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	315358	A. BUILDING _____ B. WING _____	C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	**235 DOLPHIN AVE NORTHFIELD, NJ 08225**

(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 165835, 166940, 171642, 173989, 174368, 176225, 177693, 183279 Survey Date: 03/03/2025 Census: 98 Sample: 30 + 2 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 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		3/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/23/2025

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 582	Continued From page 1 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 1 of 3 residents reviewed for Beneficiary Protection Notification, (Resident #92). This deficient practice was evidenced by the following: On 02/27/2025 at 8:38 AM, the surveyor reviewed	F 582	Criteria 1 Resident #92 was discharged. Moving forward, the social workers will ensure that any resident being discharged from skilled services, will receive a Notice of Medicare Provider Non-Coverage two days prior to discharge date.	

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F 582	Continued From page 2 the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility for Resident #92 as follows: A review of the SNFBPNR for Resident #92 indicated a NJ Exec Order 26.4b1 start date of NJ Exec Order 26.4b1 and last covered day was NJ Exec Order 26.4b1 and Resident #92 remained in the facility. A further review of the SNFBPNR revealed under 1. Was a SNFABN, Form CMS-10055 provided to the resident? No was checked. If no explain why the form was not provided: was handwritten stayed in the facility. Under 2. Was a Notice of Medicare Non-Coverage (NOMNC) (CMS 10123) provided to the resident? There was nothing marked to indicate whether the resident received the NOMNC or not. During an interview with the surveyor on 02/27/2025 at 9:23 AM, Social Worker (SW #1), was questioned regarding Resident #92, who stayed in the facility after the provider initiated the discharge from NJ Exec Order 26.4b1 services without receiving the SNFABN and NOMNC. SW #1 said that Resident #92 did not these forms after staying in the facility following discharge from NJ Exec Order 26.4b1 services because she was unaware that these forms needed to be provided to Resident #92. During an interview with the surveyor on 02/27/2025 at 9:49 AM, the US FOIA (b)(6) was questioned about Resident #92, who remained in the facility after the provider initiated the discharge from NJ Exec Order 26.4b1 services without receiving the SNFABN and NOMNC. US FOIA (b)(6) said that she recalls having a conversation with Resident #92 and their family	F 582	Criteria 2 Residents discharged from skilled services have the potential to be affected by this deficient practice. Discharged residents will be audited to identify and prevent other residents having the potential to be affected by the same deficient practice. Criteria 3 On 3/19/25, the director of social services reeducated the social workers about providing Notice of Medicare Provider Non-coverage. The responsibilities of the social workers are not limited to ensuring the residents have the right to receive notice in a timely manner prior to skilled services being terminated and the right to appeal the last cover day decision. The director of social services created the Notice of Medicare Provider Non-Coverage policy for the facility to follow and ensure the residents are given notice in a timely manner. The administrator reviewed and approved the policy. Criteria 4 The director of social services will audit all residents requiring a NOMNC monthly for 6 months. The audits will be reviewed by administrator. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5	

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F 582	Continued From page 3 regarding these forms, but she was unsure why they were not provided. NJAC 8:38-4.1(a)(7)	F 582	Completion date: 3/28/2025	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		3/27/25

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F 656	Continued From page 4 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review and review of other facility documentation, it was determined that the facility failed to develop and implement an individualized comprehensive care plan for a resident on NJ Exec Order 26.4b1 medication (medication used to treat NJ Exec Order 26.4b1). This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #12) and was evidenced by the following: On 02/24/2025 at 10:16 AM, during the initial tour, Resident #12 was identified as being on NJ Exec Order 26.4b1 medication. A review of Resident #12's Electronic Medical Record (EMR) on NJ Exec Order 26.4b1 at 2:01 PM, revealed the following: A review of the Admission Record reflected the resident had diagnoses that included history of NJ Exec Order and NJ Exec Order 26.4b1 A review of the most recent comprehensive	F 656	Criteria 1 The care plan for resident #12 was reviewed and updated on NJ Exec Order 26.4 to include I use NJ Exec Order 26.4b1 medications for management of NJ Exec Order 26.4b1 Criteria 2 All residents with the diagnosis of depression have the potential to be affected by this practice. Criteria 3 The care plans for all residents who have an active order for an anti-depressive medication were reviewed for accuracy. Our records indicate that all care plans for residents who have an active order for an anti-depressive medication are accurate. All members of the interdisciplinary team responsible for creating care plans were in-serviced by the director of nursing regarding care plan accuracy. Criteria 4	

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F 656	Continued From page 5 Minimum Data Set, an assessment tool dated NJ Exec Order 26.4b1 revealed that the resident had a Brief Interview for Mental Status score of NJ Exec out of 15 which indicated NJ Exec Order 26.4b1. A further review of the MDS reflected use of NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 A review of the Order Summary Report (OSR) with active orders dated NJ Exec Order 26.4b1, revealed the following: NJ Exec Order 26.4b1; Give 2 tablets by mouth one time a day for NJ Exec Order 26.4b1 A review of Resident #12's care plan did not include documentation that Resident #12 was on NJ Exec Order 26.4b1 medication. During an interview with the surveyor on NJ Exec Order 26.4b1 at 08:30 AM, the Registered Nurse/ Unit Manager (RN/UM #2) stated that NJ Exec Order 26.4b1 (medications that affect the NJ Exec Or used to treat conditions such as NJ Exec Order 26.4b1 should have a care plan because of potential side effects. During an interview with the surveyor on 02/28/2025 at 09:11 AM, the US FOIA (b)(6) stated that NJ Exec Order 26.4b1 medications needed to have a care plan. A review of the facility policy titled "Psychotropic Policy (Behavior Management)" with a reviewed date of 2/28/2025 revealed under Procedure #6: The goals of psychotropic medication ... will be addressed in the resident's care plan. The care plan will also include the type of psychotropic drug(s) to be monitored for side effects daily, such as gait disorders, movement disorders, cognitive or behavior changes, discomfort (pain, constipation ...), signs of hypotension...	F 656	The unit managers will audit 5 care plans per week for 6 months. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5 Completion date: March 27, 2025	

