA (b)(6)] of the observations of Resident #79 and the [US FOIA (b)(6)] confirmed that staff should have listened to the resident's request and honored his/her</p>	F 561			

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F 561	Continued From page 7 preferences. A review of the facility's "CNA Standards of Care" policy, dated September 2024, included, "All AM care is to be completed by 11:00 AM or per the resident preference." A review of the facility's "Resident Rights," dated May 2019, included the residents' right "To take part in facility activities, and meet with and participate in the activities of any social, religious, and community groups, as long as these activities do not disrupt the lives of other residents."	F 561			
F 607 SS=E	NJAC 8:39-4.1(a)(22)(24) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the	F 607			5/1/25

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F 607	<p>Continued From page 8</p> <p>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:</p> <p>Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to implement the facility's abuse policy to ensure that reference checks were completed for 10 of 10 employee files reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 3/18/25 at 9:30 AM, the surveyor reviewed 10 randomly selected employee files, which revealed the following:</p> <ol style="list-style-type: none"> 1. Licensed Practical Nurse/Unit Manager (LPN/UM) #3, with a hire date of [REDACTED] did not have a previous employee reference on file. 2. Licensed Practical Nurse (LPN) #2, with a hire date of [REDACTED], did not have a previous employee reference on file. 3. Certified Nursing Assistant (CNA) #2, with a hire date of [REDACTED] did not have a previous employee reference on file. 4. Activity Aide (AA) #1, with a hire date of 	F 607	<ol style="list-style-type: none"> 1. Reference checks for Licensed Practical Nurse/Unit Manager (LPN/UM)#3, Licensed Practical Nurse (LPN)#2, Certified Nursing Assistant (CNA)#2, Activity Aide (AA)#1, LPN #3, CNA # 3, CNA #4, Registered Nurse/Unit Manager (RN/UM) #1, Housekeeper (HK) #1 and Receptionist #1 have had references checked and documented by the Director of Human Resources (DHR) in the employee file per the facility's Abuse/Neglect Policy and Procedure. All reference checks completed on the 10 identified employees did not reveal anything that would identify potential risk of abuse/neglect of any resident, and none of them have been involved in any abuse/neglect allegations. No residents were identified to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice of not completing reference checks on employees before they are hired. A review of the abuse/neglect allegations/investigations against facility staff in the last 12 months was conducted 		

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F 607	<p>Continued From page 9</p> <p>[REDACTED], did not have a previous employee reference on file.</p> <p>5. LPN #3, with a hire date of [REDACTED] did not have a previous employee reference on file.</p> <p>6. CNA #3, with a hire date of [REDACTED] did not have a previous employee reference on file.</p> <p>7. CNA #4, with a hire date of [REDACTED], did not have a previous employee reference on file.</p> <p>8. Registered Nurse/Unit Manager (RN/UM) #1, with a hire date [REDACTED] did not have a previous employee reference on file.</p> <p>9. Housekeeper (HK) #1, with a hire date of [REDACTED] did not have a previous employee reference on file.</p> <p>10. Receptionist #1, with a hire date of [REDACTED] did not have a previous employee reference on file.</p> <p>On 3/18/25 at 10:25 AM, the surveyor interviewed the [REDACTED] who stated that in accordance with the facility policy she was supposed to perform two to three reference checks for potential candidates prior to hiring them. The surveyor informed the [REDACTED] that there were no reference checks included in 10 out of 10 employee files that were reviewed and asked the [REDACTED] to review each employee file to confirm the finding.</p> <p>At that time, the [REDACTED] stated that CNA #2 had came from [REDACTED], and had not signed the form to permit verification of reference checks. The [REDACTED] stated that if reference checks were not</p>	F 607	<p>by the Director of Nursing (DON), none were substantiated, and all staff who had allegations of abuse had reference checks conducted prior to starting employment.</p> <p>3. The [REDACTED] has been educated by the Licensed Nursing Home Administrator (LHNA) on the facility's policy titled Abuse and Neglect Policy and Procedure to ensure that all prospective employees will be carefully screened using Reference checks, Criminal Background and License check process to identify potential risk of abuse/neglect of any resident prior to hiring.</p> <p>The systemic change will be that the DHR or designee will utilize an Employee Cover Sheet to document that Job Reference Checks were attempted, the result recorded and kept with the application for employment for the prospective employee to ensure that the facility has carefully screened them to identify potential risk of abuse/neglect of any resident. The DHR or designee will conduct a comprehensive audit of current employees to ensure that job reference checks are completed and documented in the employee file on the Employee Cover Sheet. All new applicants will be carefully screened using the process of conducting reference checks prior to hiring to identify potential risk of abuse/neglect of any resident.</p> <p>4. The LHNA or designee will conduct weekly audits x 4 weeks of all new employee applications, then monthly</p>		

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NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
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F 607	<p>Continued From page 10</p> <p>permitted by the employee, it may indicate that there was something that they did not want the facility to know. The [US FOIA (b)] stated that LPN #2's references were not there because a current employee, a [US FOIA (b)(6)], referred her to work at the facility. The [US FOIA (b)] stated that LPN/UM #3's references were not completed and she had no excuse, it was her own fault. The [US FOIA (b)] stated that AA #1's references were not checked, though two references were provided.</p> <p>The [US FOIA (b)] further stated that it was very important that reference checks were completed to ensure that the employee would not cause any harm to the residents and they were safe to work in the facility. The [US FOIA (b)] further stated that she did not document attempts to call references when they did not respond. The [US FOIA (b)] stated that it was her process to phone employee references and she only documented the attempts if she received a response. The [US FOIA (b)] was unable to provide the surveyor with documented evidence that she attempted to contact employee references for 10 of 10 employee files reviewed. The [US FOIA (b)] further stated, "It was a lose, lose for all of them."</p> <p>On 3/18/25 at 12:34 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that it was important to perform two reference checks to ensure that residents received good care and that the potential employee did not do anything that was not proper.</p> <p>On 3/18/25 at 12:45 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that reference checks were required to ensure that the person was of good nature and good character. The [US FOIA (b)] further stated, if the</p>	F 607	<p>audits x 3 months of 5 new employee applications to ensure that reference checks are completed and documented on the Employee Cover Sheet prior to hiring and maintained in the employee file. The results of these audits will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and the need for further monitoring.</p>		

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F 607	Continued From page 11 background check was not good, then the facility generally held off and did not hire. A review of the facility's "Resident Abuse/Neglect Policy and Procedure" revised 2/17/23, included: "Screening: We are dedicated to thoroughly investigating the past histories of any individual we are considering hiring as an employee or otherwise engaging. All prospective employees, will be carefully screened using the following processes to identify potential risk of abuse/neglect of any resident: 1. Reference Check....These records will be maintained in the Human Resources Office."	F 607			
F 609 SS=D	NJAC 8:39-9.3(b) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609			5/1/25

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F 609	<p>Continued From page 12</p> <p>accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #NJ #00172794</p> <p>Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to submit the facility investigation to the New Jersey Department of Health (NJDOH) within five (5) days, specifically when a resident NJ Exec Order 26.4b1 for 1 of 2 residents (Resident #53) reviewed for NJ Exec Order 26.4b1.</p> <p>This deficient practice was evidenced by the following:</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1.</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated the resident's NJ was NJ.</p>	F 609	<p>1. The facility investigation for resident #53 has been sent to the New Jersey Department of Health (NJDOH). Resident #53 still resides in the facility and has not had any other NJ Exec Order 26.4b1.</p> <p>2. All residents with injuries of unknown origin have the potential to be affected by the deficient practice. No other residents were identified to have been affected by the deficient practice.</p> <p>3. The US FOIA (b)(6) has been re-educated by the Regional Nurse Consultant (RNC) to submit facility investigations to the NJDOH within five (5) days, when a resident sustains a serious bodily injury of unknown origin. All reportable events will be reviewed by the RNC to ensure the Investigational Summary is submitted to the NJDOH within 5 days.</p> <p>4. The DON or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of all reportable events to ensure the Investigational Summary is submitted to the NJDOH within 5 days. The results of these audits will be presented by the DON and reviewed at</p>		

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F 609	<p>Continued From page 13</p> <p>A review of the individual comprehensive care plan (ICCP) included a focus area, initiated on [REDACTED] that the resident had a [REDACTED] with [REDACTED] NJ Exec Order 26.4b1</p> <p>Interventions included: the use of task segmentation as needed to support [REDACTED] and assist during episodes of [REDACTED] NJ Exec Order 26.4b1, giving reminders and cues as needed. Further review of the ICCP revealed a focus area, dated [REDACTED] that the resident had [REDACTED] with periods of [REDACTED] NJ Exec Order 26.4b1 and had a history of [REDACTED] NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1</p> <p>Interventions included: an attempt to identify [REDACTED] for [REDACTED] NJ Exec Order 26.4b1</p> <p>A review of the Progress Notes (PN) included a Nurses Note (NN), dated [REDACTED] at 9:16 AM, revealed that a [REDACTED] US FOIA (b)(6)) called a nurse to the resident's room and informed them that the resident presented with [REDACTED] NJ Exec Order 26.4b1 to their [REDACTED] NJ Exec Order 26.4b1 with [REDACTED] NJ Exec Order 26.4b1, and the resident complained of [REDACTED] NJ Exec Order 26.4b1 at that time. The [REDACTED] US FOIA (b)(6)) was notified and assessed resident. The NN also indicated that the resident stated [REDACTED] NJ Exec Order 26.4b1, and sent out to the Emergency Department.</p> <p>A review of a NN dated 3/22/24 at 3:15 PM, revealed that the resident returned to the facility at 2:30 PM, with a [REDACTED] NJ Exec Order 26.4b1 [REDACTED] and [REDACTED] NJ Exec Order 26.4b1</p>	F 609	<p>the Quarterly Quality Assurance (QA) meeting to ensure compliance x 2 quarters. The QA Committee will then determine the need for continuation thereafter.</p>		