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F 656	Continued From page 6	F 656		
F 657 SS=D	NJAC 8:39-11.2(e) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to update a resident care	F 657	Criteria 1 The care plan for resident #63 was reviewed and updated on [redacted] to include I have actual [redacted] to [redacted]	3/27/25

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F 657	Continued From page 7 plan, specifically for NJ Exec Order 26.4b1 , for 1 of 30 residents reviewed for comprehensive person-centered care plans, (Resident #63). This deficient practice was evidenced by the following: During the initial tour of the facility on 02/24/2025 at 11:00 AM, Resident #63 was observed lying in bed with NJ Exec Order 26.4b1 in place on the bed and NJ Exec Order 26.4b1 in place. A review of the EMR on 02/24/2025 at 11:37 AM, revealed the following: According to the Admission Record, Resident #63 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 A review of the Quarterly Minimum Data Set, an assessment tool, dated NJ Exec Order 26.4b1 revealed under section NJ E Resident #63 had the following NJ Exec Order 26.4b NJ Exec Order 26.4b1 . A review of the physician orders indicated active treatments to all identified NJ Exec Order 26.4b According to the facility weekly NJ Exec Order 2 observation tools completed by facility nursing staff revealed the resident had the following NJ Exec Order 26.4b 1. previousl NJ Exec Order 26.4b1 NJ Exec Order 26.4b1	F 657	NJ Exec Order 26.4b1 Criteria 2 All residents with wounds or have the possibility for wounds have the potential to be affected by this practice. Criteria 3 The supervisor of nursing reviewed care plans for wounds documentation accuracy. Our records indicate that all care plans with wounds are up to date. On March 18, 2025, the Director of Nursing and Supervisors of Nursing started educating all members of the interdisciplinary team responsible for creating care plans. Plan to conclude in-service on care plan accuracy by March 27, 2025 Criteria 4 The unit managers will audit 5 care plans per week for 6 months to ensure that the care plans are updated timely and reflect current wounds. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5 Completion date: March 27, 2025	

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F 657	Continued From page 8 NJ Exec Order 26.4b1 2. on NJ Exec Order 26.4b1 3. on NJ Exec Order 26.4b1 4. on NJ Exec Order 26.4b1 . A review of the current care plan showed a Focus area of; I have NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 with initiated date of NJ Exec Order 26.4b1. There was no care plan for the NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 During an interview with the surveyor on 02/28/2025 at 09:01 AM, Registered Nurse/Unit Manager (RN/UM#2) was asked who is responsible for doing care plans. RN/UM #2 responded we (nurses) initiate base line care plan upon admission and have 72 hours to complete. Since the person (residents) is here any one can adjust the care plan as needed. RN/UM #2 went on to say I am responsible to ensure the care plan is complete and accurate. All nurses can adjust the care plan. All disciplines are responsible to complete and update care plans. When asked what her expectations are of what would be on the care plan. RN/UM #2 replied ADL's (Activities of Daily Living), NJ Exec Order 26.4b1 And whatever the system triggered based on resident needs and concerns. RN/UM #2 confirmed If there was a newly NJ Exec Order 26.4b1, the care plan should be updated to reflect NJ Exec Order 26.4b1 and it should be myself, I	F 657		

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F 657	Continued From page 9 should be capturing this. On 02/28/2025 at 01:23 PM, the surveyor requested a Comprehensive Care plan policy. The facility provided a Comprehensive Assessments and Care delivery Process policy that does not address when a care plan is to be revised and what should be included on the comprehensive care plan. During an interview with the surveyor on 02/28/2025 at 02:02 PM, the US FOIA (b)(6) was asked what the expectations is for when a care plan needs to be revised/updated. The US FOIA (b)(6) replied absolutely a care plan should have updated at the time NJ Ex Order 26.4(b) were identified. The Nurse would have been responsible to update the care plan. When asked why is that important the US FOIA (b)(6) said "So staff know the resident has a NJ Exec Order 26.4b1 and to follow the plan of care." NJAC 8:39-27.1(a)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Electronic Medical Record (EMR), and review of other facility documents it was determined that the facility 1.) failed to perform a NJ Exec Order 26.4b for a resident with NJ Exec Order 26.4b1	F 658	Criteria 1a Resident #50 was NJ Exec Order 26.4b1 and showed a NJ Exec Order 26.4b1 from prior daily NJ Exec Order 26 Criteria 2a	3/27/25

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F 658	Continued From page 10 day period for 1 of 3 residents investigated for [NJ Exec Order 26.4b] (Resident #50) and 2.) failed to follow an order for NJ Exec Order 26.4b1 for 1 (Resident #351) of 1 resident investigated for [NJ Exec O]. This deficient practice was evidenced by the following: 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 or 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 regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 02/24/2025 at 11:01 AM, during the initial tour of the facility, Surveyor #1 observed Resident #50 lying in bed [NJ Exec Order 2] and [NJ Exec Or] NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was in progress providing [NJ Exec Order 26.4b1]	F 658	All residents have the potential to be affected by this practice Criteria 3a All nurses have been reeducated by the director of nursing in proper procedure for ensuring all residents are being weighed monthly and reweighed if a loss or gain of 5 pound is noted or 3 pounds if resident weighs </= 100lbs. Criteria 4a The unit managers will audit 10 residents weights a month for 6 months to ensure all residents are being weighed monthly and reweighed if a loss or gain of 5 pound is noted or 3 pounds if resident weighs </= 100lbs. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5a Completion date: March 27, 2025 Criteria 1b Resident #351 was assessed, and the resident's medical records were reviewed. The nurse was disciplined and educated on NJ Exec Order 26.4b1 policies and procedures. Criteria 2b All residents that require a wound VAC have the potential to be affected by this practice.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11 NJ Exec Order 26.4b1). Resident #50 appeared NJ Exec Order 26.4b1 on visual observation. According to the Admission Record, Resident #50 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, revealed that Resident #50 had a Brief Interview for Mental Status (BIMS) score of NJ Exec which indicated that Resident #50 is NJ Exec Order 26.4b1 . Section NJE of the MDS revealed that Resident #50 had NJ Exec Order 26.4b1 or NJ Exec O over the past NJ Exec Order 26.4b1 and received NJ Exec Order 26.4b1) of NJ Exec Order 26.4b1 . A review of the Order Summary Report with active orders as of NJ Exec Order 26.4b1 revealed Resident #50 had the following physician orders: Nothing by NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 every day shift for NJ Exec Order 26.4b1 7-3 nurse will turn off machine when NJ Exec Order 26.4b1 achieved of NJ Exec Order 26.4b and record amount achieved. A review of Resident #50's comprehensive care plan revealed a care plan Focus: I have the	F 658	Criteria 3b All nurses have been reeducated by the director of nursing in proper procedure for ensuring all residents that require a wound VAC follow physician's orders and document on the treatment administration record (TAR). Criteria 4b The unit managers will audit 5 residents on wound VAC a week for 6 months to ensure wound VAC orders are followed and documented on the treatment administration record (TAR). The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5b Completion date: March 27, 2025	

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F 658	Continued From page 12 potential for NJ Exec Order 26.4b1 deficits r/t (related to) my NJ Exec Order 26.4b1 [redacted] I am NJ Exec Order 26.4b1 - I rely on a NJ Exec Order 26.4b1 to meet my NJ Exec Order 26.4b needs. A review of the Interventions/Tasks section of Resident #50's comprehensive care plan did not include monitoring of NJ Exec Order 26.4b. On 02/24/2025 at 12:21 PM Surveyor #1 reviewed Resident #50's NJ Exec Order 26.4b via the EMR. On NJ Exec Order 26.4b1, Resident #50 had a monthly NJ Exec Order 26.4b1. Resident #50 had a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. Resident #50 had an NJ Exec Order 26.4b1 over a NJ Ex[redacted] which was NJ Exec Order 26.4b1 at - NJ Exec Order 2[redacted] over a NJ Exec Order 26.4b1. On 02/25/2025 at 12:39 PM, Surveyor #1 reviewed the NJ Exec Order 26.4b1 Interdisciplinary Care Conference Meeting via the EMR (electronic medical record). The following entry was observed under Section NJ Exec Order 26.4b1 Summary: NJ Exec Orde[redacted] receives NJ Exec Order 26.4b1 for NJ Exec Order 26.4b[redacted]. NJ Exec Order 26.4b1 [redacted]. Continue w/current NJ Exec Order 26.4b1 as ordered. Continue to monitor NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 26.4b NJ Exec Or[redacted] NJ Exec Order 2[redacted] NJ Exec Or[redacted] Continue POC (plan of care) and follow up/reassess PRN (as needed). On 02/27/2025 at 01:22 PM, Surveyor #1 again reviewed the EMR under the NJ Exec Order 26.4b1 tab	F 658		

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F 658	Continued From page 13 section. There was still no [NJ Exec Order 26.4] performed. revealed that Resident #50 still did not have a [NJ Exec Order 26.4b1] conducted after an [NJ Exec Order 26.4b1] as indicated by Resident #50's [NJ Exec Order 2] obtained on [NJ Exec Order 26.4b1]. On 02/28/2025 at 08:38 AM, the surveyor reviewed the EMR for Resident #50. The EMR revealed that Resident #50 had not had a [NJ Exec Order 26.4b] performed as of [NJ Exec Order 26.4b1] for a [NJ Exec Order 2] This was a period of 27 days since the monthly [NJ Exec Order2] was obtained on [NJ Exec Order 26.4b1]. During an interview with Surveyor #1 on 02/28/2025 at 10:50 AM, the Registered Nurse/Unit Manager (RN/UM #3), was asked what the facility practice was concerning monthly [NJ Exec Order 26.4] and [NJ Exec Order 26.4b1]. RN/UM #3 said that [NJ Exec Order 26.4] are done by CNA's (Certified Nursing Assistants) at the beginning of the month unless they are on weekly [NJ Exec Order 26.4b] Once the [NJ Exec Order 26.4] are recorded, they are entered into the EMR. RN/UM #3 further explained that a [NJ Exec Order 2] obtained that was [NJ Exec Order 26.4b1] or more than the previous [NJ Exec Order 2] on record would require the nurse to reach out to the doctor and let him/her know right away. RN/UM #3 further explained that we try to get the [NJ Exec Order2] first thing in the morning. Surveyor #1 asked if Resident #50 should have been [NJ Exec Order 26.4b1] due to the [NJ Exec] that occurred between [NJ Exec Order 26.4b1]. RN/UM #3 replied I don't want to give you the wrong answer concerning Resident #50's [NJ Exec Order 26.4b1]. I would have to speak to the [US FOIA (b)(6)]) to get the answer. On 02/28/2025 at 11:01 AM the surveyors met with facility administration. The surveyor asked	F 658		