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F 609	<p>Continued From page 14</p> <p>A review of the Reportable Event Record/ Report for Resident #53 revealed that the event was reported to the NJDOH on NJ Exec Order 26.4b at 3:20 PM, and a summary was to follow. Further review indicated that the NJDOH staff left a voice message on NJ Exec Order 26.4b1 for the US FOIA (b) to send the Investigational Report.</p> <p>On 3/19/25 at 10:26 AM, the surveyor interviewed the US FOIA (b)(6), who stated that she was aware that she had to send the Investigational Summary to the NJDOH. The US FOIA (b) then indicated, she was holding on to it and did not send it. When asked why she did not send it, she stated that she was waiting for the NJDOH to call her again to submit it or for the NJDOH to come to the facility.</p> <p>A review of the facility's "Resident Abuse/Neglect Policy and Procedure" policy dated February 2025 revealed, "The Department of Health and Senior Services, and the office of the Ombudsman if resident is 60 or over, will be notified immediately (as soon as possible but not to exceed 2 hours) of the incident, followed by a written report within 5 days of the incident and if the alleged violation is verified, the facility shall take all appropriate corrective action."</p>	F 609			
F 610 SS=D	<p>NJAC 8:39-5.1(a) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged</p>	F 610			5/1/25

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F 610	<p>Continued From page 15 violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ00172794</p> <p>Based on interviews, record review, and review of facility documents, it was determined that the facility failed to conduct a thorough investigation for a resident who [NJ Exec Order 26.4b1] a [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1].</p> <p>This deficient practice was identified for 1 of 2 residents (Resident #53) reviewed for [NJ Exec Order 26.4b1] and was evidenced by the following:</p> <p>On 3/17/25 at 10:30 AM, the surveyor reviewed Resident #53's electronic medical record (EMR).</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: [NJ Exec Order 26.4b1]</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated [NJ Exec Order 26.4b1],</p>	F 610	<p>1. The investigation for resident #53 was reviewed, additional interviews were conducted with two Certified Nurse Aides (CNAs) who worked on the [NJ Exec Order 26.4b1] Unit on 3/21/24, 7:00AM to 3:00PM shift, and one CNA who worked 3/21/24, 3:00PM to 11:00PM and the assigned nurse who worked 3/22/24, 3:00PM to 11:00PM, who provided a written statement. No new information was provided by the staff to change the outcome of the facility investigation. Resident #53 still resides in the facility and has [NJ Exec Order 26.4b1]</p> <p>2. All residents who reside in the facility with an injury of unknown origin have the potential to be affected by the deficient practice. A review of incident reports for injuries of unknown origin has been conducted and no other residents have been identified to have been affected by the deficient practice.</p> <p>3. The [US FOIA (b)(6)] [NJ Exec Order 26.4b1] have been re-educated by</p>		

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F 610	<p>Continued From page 16</p> <p>included the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of 15, which indicated the resident's [REDACTED] was [REDACTED].</p> <p>A review of the individual comprehensive care plan (ICCP) included a focus area, initiated on [REDACTED] that the resident had a [REDACTED] with [REDACTED] related to [REDACTED] with [REDACTED]. Interventions included: the use of task segmentation as needed to [REDACTED] and assist during episodes of increased [REDACTED] giving reminders and cues as needed. Further review of the ICCCP revealed a focus area, dated [REDACTED], that the resident had [REDACTED] with [REDACTED] [REDACTED] and had a history of [REDACTED]. Interventions included: an attempt to identify triggers for [REDACTED].</p> <p>A review of the Progress Notes (PN) included a Nurses Note (NN), dated [REDACTED] at 9:16 AM, revealed that a [REDACTED] (US FOIA (b)(6)) called a nurse to the resident's room and informed them that the resident presented with [REDACTED] to their [REDACTED] and the resident complained of [REDACTED] at that time. The [REDACTED] (US FOIA (b)(6)) was notified and assessed resident. The NN also indicated that the resident stated [REDACTED], and sent out to the Emergency Department (ED).</p> <p>Further review of the NN dated [REDACTED] at 3:15 PM, revealed that the resident returned to the facility at 2:30 PM, with a [REDACTED].</p>	F 610	<p>the Regional Nurse Consultant (RNC) on the Abuse/Neglect Policy and Procedure which states that the Administrator or designee will form an investigatory team that will thoroughly investigate the allegation and document the investigation. Interviews will be conducted and statements obtained from all staff members, residents, volunteers and others that may have witnessed or have knowledge with respect to the alleged incident. All such statements will be in writing and placed in the investigatory file related to the alleged incident.</p> <p>4. The DON or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of allegations of abuse or neglect including injury of unknown origin to ensure a thorough investigation is completed.</p> <p>The results of these audits will be presented by the DON and reviewed at the Quarterly Quality Assurance (QA) meeting to ensure compliance x 2 quarters. The QA Committee will then determine the need for continuation thereafter.</p>		

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F 610	<p>Continued From page 17</p> <p>NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1</p> <p>A review of the NJ Exec Order 26.4b1 Unit's CNA assignment sheet for NJ Exec Order 26.4b1, 7:00 AM to 3:00 PM shift, revealed there was no documented evidence that statements were obtained for two (2) of three (3) CNAs who worked on the NJ Exec Order 26.4b1 Unit.</p> <p>A review of the the NJ Exec Order 26.4b1 Unit's CNA assignment sheet for NJ Exec Order 26.4b1, 3:00 PM to 11:00 PM shift, revealed there was no documented evidence that a statement was obtained for one (1) of the 3 CNAs who worked on the NJ Exec Order 26.4b1 Unit.</p> <p>A review of the the NJ Exec Order 26.4b1 Unit's assignment sheet for NJ Exec Order 26.4b1 11:00 PM to 7:00 AM shift, revealed there was no documented evidence that the assigned nurse provided a written statement.</p> <p>On 3/18/25 at 10:50 AM, the surveyor interviewed Certified Nurse Aide (CNA) #5, who stated that on NJ Exec Order 26.4b1, she discovered the NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1 and the resident NJ Exec Order 26.4b1 what happened. CNA #5 stated that the resident stated, NJ Exec Order 26.4b1."</p> <p>On 3/18/25 at 11:03 AM, the surveyor interviewed the Registered Nurse (RN) #1 who stated that she was called to the NJ Exec Order 26.4b1 unit to assess the resident and immediately upon assessing the resident she knew the resident needed to be sent to the ED to be evaluated. She then stated that none of the staff knew what happened to the resident. RN #1 stated that Licensed Nurse/Unit Manager (LPN/UM) #2 initiated the investigation and statements should have been obtained from</p>	F 610			

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F 610	Continued From page 18 all staff. On 3/18/25 at 12:26 PM, the surveyor interviewed the US FOIA (b)(6) , in the presence of the survey team who stated that it was everyone's job to care for the resident. When asked the process for conducting an investigation, the US FOIA (b)(6) stated that she followed the facility's Abuse policy. The US FOIA (b)(6) then stated that she did not receive any formal training on how to conduct an investigation. The US FOIA (b)(6) confirmed she did not obtain written statements from all staff. She further stated in hindsight, she should have obtained written statements from all staff within 24 hours of the discovery of the incident to complete a thorough investigation. A review of the facility's "Resident Abuse/Neglect Policy and Procedure" policy, revised 2/17/25, included "3. The Administrator or his/her designee will form an investigatory team that will thoroughly investigate the allegation and document the investigation ...Interviews will be conducted - and statements obtained from all staff members, residents, family, volunteers, and others that may have witnessed or have knowledge with respect to the alleged incident. All such statements will be in writing and placed in the investigatory file related to the alleged incident.	F 610			
F 641 SS=D	NJAC 8:39-5.1 (a) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641			5/1/25

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F 641	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 1 of 34 residents (Resident #121) reviewed for MDS coding accuracy.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 3/17/25 at 9:15 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #121.</p> <p>A review of the Admission Record, an admission summary, revealed that Resident #121 had diagnoses that included, but were not limited to, NJ Exec Order 26.4b1.</p> <p>A review of the comprehensive MDS assessment, with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1, revealed under section NJ Exec Order 26.4b1 that the resident was coded for NJ Exec Order 26.4b1 or more in the NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 or more in the NJ Exec Order 26.4b1. The resident NJ Exec Order 26.4b1 was documented as NJ Exec Order 26.4b1.</p> <p>A review of the resident's documented NJ Exec Order 26.4b1 revealed the following: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1</p>	F 641	<p>A significant change of correction Minimum Data Set (MDS) was completed for Resident #121 and the plan of care was reviewed and updated by the interdisciplinary team as needed. This resident had no untoward effects from this practice.</p> <p>All current residents coded with significant weight loss on their MDS had the potential to be affected by this practice. The Regional Registered Dietitian conducted an audit of current residents with significant weight loss coded on their most recent MDS. Modifications or significant changes of correction and care plan updates were complete as needed to maintain compliance. No residents had any untoward effects from this practice. The US FOIA (b)(6) provided education by the Regional Registered Dietitian on MDS coding following section K of the Resident Assessment Instrument (RAI) Manual and the calculation of monthly and 180-day weights in the electronic medical record.</p> <p>The Registered Dietitian will provide the MDS Coordinator a weekly list of residents in the 7-day look back period for MDS coding with significant weight loss. The MDS Coordinator will review Section K for any significant weight loss coding and verify with the Registered Dietitian before locking the MDS.</p> <p>The Regional Registered Dietitian will conduct weekly audits on residents triggered for significant weight loss in</p>		

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NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
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F 641	<p>Continued From page 20</p> <p>NJ Exec Order 26.4b1</p> <p>On NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1, which indicated a NJ Exec Order 26.4b1.</p> <p>On NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 which indicated a NJ Exec Order 26.4b1.</p> <p>On 3/17/25 at 10:08 AM, the surveyor interviewed the US FOIA (b)(6) about completing section NJ of the MDS. The US FOIA stated when completing section NJ of the MDS, the resident's current NJ Exec Order 26.4b1 within the look back period was compared to the resident's NJ Exec Order 26.4b1 prior to identify any NJ Exec Order 26.4b1. The US FOIA confirmed the question NJ Exec Order 26.4b1 of the MDS was coded to indicated if there was a NJ Exec Order 26.4b1. The US FOIA further explained she based the coding of the question on the resident's documented NJ Exec Order 26.4b1 and the EMR calculations of NJ Exec Order 26.4b1 within the assessment timeframe.</p> <p>The surveyor discussed with the US FOIA and US FOIA (b)(6) about the concern that Resident #121 was coded as having a NJ Exec Order 26.4b1 on the MDS with an ARD of NJ Exec Order 26.4b1 and a review of the resident's NJ Exec Order 26.4b1 did not indicate a NJ Exec Order 26.4b1. The US FOIA and regional US FOIA stated they would review the resident's EMR to provide a response.</p>	F 641	<p>section K for 4 weeks then monthly for 3 months to ensure compliance. Any untoward findings will be corrected immediately.</p> <p>The Registered Dietitian will report the audit findings and any corrective actions to the quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

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F 641	<p>Continued From page 21</p> <p>On 3/17/25 at 10:24 AM, the [US FOIA (b)(6)] and [US FOIA (b)(6)] informed the surveyor it was "human error," and the [US FOIA (b)(6)] looked at the wrong [NJ Exec Order 26.4b1] calculation on the EMR when reviewing. The [US FOIA (b)(6)] confirmed the resident did not have a [NJ Exec Order 26.4b1] after reviewing the resident's [NJ Exec Order 26.4b1] for that timeframe.</p> <p>On 3/17/25 at 10:26 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated the [US FOIA (b)(6)] was responsible for completing section [NJ E] of the MDS. The surveyor informed the [US FOIA (b)(6)] about the concern for Resident #121's MDS assessment. The [US FOIA (b)(6)] stated that she would discuss with the RD and correct the MDS assessment if needed. The surveyor requested the facility's MDS policy and the [US FOIA (b)(6)] stated there was no facility policy for MDS, but that they followed the MDS 3.0 Resident Assessment Instrument (RAI) manual.</p> <p>On 3/18/25 at 1:49 PM, the surveyor informed the [US FOIA (b)(6)] [US FOIA (b)(6)] about the above concern for the accuracy of Resident #121's MDS coding.</p> <p>On 3/19/25 at 10:08 AM, the [US FOIA (b)(6)] met with the survey team and the [US FOIA (b)(6)] acknowledged that the MDS was miscoded by the [US FOIA (b)(6)].</p> <p>A review of the latest version of the MDS 3.0 RAI Manual (updated October 2024), Chapter 3-page K-4, under steps for assessment revealed: This item compares the resident's weight in the</p>	F 641			

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F 641	Continued From page 22 current observation period with their weight at two snapshots in time: -At a point closest to 30-days preceding the current weight. -At a point closest to 180-days preceding the current weight. Coding instructions for K0300 indicated: Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more.	F 641			
F 755 SS=D	NJAC 8:39-33.2 (d) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755			5/1/25

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F 755	<p>Continued From page 23</p> <p>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:</p> <p>Based on interviews and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure accurate documentation of the receipt of a controlled substance for three (3) of six (6) Schedule II controlled substance medications ordered and received by the facility for use as an emergency backup supply, on two (2) Drug Enforcement Agency (DEA) 222 Forms (a form used to order controlled substances from a provider) reviewed.</p> <p>The deficient practice was evidenced by the following:</p>	F 755	<p>1. The two (2) Drug Enforcement Agency (DEA) 222 forms were reviewed, and it was confirmed that the three (3) Schedule II controlled substance medications ordered and received by the facility for use as an emergency backup supply were received by the facility and the DEA 222 forms were updated to reflect receipt of the medications. No residents were identified to be affected by this deficient practice.</p> <p>2. All residents residing in the facility who receive Schedule II controlled substances have the potential to be affected by this deficiency. No other DEA 222 forms were identified to have missing</p>		

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F 755	<p>Continued From page 24</p> <p>Reference: 21 CFR 1305.13 Procedure for filling DEA Forms 222.</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 registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."</p> <p>On 3/18/25 at 12:20 PM, the surveyor reviewed a binder provided by the US FOIA (b)(6), containing, but not limited to, facility DEA 222 Forms and packing slips associated with the DEA 222 Forms for controlled substance deliveries.</p> <p>A review of the facility DEA 222 Forms that were filled out and used to order controlled substances (CDS) revealed the following:</p> <p>DEA 222 Form with order form #231556857, dated 6/25/24, for eighty (80) packages of unit dose (single tablets) oxycodone 5 milligrams (mg) instant release(IR) (a schedule II-CDS used for pain) and seven (7) 30 milliliters (ml) morphine sulfate 20mg/5ml bottles (a schedule II-CDS used for pain) with the section Part 5 to be filled in by purchaser did not have the number received filled in. A supplier packing slip for the items was present.</p>	F 755	<p>information regarding the receipt of Schedule II controlled substances that were ordered by the facility for the emergency backup supply in the past twelve (12) months.</p> <p>3. The US FOIA (b)(6) was re-educated by the Regional Nurse Consultant (RNC) on the instructions for completing the DEA 222 Forms located in the Code of Federal Regulations at 21 CFR1305.13 which revealed in section (e) The purchaser must record on it's copy of the DEA Form 222 the number of commercial or bulk containers furnished on each item and the dates on which the containers are received by the purchaser, and the policy titled 4.0 Schedule II Controlled Substance Medication.</p> <p>4. The DON or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months on all DEA 222 forms to ensure all schedule II controlled substances that are ordered for the emergency backup supply have the number of items and date received recorded on the form.</p> <p>The results of these audits will be presented by the DON and reviewed at the Quarterly Quality Assurance (QA) meeting to ensure compliance x 2 quarters. The QA Committee will then determine the need for continuation thereafter.</p>		

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F 755	<p>Continued From page 25</p> <p>DEA 222 Form with order form #221727997, dated 12/5/23, for five (5) 30ml morphine sulfate 20mg/5ml bottles with the section Part 5 to be filled in by purchaser did not have the number received filled in or the date received filled in. A supplier packing slip for the morphine sulfate was not present.</p> <p>On 3/18/25 at 1:36 PM, the survey team met with the US FOIA (b)(6). The surveyor asked the US FOIA (b)(6) if she was the person responsible for filling out and maintaining the forms and the US FOIA (b)(6) stated, yes, she was. The surveyor showed the US FOIA (b)(6) the DEA 222 forms in question and the US FOIA (b)(6) acknowledged the blanks in Part 5 and stated that the forms should be filled in properly when the items come in.</p> <p>On 3/19/25 at 10:15 AM, the survey team met with the US FOIA (b)(6). The US FOIA (b)(6) provided copies of the DEA 222 forms in question, with the form dated 6/25/24, now filled in after surveyor inquiry and a packing slip for the 12/5/23, DEA 222 form for the morphine sulfate.</p> <p>The facility offered no further pertinent information.</p> <p>The surveyor reviewed the instructions for completing the DEA 222 Forms located in the Code of Federal Regulations at 21 CFR1305.13 which revealed in section (e) "The purchaser must record on its copy of the DEA Form 222 the number of commercial or bulk containers furnished on each item and the dates on which</p>	F 755			

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F 755	Continued From page 26 the containers are received by the purchaser." The surveyor reviewed the facility policy titled 4.0 Schedule II Controlled Substance Medication which revealed: General Information To provide guidelines for facilities to follow relating to the handling of controlled substances within the facility ...In a manner that promotes proper storage and compliance with state and federal guidelines. NJAC 8:39-29.3(a)6, 29.4(g), 29.7(c) 21 CFR 1305.13(e)	F 755			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757			5/1/25