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F 658	Continued From page 14 the facility [redacted] if Resident #50 should have been [redacted] according to their facility [redacted] policy. The [redacted] told the surveyor, "Yes, Resident #50 should have had a [redacted] conducted for an NJ Exec Order 26.4b1." A review of a facility policy titled [facility name] with the subject: Weights / Re-Weights, revised 6/29/21, revealed the following under Policy: Thereafter all residents are to be weighed monthly and reweighed if a loss or gain of 5 pounds is noted (or 3 pounds if resident weighs </= 100 pounds). In addition, the policy further revealed at Procedure/Responsibilities/Action at 2. The unit manager compares the monthly weights to the previous month's weights and requests re-weights for any weight discrepancies over or under 5 pounds (or 3 pounds if resident is 100 pounds or less). 2. On 2/25/2025 at 8:39 AM, Resident #351 showed Surveyor #2 their NJ Exec Order 26.4b1 on the [redacted] connected to the NJ Exec Order 26.4b1 [redacted]. Resident #351 stated that it was not changed the previous day as scheduled. The surveyor observed the undated NJ Exec Order 26.4b1 located in the resident's NJ Exec Order 26.4b1 stained with brownish material from the [redacted] On 2/25/2025 at 8:57 AM, a review of the EMR revealed the following: A review of the Admission Record reflected the resident had diagnoses that included [redacted]	F 658		

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F 658	Continued From page 15	F 658		

NJ Exec Order 26.4b1).

A review of the most recent comprehensive MDS dated NJ Exec Order 26.4b1, reflected a BIMS score of NJ Exe out of 15, which indicated an NJ Exec Order 26.4b1. A further review of the MDS reflected the resident received NJ Exec Order 26.4b1.

A review of the Clinical Physician Orders included a physician's order (PO) initiated on NJ Exec Order 26.4b and reordered on NJ Exec Order 26.4b1 for the following: NJ Exec Order 26 every shift for NJ Exec Order 2; NJ Exec Order 26.4b1 every Monday, Wednesday, Friday for NJ Exec Order 26.4b1 .. NJ Exec O; Clean site with NJ Exec Order 26.4b1, NJ Exec Order 26, apply NJ Exec Order 26.4b1.

A review of the corresponding NJ Exec Order 26.4b1 Treatment Administration Record (TAR) revealed the resident's NJ Exec Order 26.4b1 was changed on NJ Exec Order 26.4b1 by the registered nurse on duty. However, the registered nurse's skilled charting notes reflected the NJ Exec Order 26.4b1 in place on the NJ Exec Order 26.4b1 and that NJ Exec Order 26.4b1 was not required. There was no documentation in the EMR why the NJ Exec Order 26.4b1 was not required.

During an interview with Surveyor #2 on 2/26/2025 at 12:30 PM, RN/UM #2 stated that NJ Exec Order 2 treatments had to be dated and labeled with the nurses' initials. RN/UM #2 further stated that if a NJ Exec Order 26.4b was not NJ Exec Order 26.4b1 then the nurse had to write #9 in the TAR which would be linked to a progress note where the nurse had to write the reason why a NJ Exec Order 26.4b was not

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F 658	Continued From page 16 changed. The RN/UM #2 acknowledged that the registered nurse on duty should not have checked the TAR as that meant that the [NJ Exec Order 2] was changed. During an interview with Surveyor #2 on 2/28/2025 at 9:11 AM, the[US FOIA (b)(6)] stated that [NJ Exec Order 2] treatments should be followed as ordered and that the nurses needed to sign and date the [NJ Exec Order 2] as well as sign the TAR. The [US FOIA (b)(6)] further stated that if the nurses are not able to do the treatment, they need to call the doctors and put in a progress note. A review of the facility provided policy titled "Medication and Treatment Orders" dated 10/15/2019 did not include the process for documenting and completing physician's order for wound treatments.	F 658		
F 688 SS=D	NJAC 8:39- 27.1(a) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		3/27/25

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F 688	Continued From page 17 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the electronic medical record (EMR), and review of other facility documentation, it was determined that the facility failed to consistently apply a [redacted]. This deficient practice was identified for 1 of 1 resident reviewed for NJ Exec Order 26.4b1 (Resident #1), and was evidenced by the following: During the initial tour on 02/24/2025 at 11:53 AM, the surveyor observed Resident #1 awake, NJ Exec Order 26.4b1, lying in bed, with his/her right [redacted] in a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 toward the [redacted] There was [redacted] or [redacted] in place at that time. The resident was NJ Exec Order 26.4b1 [redacted] and was unable to provide health history or answer questions. On 2/25/25 at 1:23 PM, surveyor observed Resident #1 with NJ Exec Order 26.4b1. On 2/26/25 at 9:29 AM, surveyor observed Resident #1 with no NJ Exec Order 26.4b1. A review of the Electronic Medical Record (EMR) on NJ Exec Order 26.4b1, revealed the following: Resident #1 had a medical diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted]	F 688	Criteria 1 Resident #1's care plan was immediately updated to state, "NJ Exec Order 26.4b1 management: I wear a NJ Exec Order 26.4b1 from 8am to 8pm. Make sure my [redacted] is [redacted] and [redacted] with NJ Exec Order 26.4b1. If anything is noticed, report to nurse right away. I frequently refuse to NJ Exec Order 26.4b1 [redacted] Please offer it to me daily." Interventions selected to appear on CNA documentation. Criteria 2 All residents that require a splint/brace have the potential to be affected by this practice. Criteria 3 All nursing staff have been reeducated by the director of nursing on the proper procedure for ensuring residents that require splints/braces have documentation of this task/intervention on the plan of care (POC). Criteria 4 The unit managers will audit 5 residents with splints/braces 5 days a week for six months to ensure that there is documentation of this task/intervention on the residents□ plan of care (POC). The director of nursing will review the audits	