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F 757	<p>Continued From page 27</p> <p>stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for one (1) of five (5) residents reviewed for unnecessary medications. (Resident #74).</p> <p>The deficient practice was evidenced by the following:</p> <p>The surveyor reviewed Resident #74's electronic medical record (EMR) which revealed the following.</p> <p>A review of the Admission Record (AR, an admission summary), reflected that the resident was admitted to the facility with diagnoses which included, NJ Exec Order 26.4b1 [REDACTED]</p> <p>A review of most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 [REDACTED], reflected that the resident had a Brief Interview for Mental Status (BIMS), score of [REDACTED] out of 15, which indicated the resident was NJ Exec Order 26.4b1 [REDACTED]. A review of Section [REDACTED] of the MDS reflected that the resident was occasionally NJ Exec Order 26.4b1 [REDACTED]</p> <p>The surveyor reviewed Resident #74's medications. The resident's list of medication</p>	F 757	<p>1. Resident #74s drug regimen was reviewed by the physician and a diagnosis of NJ Exec Order 26.4b1 [REDACTED] has been added to the medical record. The physician for resident #74 also documented the need and benefit for continued use of the medication NJ Exec Order 26.4b1 [REDACTED].</p> <p>2. All residents who reside in the facility and have a physicians order for Flomax (Tamsulosin HCl) without an appropriate diagnosis have the potential to be affected by this deficient practice. A comprehensive review of current residents who receive Flomax (Tamsulosin HCl) has been conducted and none were found to have been affected by the deficient practice.</p> <p>3. The Director of Nursing (DON) or designee has educated nurse managers, supervisors and charge nurses on the Federal Drug Administration (FDA) approved indication for use of Flomax (Tamsulosin HCl) and to notify the physician if the appropriate diagnosis of BPH is not present so the risk versus benefit can be reviewed and documented in the residents medical record. The systemic change will be that a monthly report will be run in the electronic health record (EMAR) to identify physicians orders for Flomax (Tamsulosin HCl) to ensure that the appropriate diagnosis of BPH is in place and/or that the risk versus benefit is documented by the physician in</p>		

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F 757	<p>Continued From page 28</p> <p>orders reflected an order for NJ Exec Order 26.4b1 Give 1 caplet by mouth in the evening.</p> <p>The surveyor reviewed the manufacturer's package insert for NJ Exec Order 26.4b1. The package insert reflects Federal Drug Administration (FDA) approved indication for use of the medication. FDA indication reflected was treatment of NJ Exec Order 26.4b1.</p> <p>Further review of the Resident #74's EMR did not reveal a diagnosis of NJ Exec Order 26.4b1 in the resident's diagnoses list or in physician's progress notes.</p> <p>The surveyor reviewed Resident #74's physician's progress notes (PPN). The PPN did not reflect any mention of an assessment of the resident for NJ Exec Order 26.4b1 the use of NJ Exec Order 26.4b1 for any reason or any assessment of the effectiveness of the medication in the resident.</p> <p>The surveyor reviewed the resident's individualized comprehensive care plan (ICCP) dated NJ Exec Order 26.4b1. The ICCP reflected a focus area for NJ Exec Order 26.4b1 but did not reflect NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 use.</p> <p>The surveyor reviewed the resident's laboratory test results that were available in the EMR. The results did not reflect any test for NJ Exec Order 26.4b1 being done.</p> <p>On 3/18/25 at 12:41 PM, the surveyor interviewed Resident #74's primary care physician (PMD) by telephone. The PMD stated they were aware of Resident #74 taking NJ Exec Order 26.4b1 and that they had a diagnosis of NJ Exec Order 26.4b1. The surveyor asked if it was</p>	F 757	<p>the medical record.</p> <p>4. The DON or designee will conduct a weekly random audit x 4 weeks, then monthly x 3 months of 3 residents who receive Flomax (Tamsulosin HCl) to ensure they have the FDA approved indication of BPH.</p> <p>The results of these audits will be presented by the DON and reviewed at the Quarterly Quality Assurance (QA) meeting to ensure compliance x 2 quarters. The QA Committee will then determine the need for continuation thereafter.</p>		

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F 757	<p>Continued From page 29</p> <p>common practice to include the diagnosis and medication in the progress notes. The PMD stated yes but not every visit. The surveyor asked if once a year would be common. The PMD stated yes. The surveyor asked if periodic documentation or periodic assessment of the effectiveness of a medication common practice. The PMD stated, yes. The surveyor informed the PMD that they could not locate any diagnosis, progress note or assessment that addresses the NU Exec Order 26.45 use. The PMD stated that they must have forgotten or missed that and would add a diagnosis right away.</p> <p>On 3/19/25, the surveyor reviewed Resident #74s PPN which revealed a note by the PMD entered after surveyor inquiry that reflected use of NU Exec Order 26.45</p> <p>On 3/18/25 at 1:36 PM, the survey team met with the facility US FOIA (b)(6) for concerns.</p> <p>The surveyor asked if all medications should have a diagnosis or rationale for use and be assessed periodically for effectiveness. The US FOIA (b)(6) and US FOIA (b)(6) both stated, yes, they should and the PMD should be documenting.</p> <p>The surveyor reviewed the facility provided policy titled Physician Visits. The policy reflected, under section 5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation.</p> <p>The facility did not provide any further relevant</p>	F 757			

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F 757	Continued From page 30 documentation.	F 757			
F 880 SS=D	<p>N.J.A.C. 8:39-35.2(d)6. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of</p>	F 880			5/1/25

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F 880	<p>Continued From page 31</p> <p>communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control and sanitary practices for storing medical devices and equipment while not in use.</p>	F 880	<p>1. Resident #9 immediately had their NJ Exec Order 26.4b1 removed from floor, sanitized, and the NJ Exec Order 26.4b1 and storage bag replaced. Resident #9 has not had any NJ Exec Order 26.4b1 related to the</p>		

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F 880	<p>Continued From page 32</p> <p>This deficient practice was identified in one (1) of three (3) observations during the Medication Pass observation (med-pass).</p> <p>This deficient practice was evidenced by the following:</p> <p>On 3/17/25 at 9:00 AM, the surveyor observed medication being administered to Resident #91. The surveyor then observed an [NJ Exec Order 26.4b1] and a [NJ Exec Order 26.4b1] on the floor at the foot of the bed of Resident #9, the roommate of Resident #91. The [NJ Exec Order 26.4b1] and machine were not observed to be in a bag or other container.</p> <p>The surveyor completed the med-pass observation and contacted the Licensed Practical Nurse/Unit Manager (LPN/UM#3) for that unit. The surveyor showed LPN/UM#3 the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] located on the floor and asked if that was the way the equipment should be stored when not being used. LPN/UM#3 stated, no, it should be on a table and in a plastic bag. LPN/UM#3 stated that she did not know how it got on the floor and why the over bed table was missing. LPN/UM#3 then instructed the LPN assigned to the medication cart to get an over bed table, clean it with cleaning wipes, immediately replace the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] and clean the [NJ Exec Order 26.4b1] machine.</p> <p>On 3/18/25 at 1:36 PM the survey team met with the facility [US FOIA (b)(6)] for concerns.</p>	F 880	<p>[NJ Exec Order 26.4b1] being placed on the floor. The [US FOIA (b)(6)] who placed the machine on the floor was immediately educated regarding not placing [NJ Exec Order 26.4b1] machines on the floor to avoid it becoming contaminated.</p> <p>2. All residents who receive nebulizer treatments have the potential to be affected by the deficient practice. A facility-wide audit has been conducted for current residents who receive nebulizer treatments and no other nebulizer machines were found to be on the floor or stored incorrectly.</p> <p>3. Current nursing staff have been re-educated by the Infection Preventionist (IP) nurse on the correct storage and maintenance of nebulizer machines to prevent contamination and the possibility of the spread of infection. The facility policy was reviewed and updated to include the storage and maintenance of nebulizer machines, masks and tubing.</p> <p>4. The IP nurse or designee will conduct weekly random audits x 4 weeks, then monthly x 3 months of 5 residents who receive nebulizer treatments to ensure they are being properly stored to prevent contamination.</p> <p>The results of these audits will be presented by the IP nurse or designee and reviewed at the Quarterly Quality Assurance (QA) meeting to ensure compliance x 2 quarters. The QA Committee will then determine the need for continuation thereafter.</p>		

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F 880	<p>Continued From page 33</p> <p>The surveyor asked the [US FOIA (b)] if residents' medical equipment, [NJ Exec Order 28.4b1] or [NJ Exec Order 2] should be stored on the floor when not being used. The [US FOIA (b)] stated, no, no equipment should be stored on the floor, and it should always be in a bag when not being used.</p> <p>A review of the facility's "Oxygen Administration" policy did not include any information regarding storage or use of nebulizers, masks or tubing.</p> <p>A review of the facility's "Medication Storage" policy did not include any information regarding nebulizers, tubing or mask storage.</p> <p>A review of the facility's "Medication Administration" policy dated November 2024, did not include any information regarding nebulizer, mask or tubing use or storage.</p> <p>A review of the facility's "Infection Control Program" policy dated December 2024, included, under Contents of Program: The following policies will be included in the program in order to investigate and prevent infections in the facility: Risk Management of procedure related infections: ...Nebulizer and oxygen therapy management...</p> <p>The facility did not supply any policy referencing the use or storage of nebulizer machines, tubing or masks.</p> <p>The facility did not provide any further pertinent information.</p>	F 880			
F 919 SS=D	<p>NJAC 8:39-19.4(k)</p> <p>Resident Call System</p> <p>CFR(s): 483.90(g)(1)(2)</p>	F 919			5/1/25