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F 688	Continued From page 18 A review of the resident's most recent individual comprehensive care plan (ICCP) dated [redacted], revealed the following focus area: The resident has an ADL (Activity of Daily Living) [redacted] "Goals" included, "The resident will maintain current level of function in all ADLs through the review date." Under "Interventions" included but were not limited to: [redacted]: I [redacted] a [redacted] from 8am to 8pm. Make sure my [redacted] is [redacted] and [redacted] with [redacted]. If anything is noticed, report to nurse right away. A review of the Occupational Progress Note/Discharge Summary dated [redacted], revealed that Resident #1 was discharged from therapy on [redacted]. The Assessment Goals indicated that Resident #1 is on a [redacted] with staff for [redacted]) and hand as [redacted]. The Plan included, "Patient discharged from [redacted] at this time. Resident sitting safely in a [redacted] wheelchair with [redacted]. Resident wearing [redacted] on 8 am and off 8 pm as [redacted] with [redacted] during [redacted]." An [redacted] Daily Note dated [redacted] revealed, "Patient provided with new [redacted]) by [redacted] on [redacted]. Follow up this day: [redacted]. Patient with [redacted] and reports [redacted]	F 688	monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5 Completion date: March 27, 2025	

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F 688	Continued From page 19 During an interview with the surveyor, License Practical Nurse (LPN #3) when asked if Resident #1 used any adaptive equipment, LPN #3 stated she had to check. LPN #3 checked the EMR and identified under "Task" that Resident #1 wore a [NJ Exec Order 26.4b1]. LPN #3 was unable to provide any additional information at that time. On 02/26/2025 at 9:45 AM, during an interview with the surveyor, Registered Nurse/ Unit Manager (RN/UM#1), after reviewing the EMR, stated that Residents #1's Care Plan indicated that a [NJ Exec Order 26.4b1] was in use for [NJ Exec Order 26.4b1]. RN/UM #1 added that it is the responsibility of the Certified Nursing Assistant (CNA) to place and take off the [NJ Exec Order 26.4b1]. When the surveyor asked where the [NJ Exec Orde] would be documented, RN/UM #1 stated that there is no place to document, just indicates it is care planned. Shortly after this interview, the surveyor and RN/UM #1 went to Resident #1's room. RN/UM #1 acknowledged that Resident #1 was not [NJ Exec Order 26.4] a [NJ Exec Orde] however, there was a [NJ Exec Orde] RN/UM #1 also acknowledged that there was [NJ Exec Order 26.4b1] available in the resident's room. At that time, CNA #1 stated that the nurse (RN#2) just placed the [NJ Exec Order 26.4b1] in Resident #1's [NJ Exec Orde]. When the surveyor inquired as to the use of the [NJ Exec Order 26.4b1], CNA #1 stated that he/she recalled Resident #1 using a [NJ Exec Order 26.4b1] but was unable to determine how long ago it had been since Resident #1 had last worn it. On the same day at 1:17 PM, Resident #1 was observed at the nursing station [NJ Exec Order 26.4] a [NJ Exec O]	F 688		

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F 688	Continued From page 20 NJ Exec Order 26.4b1 On the same day at 1:33 PM during an interview with the surveyor, the US FOIA (b)(6)) stated that the nurse (LPN#2) called and stated that the resident was care planned for a NJ Exec Orde and didn't have one. The US FOIA (b) stated that NJ Exec Order 26.4 placed a NJ Exec Order 26.4b1 on Resident #1 shortly after the call. The US FOIA (b) was unable to state whether Resident #1 had a history of refusing the NJ Exec Order 26.4b1 and that there was no documentation indicating NJ Exec Order 26. The US FOIA (b) added that Resident #1 was on 'NJ Exec Order 26.4b1 that included NJ Exec Order 26.4b1 The US FOIA (b) stated that the expectation for NJ Exec Order 26.4b1 is that documentation would include NJ Exec Order 26.4b1 of NJ Exec Orde The US FOIA (b) confirmed that there was no documentation regarding the use of the NJ Exec Order 26.4b1. The US FOIA (b) further stated that a new "Plan of Care Note" was added to 'NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 to NJ Ex Order 26.4(b)(1) every morning and remove at bedtime for NJ Exec Order 26.4b1 During an interview with the surveyor on 03/03/2025 at 10:16 AM, the NJ Ex Order 26.4(b)(1) CNA #2, stated that Resident #1 was not on her NJ Exec Order 26.4b1 She added that Resident #1 is on NJ Exec Order 26.4b1 " which is different than NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 is provided by the floor CNA's and involves doing NJ Exec Orde and NJ Exec Order 26.4b1 during routine care. During an interview with the surveyor on 03/03/2025 at 11:10 AM, the US FOIA (b)(6) stated that a NJ Exec Order 26.4b1 does not require a physician order. The US FOIA (b) added that the EMR was updated to provide an area to document the use of NJ Exec Order 26.4b1 by the CNA.	F 688		

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F 688	Continued From page 21 On review of the facility policy titled, [facility name] Policy & Procedure," dated 07/22/2020, reflects the following: #7 Once restorative goals are achieved the resident will transfer to the Functional Maintenance/Restorative Program. #9 Any change in resident's status will be reported to the unit manager. The unit manager will re-evaluate to determine if resident needs to be evaluated by therapy for therapy services or rehabilitation/restorative service.	F 688		
F 690 SS=D	NJAC 8:39-27.1 (a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		3/27/25

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F 690	Continued From page 22 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to a.) ensure there was a physician order for the use of a [NJ Exec Order 26.4b1] and care plan, b.) ensure a resident with a [NJ Exec Order 26.4b] had the [NJ Exec Order 26.4b1] in a [NJ Exec Order 26.4b1] for dignity, and c.) failed to ensure a [NJ Exec Order 26.4b1] did not come in contact with the floor to prevention possible contamination. This deficient practice was identified for 3 of 3 Residents reviewed for [NJ Ex Order 26.4(b)] use (Resident #6, Resident # 17, and Resident #348) and was evidenced by the following: On 02/25/2025 at 12:57 PM, Surveyor #1 observed Resident #17 lying in bed with their [NJ Exec Order 26.4b1] hanging from the bed frame. The [NJ Exec Order 26.4b1] was not in a [NJ Exec Order 26.4b1] and was visible from the hallway. On 02/25/2025 at 03:14 PM, a review of the EMR revealed the following: According to the Admission Record, Resident #17	F 690	Criteria 1a A physician's order, care, and diagnosis were immediately entered for resident #17 and the care plan reflects the order. The policy was updated to reflect the need for foley care order and care plan for resident that requires a [NJ Exec Order 26.4b1]. Criteria 2a All residents that require a Foley catheter have the potential to be affected by this practice. Criteria #3a: On February 28, 2025, the Director of Nursing and Supervisor of Nursing started educating the nursing staff on proper procedure for ensuring that there is a physician's order, care, and diagnosis for residents that require a Foley catheter. Plan to conclude in-service on March 27, 2025. Criteria 4a The unit managers will audit 5 residents	

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F 690	Continued From page 23 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] A review of the quarterly Minimum Data Set (MDS) dated NJ Exec Order 26.4b1 indicated Resident #17 had an NJ Exec Order 26.4b1. A review of the most recent Admit/Readmit screener indicated that Resident #17 had a NJ Exec Order 26.4b1 A review of the Order Summary Report with Active Orders as of NJ Exec Order 26.4b1 revealed that there was no physician order for the use of the NJ Exec Order 2 or the reason and care of the NJ Exec Order 2 A review of the Comprehensive Care plan did not include the use and care of the NJ Exec Order During an interview with Surveyor #1 on 02/28/2025 at 10:24 AM, Licensed practical Nurse (LPN #1) was asked does a NJ Exec Order 26.4b1 use require a physician order. LPN #1 responded yes, there should be a physician order for use and care of the NJ Exec Order 26.4b1 During an interview with Surveyor #1 on 02/28/2025 at 10:34 AM, Registered Nurse/Unit Manager (RN/UM #2) was asked does a NJ Exec Order 2 [redacted] use require a physician order. RN/UM #2 replied Yes, there should an physician order for the NJ Exec Order 2 When questioned if a resident has a NJ Exec Order 26.4b1, should there be a care plan. RN/UM #2 said Yes, there has to be a care plan for the NJ Exec Order 2 During an interview with the Surveyor #1 on 02/28/2025 at 02:05 PM, the US FOIA (b)(6)	F 690	per week for six months. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5a Completion date: March 27, 2025 Criteria 1b NJ Exec Order 26.4b1 was immediately placed in a NJ Exec Order 26.4b1 the bedside for resident #17, resident #6, and resident #348. Criteria 2b All residents that require a Foley catheter have the potential to be affected by this practice. Criteria 3b On February 28, 2025, the Director of Nursing and Supervisor of Nursing started educating the nursing staff on the proper procedure for ensuring a catheter bag is in a dignity bag. Plan to conclude in-service on March 27, 2025. Criteria 4b The unit managers will audit 5 residents per week for six months. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued	

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F 690	Continued From page 24 ([redacted] was asked what the expectation is for a resident who is admitted to the facility with a [redacted]. The [redacted] replied it is necessary to have a care plan. The [redacted] confirmed "Yes there should have been a physician order." The [redacted] also said it is important to have [redacted] for dignity and infection control. On 02/28/2025 at 12:01 PM, a review of a facility policy titled [redacted] Care did not include that the resident would need a physician order or care plan for the use of a [redacted]. On 02/28/2025 at 01:26 PM, a review of a facility policy titled Admission or Re-Admission updated [redacted], revealed under Procedure section 5. The RN or LPN will report and record all [redacted] and obtain applicable order form the physician for instructed use (i.e. [redacted]). Upon initial tour of the facility on 2/24/2025 at 11:32 AM, Surveyor #2 observed Resident #6 lying in bed in his/her bedroom. The [redacted] had no [redacted] and was visible from the hallway. On 02/24/2025 at 01:08 PM, Surveyor #2 reviewed the electronic medical records (EMR) for Resident #6 as follows: According to the Admission Record Resident #6 was admitted to the facility with various diagnoses, including but not limited to [redacted]	F 690	compliance and or any recommendations by the QAPI Team. Criteria 5b Completion date: March 27, 2025 Criteria 1c [redacted] was immediately [redacted] for resident #6 and resident #348. Criteria 2c All residents that require a Foley catheter have the potential to be affected by this practice. Criteria 3c On February 28, 2025, the Director of Nursing and Supervisor of Nursing started educating the nursing staff on proper procedure for ensuring a Foley catheter tubing/bag does not come in contact with the floor. Plan to conclude in-service on March 27, 2025. Criteria 4c The unit managers will audit 5 residents per week for 6 months to ensure the residents Foley catheter tubing/bags do not come in contact with the floor. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5c	