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F 919	<p>Continued From page 34</p> <p>§483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-</p> <p>§483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews on 3/13/2025 and 3/14/2025, in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that all devices used to identify call bell notifications were properly functioning. This deficient practice had the potential to affect 6 of 170 residents and was evidenced by the following:</p> <p>An observation on 3/13/2025 at 12:22 PM, revealed that the call bell for resident room C-113 did not give audible notification of activation at the nurse's station when tested by the US FOIA (b)(6)</p> <p>An observation at 12:25 PM, revealed that the call bell for resident room C-117 did not give audible notification of activation at the nurse's station when tested by the US FOIA (b)(6)</p> <p>An observation at 12:30 PM, revealed that the call bell for resident room C-119 did not give audible notification of activation at the nurse's station when tested by the US FOIA (b)(6)</p> <p>At the time, the surveyor interviewed the US FOIA (b)(6) who confirmed the observation and stated that the call bell system was recently upgraded and</p>	F 919	<p>1. The call bell system in rooms C-113, C117, and C-119 have been repaired on 4/2/2025 and give an audible notification when activated. The residents in those rooms have not had any complaints related to the call bell system not giving audible notification when activated, the call bell system also has a visual light notification that has been functioning properly and alerts staff to respond and attend to the resident.</p> <p>2. All residents who reside in the facility have the potential to be affected by the deficient practice. The Director of Maintenance (DOM) completed a facility wide inspection of the call bell system and no other call lights were found to be malfunctioning.</p> <p>3. The US FOIA (b)(6) was re-educated by the facility Administrator on the importance of maintaining the call bell system to ensure that residents can call for staff assistance which relays the call directly to a staff member or to a centralized staff work area. The DOM has provided re-education to the facility staff to notify the DOM</p>		

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F 919	Continued From page 35 the section of the building that we were testing was part of the old call bell system. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	F 919	immediately if any call light is not functioning properly. 4. The DOM or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of 20 resident rooms to ensure that the call bell system gives an audible notification when activated. The results of these audits will be presented by the DOM or designee and reviewed at the Quarterly Quality Assurance (QA) meeting to ensure compliance x 2 quarters. The QA Committee will then determine the need for continuation thereafter.		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ170517 Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? -No residents were identified to be affected by the deficient practice. A review of the care residents received on day shift on 01/14/24, 01/15/24, 01/16/24, 01/17/24, 01/18/24, 01/19/24 and 01/20/24 revealed no complaints or grievances related to resident care were reported on these dates on the day shift. - A review of the care residents received on day shift on 02/23/25, 02/24/25, 02/25/25, 02/26/25, 02/27/25, 02/28/25	5/1/25

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

TITLE

(X6) DATE

Electronically Signed

04/04/25

New Jersey Department of Health

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S 560	<p>Continued From page 1</p> <p>nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>1. For the week of Complaint staffing from 01/14/2024 to 01/20/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:</p> <p>-01/14/24 had 12 CNAs for 166 residents on the day shift, required at least 21 CNAs. -01/15/24 had 17 CNAs for 166 residents on the day shift, required at least 21 CNAs. -01/16/24 had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs. -01/17/24 had 18 CNAs for 164 residents on the day shift, required at least 20 CNAs. -01/18/24 had 18 CNAs for 164 residents on the day shift, required at least 20 CNAs. -01/19/24 had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs.</p>	S 560	<p>and 03/01/25 revealed no complaints or grievances related to resident care were reported on these dates on the day shift.</p> <p>- A review of the care residents received on day shift on 03/02/25, 03/03/25, 03/04/25, 03/05/25, 03/06/25, 03/07/25, and 03/08/25 revealed no complaints or grievances related to resident care were reported on these dates on the day shift.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice has the potential to affect all residents residing in the facility.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - The Staffing Coordinator was re-educated by the Director of Nursing on The State of New Jersey Department of Health requirement on the minimum ratio of one certified nurse aide (CNA) to every eight residents for day shift. -Staffing needs are assessed daily and in event there is CNA shortage and ratio of one CNA to every eight residents on day shift is not being met then; nurse manager/supervisors will recruit CNA staff from previous or upcoming shift. The facility utilizes 5 agency companies, and CNA unit clerks will be utilized to assist with providing resident care to meet minimum state staffing requirements of one CNA to every 8 residents on day shift. -The facility has implemented referral and sign on bonuses; online advertisements</p>	

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S 560	<p>Continued From page 2</p> <p>-01/20/24 had 14 CNAs for 165 residents on the day shift, required at least 21 CNAs.</p> <p>2. For the 2 weeks of staffing prior to survey from 02/23/2025 to 03/08/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <p>-02/23/25 had 16 CNAs for 169 residents on the day shift, required at least 21 CNAs. -02/24/25 had 15 CNAs for 169 residents on the day shift, required at least 21 CNAs. -02/25/25 had 15 CNAs for 168 residents on the day shift, required at least 21 CNAs. -02/26/25 had 19 CNAs for 167 residents on the day shift, required at least 21 CNAs. -02/27/25 had 16 CNAs for 167 residents on the day shift, required at least 21 CNAs. -02/28/25 had 18 CNAs for 167 residents on the day shift, required at least 21 CNAs. -03/01/25 had 18 CNAs for 167 residents on the day shift, required at least 21 CNAs.</p> <p>-03/02/25 had 13 CNAs for 167 residents on the day shift, required at least 21 CNAs. -03/03/25 had 16 CNAs for 166 residents on the day shift, required at least 21 CNAs. -03/04/25 had 17 CNAs for 163 residents on the day shift, required at least 20 CNAs. -03/05/25 had 10 CNAs for 163 residents on the day shift, required at least 20 CNAs. -03/06/25 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -03/07/25 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -03/08/25 had 19 CNAs for 169 residents on the day shift, required at least 21 CNAs.</p> <p>On 3/18/25 at 12:19 PM, the surveyor interviewed</p>	S 560	<p>and social media posts are utilized to recruit new employees.</p> <p>-The facility has initiated an increase in CNA rates for weekends and other options to assist in meeting minimum state staffing requirement of one CNA to every eight residents on day shift.</p> <p>-The facility is actively recruiting CNA candidates from local CNA training programs.</p> <p>4. How the corrective action be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place? The Administrator, Director of Nursing or designee will conduct weekly CNA staffing schedule audits x 4 weeks and then monthly x 3 months to ensure the minimum state staffing requirement of one CNA to every eight residents on day shift on the day shift.</p> <p>The DON or designee will report and will review audit findings during the Quality Assurance (QA) quarterly meetings x 2 quarters to ensure facility corrective actions for the deficient practice will not recur.</p>	

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S 560	<p>Continued From page 3</p> <p>the Staffing Coordinator (SC) who stated that she was never told what the required minimum direct care staff-to-resident ratios were as mandated by the state of New Jersey. The SC further stated that she thought the facility was required to staff one CNA to eight residents on all shifts, but she honestly did not know. The SC stated that the staffing requirements were not met. The SC explained that her role was to ensure that the facility had the proper number of aides to match the census of the building. The SC further stated that she did the best that she could, and could not prevent call outs.</p> <p>At that time, the SC stated that on 1/17/24, the facility census bumped up to 168 from 166 on the 11:00 PM to 7:00 AM shift. The SC stated that on the Apple Unit, there were two CNAs for 29 residents, on the Aspen unit there were two CNAs for 18 residents, on the Birch Unit there were two CNAs for 58 residents, on the Cedar Unit there were three CNAs for 52 residents, and on the Spruce Unit there was one CNA for 11 residents.</p> <p>On 3/18/25 at 12:34 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the required minimum direct care staff-to-resident ratios was one CNA to eight residents on the day shift, one CNA to ten residents on the evening shift, and one CNA to fourteen residents on the night shift. The LNHA stated that it was a joint effort from the SC, the Director of Nursing (DON), and the LNHA to ensure that the staffing ratios were met. The LNHA stated that it was a challenge, but we do our utmost best to try and meet the staffing ratio requirements. The LNHA further stated that it was important to meet the staffing regulation in order to give care.</p>	S 560			

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S 560	Continued From page 4 On 3/18/25 at 1:49 PM, in the presence of the survey team, the LNHA stated that it was a team effort between the LNHA and the DON to ensure that the SC was familiar with the CNA staffing to resident ratios. A review of the facility's "Staffing Policy" reviewed December 2024, included: "the goal is to provide adequate staffing to meet needed care and services for our resident population. Our nursing staff's goal is to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessment and individual care plans."	S 560			
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.	S1405			5/1/25

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/19/2025
NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
(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
S1405	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide physical health examinations to newly hired employees within the required time frame for 3 of 10 newly hired employees reviewed.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 3/18/25 at 9:15 AM, the surveyor requested from the Director of Nursing (DON) the health files for 10 newly hired facility employees, including their pre-employment physical examinations.</p> <p>The surveyor reviewed the health files on 3/18/25 which revealed the following:</p> <p>1. Registered Nurse/Unit Manager (RN/UM) #1's Date of Hire (DOH) was on [REDACTED] NJ Exec Order 26.40. The Director of Human Resources (DHR) confirmed that the first day worked was on [REDACTED] NJ Exec Order 26.40 and she was placed on the schedule on [REDACTED] NJ Exec Order 26.40. The physical was performed on [REDACTED] NJ Exec Order 26.40.</p> <p>2. Certified Nursing Assistant (CNA) #3's DOH was on [REDACTED] NJ Exec Order 26.40. The DHR confirmed that the first day worked was on [REDACTED] NJ Exec Order 26.40. The physical was performed on [REDACTED] NJ Exec Order 26.40.</p> <p>3. CNA #4's DOH was on [REDACTED] NJ Exec Order 26.40. The DHR confirmed that the first day worked was on [REDACTED] NJ Exec Order 26.40. The physical was performed on [REDACTED] NJ Exec Order 26.40.</p>	S1405	<p>1. No residents were identified as having been affected by the deficient practice of not having employee physicals completed before they begin employment. Registered Nurse/Unit Manager (RN/UM) #1 and Certified Nurse Assistant (CNA) #3 are no longer employed at the facility and CNA #4 has been physically able to perform their job requirements.</p> <p>2. All residents who reside in the facility have the potential to be affected by the deficient practice. A review of current nursing staff hired in the past 30 days has been conducted to ensure that they receive a physical from a Registered Nurse on or before date of hire and that the physician or advanced practice nurse has examined them within 30 days of hire, no other staff were found to have missing or delayed physical examinations.</p> <p>3. Registered Nurse (RN) #1 has been re-educated by the Director of Nursing (DON) on the requirement for all new employees to have physical examinations performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment. If the new employee receives a nursing assessment by an RN upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment.</p>	

New Jersey Department of Health

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S1405	<p>Continued From page 6</p> <p>On 3/18/25 at 11:29 AM, the surveyor interviewed Registered Nurse (RN) #1 who stated that she saw new employees and obtained their vital signs before they started working and then the doctor had thirty days to complete the physical assessment. RN #1 stated that "we sometimes had scheduling issues, especially if the doctor was out or was on vacation."</p> <p>On 3/18/25 at 12:45 PM, the surveyor interviewed the Director of Nursing (DON) who stated that new hire assessments should be done on the first day of orientation to see if they were physically fit, and then in one month, the doctor should see them to make sure that they were physically fit to work. The DON further stated that the assessment should be conducted within the required time frame.</p> <p>A review of the facility's "Mandatory staff qualifications/health history and examinations" policy included: The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to their first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.</p>	S1405	<p>4. The DON or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of all newly hired employees to ensure that they have their physical examinations completed by a physician within 30 days from the first day of employment.</p> <p>The results of these audits will be presented by the DON or designee and reviewed at the Quarterly Quality Assurance (QA) meeting to ensure compliance x 2 quarters. The QA Committee will then determine the need for continuation thereafter.</p>	
S2310	8:39-31.6(h) Mandatory Physical Environment	S2310		5/1/25

New Jersey Department of Health

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S2310	<p>Continued From page 7</p> <p>Copies of the emergency operations plan shall be sent to municipal and county emergency management officials for their review.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview on 3/13/2025 and 3/14/2025, in the presence of the Director of Maintenance (DOM), it was determined that the facility failed to ensure that copies of the emergency operations plan were sent to municipal and county emergency management officials for their review. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>In an interview on 03/13/2025, the surveyor requested the most current and up to date EPP for review.</p> <p>A record review on 3/14/2025, revealed that there was no documentation provided showing that the EPP was reviewed and/or sent for review to local, county or state emergency management agencies.</p> <p>At the time, the surveyor interviewed the DOM who confirmed the observation and stated that the EPP was not to emergency management officials for review.</p> <p>The facility's Director of Nursing (DON) and DOM was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00</p>	S2310	<p>1. No residents were identified to have been affected by the deficient practice of not ensuring that copies of the emergency operations plan for the facility were sent to municipal and county emergency management officials for their review. A copy of the current facility emergency operations plan has been sent to the municipal and county management officials for review.</p> <p>2. All residents residing in the facility have the potential to be affected by the deficient practice.</p> <p>3. The Director of Maintenance (DOM) has been re-educated by the Administrator on the requirement of ensuring that copies of the emergency operations plan for the facility were sent to municipal and county emergency management officials for their review.</p> <p>4. The Administrator or designee will review the emergency operations plan quarterly x 1 year to ensure that any changes or updates to the plan are sent to the municipal and county emergency management officials for review. These reviews will be presented at the quarterly Quality Assurance meetings x 1 year.</p>	

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S2310	Continued From page 8 PM.	S2310			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315226	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 5/2/2025	Y3
NAME OF FACILITY HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		

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 F0561	Correction	ID Prefix F0607	Correction	ID Prefix F0609	Correction
Reg. # 483.10(f)(1)-(3)(8)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	05/01/2025	LSC	05/01/2025	LSC	05/01/2025
ID Prefix F0610	Correction	ID Prefix F0641	Correction	ID Prefix F0755	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	05/01/2025	LSC	05/01/2025	LSC	05/01/2025
ID Prefix F0757	Correction	ID Prefix F0880	Correction	ID Prefix F0919	Correction
Reg. # 483.45(d)(1)-(6)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(g)(1)(2)	Completed
LSC	05/01/2025	LSC	05/01/2025	LSC	05/01/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/19/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061007	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 5/2/2025	Y3
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/01/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/19/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061007	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 5/2/2025	Y3
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix S2310	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. # 8:39-31.6(h)	Completed
LSC	05/01/2025	LSC	05/01/2025	LSC	05/01/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/19/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

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

PRINTED: 08/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315226	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
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E 000	Initial Comments	E 000			
E 004 SS=F	<p>Hunterdon Care Center was found to be in NON-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>Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the</p>	E 004			5/1/25

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

TITLE

(X6) DATE

Electronically Signed

04/03/2025

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

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E 004	<p>Continued From page 1 requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>. This REQUIREMENT is not met as evidenced by: Based on record review and interviews on 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that the emergency operations plan (EPP) was reviewed and updated annually. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>In an interview on 03/13/2025, the surveyor requested the most current and up to date EPP for review.</p> <p>A record review on 03/14/2025 revealed that the document titled - "EMERGENCY OPERATIONS PLAN ANNUAL REVIEW" contained signatures from the US FOIA (b)(6) for the years 2017 - 2022. There were no signatures for the annual review for 2023 or 2024.</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed</p>	E 004	<p>1. The facility Emergency Preparedness Plan (EPP) binder was missing signatures for the annual review of the most recent review. The Administrator, Director of Nursing (DON) and the Director of Maintenance (DOM) reviewed and signed the most up to date EPP. No residents were identified to have been affected by the deficient practice.</p> <p>2. This deficient practice had the potential to affect all residents.</p> <p>3. The US FOIA (b)(6) was educated by the Administrator to ensure the EPP binder is reviewed annually and the required signatures by the DOM, DON and Administrator are in the EPP binder. The EPP policy was reviewed by the Administrator, DON and the DOM to ensure the EPP binder is up to date and reviewed annually. It was determined no policy updates were necessary at this time.</p>		

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E 004	Continued From page 2 that the EPP that was provided was the most up to date and that there were no signatures for 2023 or 2024. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM.	E 004	4. The Administrator or designee will do monthly audits on the EPP binder to make sure everything is up to date, for one year. Findings will be brought to the quarterly Quality Assurance (QA) meetings for one year.		
E 006 SS=F	N.J.A.C 8:39-31.2 (e) Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a) (1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The	E 006		5/1/25	

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E 006	<p>Continued From page 3</p> <p>plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interviews 03/13/2025 and 03/14/2025 in the presence of</p>	E 006	<p>1. The facility did not comply with updating the risk assessment for the</p>		

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E 006	Continued From page 4 the US FOIA (b)(6) , it was determined that the facility failed to complete or document a community-based risk assessment using an all-hazards approach on an annual basis. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview on 03/13/2025, the surveyor requested the most current and up to date EPP for review. A record review on 03/14/2025 revealed that the community-based risk assessment, using an all-hazards approach was last updated in 2017. In an interview at the time, the US FOIA (b)(6) confirmed the record review. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM.	E 006	facility on an annual basis. The facility updated their Emergency Preparedness Plan (EPP) binder with an updated community-based risk assessment. No residents were identified to have been affected by the deficient practice. 2. The deficient practice had the potential to affect all the residents. 3. An audit was completed to ensure all necessary documentation was in the EPP binder. The US FOIA (b)(6) US FOIA (b)(6) was re-educated by the Administrator on the importance of ensuring that the binder is up to date with all the latest risk factors in place. 4. The Administrator or designee will conduct a quarterly review on the EPP binder to ensure the binder and all its required information is up to date, for one year. All results will be brought to the quarterly Quality Assurance (QA) meetings for one year		
E 039 SS=F	N.J.A.C 8:39-31.2 (e) EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:	E 039			5/1/25

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E 039	<p>Continued From page 5</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p>	E 039			

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E 039	<p>Continued From page 6</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p>	E 039			

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E 039	<p>Continued From page 7</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p>	E 039			

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E 039	<p>Continued From page 8</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of</p>	E 039			

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E 039	<p>Continued From page 9</p> <p>the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that</p>	E 039			

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E 039	<p>Continued From page 10</p> <p>requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p>	E 039			

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E 039	<p>Continued From page 11</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not</p>	E 039			

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E 039	<p>Continued From page 12</p> <p>limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p>	E 039			