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F 690	Continued From page 25 NJ Exec Order 26.4b1 [redacted] A review of Resident #6's Order Summary Report indicated the following: start date NJ Exec Order 26.4b1 ensure NJ Exec Order 26.4b1 is below the NJ Exec Order 26.4b off the floor and in a NJ Exec Order 26.4b1. During an interview with Surveyor #2 on 2/26/2025 at 9:38 AM, the US FOIA (b)(6) said that residents with a NJ Exec Orde should have NJ Exec Order 26.4b1 to maintain dignity and protect against contamination, such as preventing the NJ Exec Order 26.4b1 from touching the floor. During an interview with Surveyor #2 on 2/28/2025 at 2:08 PM, the US FOIA (b) said that residents with a NJ Exec Orde should have a NJ Exec Order 26.4 for dignity and infection control purposes. 3. On 2/24/2025 at 10:09 AM, during the initial tour, Surveyor #3 observed Resident #348 in bed with an NJ Exec Order 26.4b1 and NJ Exec Order 2 lying on the floor filled with NJ Exec Orde from the hallway. On 2/25/2025 at 10:52 AM, a review of the EMR revealed the following: A review of the Admission Record reflected the resident had diagnoses that included NJ Exec Order 26.4b1 [redacted] A review of the most recent comprehensive MDS dated NJ Exec Order 26.4b1, revealed Resident #348 had a Brief Interview for Mental Status (BIMS) score of NJ Exe out of 15 which indicated NJ Exec Order 26.4b1. The	F 690	Completion date: March 27, 2025	

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F 690	Continued From page 26 MDS further reflected the resident used an [NJ Exec Order 26.4b1]. A review of the Order Summary Report (OSR) with active orders as of [NJ Exec Order 26.4b1] revealed the following physician orders: A physician order with a start date of [NJ Exec Order 26.4b1] indicating use of [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] every shift for proper [NJ Exec Order 26.4b1] and storage. The order also included to ensure [NJ Exec Order 26.4b1] is below the [NJ Exec Order 26.4b1] off the floor and in a [NJ Exec Order 26.4b1]. During an interview with Surveyor #3 on 02/25/2025 at 12:51 PM, the [US FOIA (b)(6)] [redacted] stated the [NJ Exec Order 26.4b1] should not touch the floor and should be put in a [NJ Exec Order 26.4b1] to prevent spread of infection. During an interview with the surveyor on 02/26/2025 at 12:28 PM, RN/UM #2 stated the [NJ Exec Order 26.4b1] needed to be in a [NJ Exec Order 26.4b1] and cannot be on the floor. RN/UM #2 further stated that the staff were educated on this. During an interview with the surveyor on 02/28/2025 at 9:12 PM, the [US FOIA (b)(6)] [redacted]) stated that [NJ Exec Order 26.4b1] should be in [NJ Exec Order 26.4b1] and cannot be on the floor. A review of the facility-provided policy titled "Urinary Catheter Bags Care Maintenance" dated 2/7/2025, indicated under section Procedure #15: Check to ensure the catheter drainage tube is not touching the floor and the drainage bag is covered. NJAC 8:39-19.4(a) 27.1(a)(b)	F 690		

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to: a.) administer NJ Exec Order 26.4b1 according to the physician's order, b.) ensure NJ Exec Order 26.4b1, and nasal NJ Exec Order 26.4b were stored properly, and c.) obtain physician order for NJ Exec Order 26 administration. This deficient practice was identified for 2 of 2 residents (Residents #75 and #349) reviewed for NJ Exec Order 26.4b1 care according to the standard of clinical practice, and the facility's policy and procedure. The deficient practice was evidenced by the following: 1.) Upon initial tour of the facility on 02/24/2025 at 10:19 AM, Surveyor #1 observed Resident #75 using NJ Exec Order 26 through a NJ Exec Order 26.4b1 connected to an NJ Exec Order 26.4b1 that provides extra NJ Exec Order 26 to those who have NJ Exec Order 26.4b1. However, the NJ Exec Order 26.4b1 was not labeled. Additionally, another NJ Exec Order 26.4b1 was found resting on the seat of the resident's wheelchair, NJ Exec Order 26.4b1 that was also unlabeled and exposed to the environment.	F 695	Criteria 1a To ensure this deficient practice does not affect resident #75, the nursing staff was immediately reeducated on policy and procedures regarding administering NJ Exec Order 26 according to the physician's orders, and documentation. Criteria 2a All residents that require oxygen have the potential to be affected by this practice. Criteria 3a All nurses have been reeducated by the director of nursing in proper procedure for ensuring the nurse administers oxygen according to the physician's orders, for residents on oxygen therapy. Criteria 4a The Supervisor of Nursing will audit of 5 residents, per week for 6 months, that require oxygen to ensure oxygen therapy is administered according to the physician's orders. The director of nursing will review the audits monthly. For two	3/27/25