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E 039	<p>Continued From page 13</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interviews 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to analyze and document the facility's response of all drills, tabletop exercises, and emergency events. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>In an interview on 03/13/2025, the surveyor requested the most current and up to date Emergency Preparedness Plan (EPP) for review.</p> <p>A record review on 03/14/2025 revealed that EPP drills were conducted on 09/26/2024 and 10/17/2024. An analysis of the scenario and the facility's response to the drills were not provided.</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed that the only documentation of the drills was the Sign-in sheet.</p>	E 039	<p>1. The facility failed to document an analysis of the scenario and the facilities response to the Emergency Preparedness Plan (EPP) drills which were conducted on 09/26/2024 and 10/17/2024. A response analysis of the EPP drills has been completed by the Administrator and the Director of Maintenance (DOM). No residents were identified to have been affected by the deficient practice.</p> <p>2. All residents had the potential of being affected by this deficient practice.</p> <p>3. The Administrator educated the US FOIA (b)(6) on the guidelines found in CFR 483.74 with regard to documenting and analyzing the scenario of the drill.</p> <p>4. The administrator will audit all aspects of the EPP drill, including the documentation of the scenario and response analysis each quarter for one year. All findings will be brought to the quarterly Quality Assurance (QA) meeting</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315226	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
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E 039	Continued From page 14 The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM.	E 039	for one year.		
K 000	N.J.A.C 8:39-31.2 (e) INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/13/2025 and 03/14/2025. Hunterdon Care Center and was found to be in NON-COMPLIANCE with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Hunterdon Care Center is a one story building that was built in 1986. It is composed of Type II protected construction. The facility is divided into eight smoke zones. The generator powers approximately 40 % of the building per the Maintenance Director.	K 000			
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 211		5/1/25	

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K 211	<p>Continued From page 15</p> <p>by: Based on observations and interviews on 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that the means of egress was continuously maintained free of all obstructions to full use in case of emergency in accordance with NFPA 101:2012 Edition, Section 19.2.2.4, 19.2.11 and 7.1.10.1. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 12:46 PM revealed that the exit door from stair 1-C did not readily open when attempted by the US FOIA (b)(6)</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed that the door was very difficult to open and stated that the internal closer was broken and that they would have to take the door down to repair it.</p> <p>An observation on 03/14/2025 at 11:06 AM revealed that the A-1 Lounge access-controlled exit door did not unlock when the code was entered by the US FOIA (b)(6)</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed the observation, unplugged the access control keypad and stated that they would have someone repair it right away.</p> <p>An observation at 11:17 AM revealed that the exit near A-2 nurses' station did not readily open when tested by the US FOIA (b)(6)</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed the observation and stated that they would conduct after-winter maintenance inspections on</p>	K 211	<p>The issues with means of egress found in three locations of the facility during the survey have been corrected. The Director of Maintenance (DOM) replaced a keypad on the A-1 Lounge access-controlled exit door, replaced the internal closer on both doors on the exit door from stair 1-C and exit near A-2 nurses' station and replaced the sill plate to its proper position. No residents were identified to have been affected.</p> <p>All residents had the potential to be affected. All means of egress and exit doors in the facility have been inspected by the DOM and no other issues were identified.</p> <p>The US FOIA (b)(6) was re-educated by the Administrator that the means of egress must be continuously maintained free of all obstructions to full use in case of an emergency in accordance with NFPA guidelines.</p> <p>Auditing areas with means of egress was added to the list of items the Director of Maintenance evaluates monthly for compliance.</p> <p>The Director of Maintenance will conduct audits on areas with means of egress to ensure the areas are continuously maintained free of all obstructions to full use in case of an emergency. Any untoward findings will be corrected immediately.</p> <p>The Director of Maintenance or Designee will report the audit findings and any corrective actions to the quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements</p>		

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K 211	Continued From page 16 all the exit doors. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM.	K 211	and to evaluate the need for further monitoring		
K 324 SS=F	N.J.A.C 8:39-31.1(c), 31.2 (e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced	K 324		5/1/25	

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K 324	<p>Continued From page 17</p> <p>by: Based on observations and interview on 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that cooking equipment was maintained in accordance with NFPA 101:2012 Edition, Sections 9.2.3, NFPA 17 A :2009 Edition, Section 4.3.1.5, 7.2.2 and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Observations on 03/14/2025 revealed that the kitchen range-hood fire suppression system contained 9 unprotected spray nozzles.</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed that the system spray nozzles were not provided with a cap or other suitable device to prevent the entrance of grease vapors, moisture or other foreign materials into the piping.</p> <p>The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e) NFPA 17 A, 96</p>	K 324	<p>1. The kitchen range hood had 9 unprotected spray nozzles for missing caps. The facility contracted a local Fire Protection Company to install spray nozzle caps. The Fire Protection Company reviewed the manufacturer guidelines and determined that the kitchen range hood fire suppression system spray nozzles do not require rubber nozzle caps or chrome caps. According to the manufacturer, the correct nut and seal have been properly installed. No residents were identified to have been affected by the deficient practice.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The US FOIA (b)(6) was re-educated by the Administrator on the importance of following the manufacturer guidelines on the nozzles in the kitchen range hood to prevent the entrance of grease vapors, moisture or other foreign materials into the piping.</p> <p>4. The DOM or designee will inspect the kitchen range hood monthly for the first 6-months and then quarterly for one year to assure that the spray nozzles have the correct nut and seal per the manufacturer guidelines. Results of these inspections will be discussed at the quarterly Quality Assurance (QA) meeting for one year.</p>		
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</p>	K 353		5/1/25	

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K 353	<p>Continued From page 18</p> <p>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>_____</p> <p>b) Who provided system test</p> <p>_____</p> <p>c) Water system supply source</p> <p>_____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations and interviews on 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that fire sprinkler systems were Inspected, Tested and Maintained (ITM) in accordance with NFPA 101: 2012 Edition, Sections 9.7.5, 9.7.7 and NFPA 25:2011 Edition, Section 5.1.1.2, 5.3.2 and 5.3.4. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>A record review on 03/13/2025 revealed that quarterly fire sprinkler inspections were conducted on 05/13/2024, 08/13/2024 and 12/06/2024.</p> <p>In in interview at the time, the surveyor requested documentation of a Quarter-1 fire sprinkler inspection.</p>	K 353	<p>The outdated gauge on the anti-freeze loop identified during the survey was replaced. The sprinkler company conducted an anti-freeze loop inspection to bring this facility back into compliance. No residents were identified as affected by this practice.</p> <p>All residents had the potential to be affected by this practice.</p> <p>The US FOIA (b)(6) was re-educated by the Administrator that the sprinkler system and automatic sprinkler and standpipe systems must be inspected, tested, and maintained in accordance with NFPA guidelines. Quarterly fire sprinkler inspections and the annual anti-freeze inspection date have been added to the Director of Maintenance list of inspections for tracking. The Director of Maintenance will ensure that these inspections are</p>		

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K 353	Continued From page 19 In an interview on 03/14/2025 at 1:30 PM, the [US FOIA (b)(6)] confirmed that only 3 of the 4 Quarterly fire sprinkler inspections were conducted in 2024. An observation on 03/14/2025 at 11:38 AM revealed the tag on the anti-freeze loop indicated the most recent annual inspection of the anti-freeze solution's freezing point was performed on 02/16/2022. An observation at 11:40 AM revealed that the gauge on the anti -freeze loop was dated 2013, over the 5-year requirement for replacement or recalibrating. The facility's [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 13, 25	K 353	scheduled, conducted and documented as complete to maintain compliance. The new gauge on the anti-freeze loop is dated and will be replaced in 5 years as required. The next anti-freeze loop inspection will be scheduled to maintain the annual requirement. The Director of Maintenance will conduct audits to monitor for any issues with the automatic sprinkler and standpipe systems to maintain compliance x 4 weeks then monthly for 3 months to ensure compliance. Any untoward findings will be corrected immediately. The Director of Maintenance or Designee will report the audit findings and any corrective actions to the quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 03/13/2025 and 03/14/2025 in the presence of the [US FOIA (b)(6)] it was determined that the facility failed to ensure that portable fire extinguishers were installed so that	K 355	The five portable fire extinguishers identified as being installed with the top of the fire extinguisher more than 5 feet above the floor have been lowered in accordance with NFPA guidelines. No		5/1/25

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K 355	<p>Continued From page 20</p> <p>the top of the fire extinguisher was not more than 5 feet above the floor in accordance with NFPA 101:2012 Edition, Sections 9.7.5 and NFPA 10 :2010 Edition, Section 6.1.3.8. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Observations on 03/13/2025 from 12:07 PM to 1:15 PM revealed:</p> <ol style="list-style-type: none"> 1. The top of the fire extinguisher in the B-wing "Resident Lounge" was at 70-inches above the floor. 2. The top of the fire extinguisher near room 134 on C-wing was at 67-inches above the floor. 3. The top of the fire extinguisher near room 120 on C-wing was at 68-inches above the floor. 4. The top of the fire extinguisher in the C-wing "Resident Lounge" was at 68-inches above the floor. <p>Observations on 03/14/2025 at 12:23 PM revealed that the top of the fire extinguisher near room 11 in the basement area was 70-inches above the floor.</p> <p>In interviews at the times, the [US FOIA (b)(6)] confirmed the observations.</p> <p>The facility's [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e) NFPA 10</p>	K 355	<p>residents were identified as affected by this practice.</p> <p>All residents had the potential to be affected by this practice. The Maintenance Director conducted an audit of all facility fire extinguishers and found no other portable fire extinguishers out of compliance.</p> <p>The [US FOIA (b)(6)] was re-educated by the Administrator that portable fire extinguishers cannot be installed with the top of the fire extinguisher more than 5 feet from the floor.</p> <p>Monitoring of the installation of portable fire extinguishers has been added to the monthly task list for the Director of Maintenance to maintain compliance. The Director of Maintenance will conduct audits on the portable fire extinguishers to monitor for any installation issues x 4 weeks then monthly for 3 months to ensure compliance. Any untoward findings will be corrected immediately.</p> <p>The Director of Maintenance or Designee will report the audit findings and any corrective actions to the quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

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K 361 SS=F	<p>Corridors - Areas Open to Corridor CFR(s): NFPA 101</p> <p>Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that spaces open to the corridor were protected by an electrically supervised automatic smoke detection system in accordance with NFPA 101:2012 Edition, Section 19.3.6.1. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation on 03/13/2025 at 12:55 PM revealed that the "Resident Lounge" on C-wing contained 2 entrances from the corridor. One of the 2 entrances was not provided with a door which made the space open to the corridor. The "Residents Lounge" was not provided with an electrically supervised automatic smoke detection system.</p> <p>In an interview at the time, The US FOIA (b)(6) confirmed the observation.</p> <p>The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM.</p>	K 361	<p>An electrically supervised automatic smoke detection system has been installed in accordance with NFPA guidelines in the Resident Lounge on C-wing. No residents were identified as affected by this practice. All residents had the potential to be affected by this practice. The Maintenance Director completed an audit throughout the facility to ensure each room which requires an electrically supervised smoke detection system had one in place. No other areas were noted as deficient in this practice. The US FOIA (b)(6) was re-educated by the Administrator that spaces open to the corridor must be protected by an electrically supervised automatic smoke detection system. Corridor monitoring for electronically supervised automatic smoke detection has been added to the monthly task list for the Director of Maintenance to maintain compliance. The Director of Maintenance will conduct audits of open corridors to ensure the electronically supervised automatic smoke detection system are in place and</p>		5/1/25

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K 361	Continued From page 22 N.J.A.C 8:39-31.2 (e)	K 361	functioning weekly 4 weeks then monthly for 3 months to ensure compliance. Any untoward findings will be corrected immediately. The Director of Maintenance or Designee will report the audit findings and any corrective actions to the quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.		
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 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	K 363		5/1/25	

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K 363	<p>Continued From page 23</p> <p>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 observations and interviews on 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that doors were not blocked open in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.10. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation on 03/13/2025 at 12:05 PM revealed that the door to the "Resident Lounge" on B-wing was being held open by the base of an oscillating pedestal fan.</p> <p>An observation at 12:10 PM revealed that the door to the nourishment room on B-wing was being held open with a trash bin.</p> <p>An observation at 12:35 PM revealed that the door to the Oxygen storage room on C-wing did not positive latch.</p> <p>An observation at 12:55 PM revealed that the "Resident Lounge" on C-wing was being held</p>	K 363	<p>The three doors found propped open during the survey were corrected immediately. The fan was removed from the door to the resident lounge on B-wing. The trash bin was removed from the door on B-wing to the nourishment room. The trash can to the resident lounge on C-wing was removed. The latch to the door to the oxygen storage room was adjusted to ensure the door closes tightly with a positive latch. No residents were identified as affected by this practice. All residents had the potential to be affected by this practice. The Maintenance Director completed an audit throughout the facility to ensure no other doors were blocked open and that the doors had positively latching hardware. No other areas were noted as deficient in this practice.</p> <p>The US FOIA (b)(6) was re-educated by the Administrator that doors cannot be blocked open in accordance with NFPA guidelines and</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315226	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363	Continued From page 24 open with a trash can. In interviews at the times, the [US FOIA (b)] confirmed the observations. The facility's [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K 363	must have positive latching hardware. Monitoring of corridor doors has been added to the monthly task list of the Director of Maintenance to maintain compliance with door closing and latching. The Director of Maintenance will conduct audits of the closing and latching of corridor doors to ensure that the corridor doors latch and close properly weekly for 4 weeks then monthly for 3 months to ensure compliance. Any untoward findings will be corrected immediately. The Director of Maintenance or Designee will report the audit findings and any corrective actions to the quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 372		5/1/25	

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K 372	<p>Continued From page 25</p> <p>Based on observations and interviews on 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that penetrations through fire/smoke barriers were protected by a system or materials capable of restricting the transfer of fire/smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation on 03/13/2025 at 11:35 AM revealed that the fire/smoke barrier contained a 6-inch unprotected penetration under the duct and through the wall on B-wing.</p> <p>An observation on 03/14/2025 at 10:52 AM revealed that the fire/smoke barrier on A-1 contained a 2-inch by 2-inch unprotected penetration for the pass through of wires.</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed the observations.</p> <p>The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/14/2025 at 2:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e) NFPA 80, 105</p>	K 372	<p>The unprotected penetrations on B-wing and A1-wing were filled with fire rated spray to restrict the transfer of fire/smoke in accordance with NFPA guidelines. No residents were identified as affected by this practice.</p> <p>All residents had the potential to be affected by this practice. The Maintenance Director completed an audit throughout the facility to ensure no other penetrations were observed that could allow the transfer of fire/smoke without a system or materials in place capable of restricting the transfer of fire/smoke. No other areas were noted as deficient in this practice.</p> <p>The US FOIA (b)(6) was re-educated by the Administrator that penetrations through fire/smoke barriers must be protected by a system or materials capable of restricting the transfer of fire/smoke in accordance with NFPA guidelines.</p> <p>Monitoring of penetrations to ensure there is a system or materials capable of restricting the transfer of fire/smoke has been added to the monthly task list of the Director of Maintenance to maintain compliance with smoke barriers.</p> <p>The Director of Maintenance will conduct audits of penetrations through fire/smoke barriers weekly for 4 weeks then monthly for 3 months to ensure compliance. Any untoward findings will be corrected immediately.</p> <p>The Director of Maintenance or Designee will report the audit findings and any corrective actions to the quarterly Quality Assurance Meeting x 2 quarters for</p>		

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NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
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K 372	Continued From page 26	K 372	necessary suggestions or improvements and to evaluate the need for further monitoring.	5/1/25	
K 918 SS=F	<p>Electrical Systems - Essential Electric Syste CFR(s): NFPA 101</p> <p>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 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>	K 918			

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NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
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K 918	<p>Continued From page 27</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 observations and interviews on 03/13/2025 and 03/14/2025 in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance of emergency generators was in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 8.3.7.1, and 8.3.8. These deficient practices had the potential to affect all residents and was evidenced by the following:</p> <p>A record review on 03/13/2025 revealed that documentation regarding annual fuel quality test could not be located.</p> <p>In an interview at the time, the surveyor requested annual fuel quality test.</p> <p>An observation on 03/14/2025 at 12:16 PM revealed that 2 of 2 emergency generator batteries were lead acid type.</p> <p>In an interview at the time the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid batteries. The US FOIA (b)(6) confirmed that the batteries were of a lead-acid type and stated that monthly testing was not conducted.</p> <p>No further documentation was provided regarding the annual fuel quality test.</p> <p>The facility's US FOIA (b)(6) was informed of the deficient practice at the Life</p>	K 918	<p>An annual fuel quality test was conducted immediately to ensure compliance. A lead acid battery tester was purchased, and the emergency generator batteries were tested and found operable. The electrolyte specific gravity for the lead-acid batteries was recorded. No residents were identified as affected by this practice.</p> <p>All residents had the potential to be affected by this practice. Testing of the fuel quality and batteries were complete as required in accordance with NFPA guidelines. No other areas were noted as deficient in this practice.</p> <p>The US FOIA (b)(6) was re-educated by the Administrator that the fuel quality test for the generator must be done annually and that lead acid batteries for the back-up generator must be tested monthly with the electrolyte specific gravity recorded in accordance with NFPA guidelines.</p> <p>The annual inspection for fuel quality testing was added to the Maintenance Directors tracking system for inspections in preparation for the next annual inspection.</p> <p>Monthly battery testing and recording of the electrolyte specific gravity for lead-acid batteries was added to the monthly task list for the Director of Maintenance to maintain compliance with essential electrical systems.</p> <p>The Director of Maintenance will conduct</p>		

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NAME OF PROVIDER OR SUPPLIER HUNTERDON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822		
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K 918	Continued From page 28 Safety Code exit conference on 3/14/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 99, 110	K 918	battery testing of any new lead-acid batteries and record the electrolyte specific gravity weekly for 4 weeks then monthly for 3 months to ensure compliance. Any untoward findings will be corrected immediately. The Director of Maintenance or Designee will report the audit findings and any corrective actions to the quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315226	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/2/2025
NAME OF FACILITY HUNTERDON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822	

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 E0004	Correction	ID Prefix E0006	Correction	ID Prefix E0039	Correction
Reg. # 483.73(a)	Completed	Reg. # 483.73(a)(1)-(2)	Completed	Reg. # 483.73(d)(2)	Completed
LSC	05/01/2025	LSC	05/01/2025	LSC	05/01/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/19/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315226	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 5/2/2025
NAME OF FACILITY HUNTERDON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1 LEISURE COURT FLEMINGTON, NJ 08822	

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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 K0211	05/01/2025	LSC K0324	05/01/2025	LSC K0353	05/01/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	05/01/2025	LSC K0361	05/01/2025	LSC K0363	05/01/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0372	05/01/2025	LSC K0918	05/01/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/19/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			