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F 695	Continued From page 28 On 02/25/2025 at 10:56 AM, Surveyor #1 reviewed the electronic medical records for Resident #75 as follows: According to the Admission Record Resident #75 was admitted to the facility with diagnoses, including but not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident #75's Order Summary Report indicated the following: start date NJ Exec Order 26.4b1, check NJ Exec Order 26.4b1 [redacted]) every shift if the NJ Exec Order 26.4b1 and the resident is NJ Ex Order Exec Order 26.4b1 [redacted] at a rate of NJ Exec Order 2 per NJ Exec Order 2 via NJ Exec Orde [redacted] every 8 hours as needed for NJ Exec Orde A review of Resident #75's Treatment Administration Record (TAR) revealed an order for monitoring NJ Exec Order every shift if it drops below NJ Exec Or and for administering NJ Exec Order 26.4b1 per NJ Exec Order 2 via NJ Exec Order 26.4b1 every 8 hours as needed for NJ Exec Orde However, there was no documentation in the TAR indicating that the as needed NJ Exec Order 26 was being administered. During an interview with Surveyor #1 on 2/26/2025 at 9:38 AM, the US FOIA (b)(6) [redacted] said that if NJ Exec Order 26.4b1 is not in use, it should be stored in a plastic bag and not left open to the environment for infection control purposes. During an interview with Surveyor #1 on 2/26/2025 at 1:22 PM, the Registered Nurse/Unit	F 695	quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5a Completion date: March 27, 2025 Criteria 1b The staff immediately ensured resident #75 had NJ Ex Order 26.4(b)(1), and NJ Ex Order2 [redacted] labeled and stored properly. Criteria 2b All residents that require oxygen have the potential to be affected by this practice. Criteria 3b All nurses will be reeducated by the director of nursing in proper procedure for ensuring residents that require oxygen have respiratory tubing, and nasal canula labeled and stored properly. Criteria 4b The Supervisor of Nursing will audit 5 residents, per week for 6 months, that require oxygen to ensure respiratory tubing, and nasal canula are labeled and stored properly. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5b	

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F 695	Continued From page 29 Manager #1 said that NJ Exec Order 26.4b1 should have a physician's order, be NJ Exec Order 26.4b and dated every Friday, and be stored in a plastic bag when not in use for infection control purposes. Additionally, any NJ Exec Order 26 used as needed should be recorded on the TAR. A review of the facility provided policy, with a review date of 2/28/2025, titled, "Oxygen Administration" revealed under the section titled "Procedure" that, "Every nasal cannula, will be changed once per week on a selective day labeled appropriately. When not in use, nasal cannula and tubing will be placed in plastic bag and tied to tank and/or concentrator." 2. On 02/24/2025 at 10:13 AM, during the initial tour of the facility, Surveyor #2 observed Resident #349 in bed connected to an NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1 On 02/25/2025 at 8:25 AM, Surveyor #2 observed the resident in bed receiving NJ Exec Order 26.4b1 of NJ [redacted] per NJ Exec Order 26 via NJ Exec Order 26.4b1 connected to the NJ Exec Order 26.4b1 On 2/25/2025 at 11:00 AM, a review of the EMR revealed the following: A review of the Admission Record reflected the resident had diagnoses that included history of NJ Exec Order 26.4b1 [redacted]. A review of the Clinical Physician Orders active and discontinued as of NJ Exec Order 26.4b1 at 12:47 PM, did not include a physician order for NJ Exec Order 26 administration since admission. A review of the Resident #349's comprehensive	F 695	Completion date: March 27, 2025 Criteria 1c The nursing management team immediately reviewed physician's orders for resident # 349 and the resident had no order for NJ Exec Order 26.4b The resident does not require NJ Exec Order 26.4 The nursing staff was immediately educated regarding the need to update the care plan and get a physician order for residents who require NJ Exec Order 26.4b1. Criteria 2c All residents who require oxygen have the potential to be affected by this practice. Criteria #3c: All nurses were reeducated by the director of nursing in proper procedure for ensuring residents who require oxygen have a physician's order. Criteria #4c: The Supervisor of Nursing will audit 5 residents, per week for 6 months, that require oxygen to ensure there is a physician order for oxygen administration. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5c Completion date: March 27, 2025	

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F 695	Continued From page 30 care plan did not reveal a goal and interventions for the focus of resident having periods of [redacted]. During an interview with the Surveyor #2 on 02/26/2025 at 12:20 PM, the Registered Nurse/ Unit Manager (RN/UM #2) stated that [redacted] administration should have a physician order. During an interview with the Surveyor #2 on 02/28/2025 at 9:10 AM, the [redacted] stated that a physician order was absolutely needed for [redacted] administration. A review of the facility provided policy titled "Oxygen Administration" dated reviewed 2/28/2025, did not include physician orders for oxygen administration.	F 695		
F 755 SS=D	NJAC 8:39-27.1(a) 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 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.	F 755		3/27/25

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F 755	Continued From page 31 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §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 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of facility documentation, it was determined that the facility failed to ensure accurate accountability of controlled drugs to prevent loss or diversion. This deficiency was identified for 2 of 4 medication carts inspected. This deficient practice was evidenced by the following: On 02/26/2025 at 11:30 AM, the surveyor inspected F-Hall medication cart in the presence of the Registered Nurse/Unit Manager #1 (RN/UM #1). A review of the shift-to-shift Narcotic Record Controlled Count Sign Sheet (NRCCSS), which is used in healthcare settings to track the administration and accountability of controlled substances, revealed missing signatures for the following dates and shifts: 2/01/2025 for the outgoing nurse (7:00 AM - 3:00 PM), and 2/09/2025, for both the incoming and outgoing	F 755	Criteria 1 To ensure no resident is affected by the deficient practice, all nurses have been reeducated to ensure that the controlled drug log is signed by 2 nurses every shift. Criteria 2 All residents have the potential to be affected by this practice. Criteria 3 All nurses have been reeducated by the director of nursing in proper procedure for ensuring the controlled drug log is signed by 2 nurses every shift. Criteria 4 The unit manager will audit E-hall and F-hall controlled drug log 5 days per week for 6 months to ensure two nurses are signing the controlled drug log every shift.	

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F 755	Continued From page 32 nurses (11:00 PM - 7:00 AM). On 02/26/2025 at 11:38 AM, the surveyor inspected E-Hall medication cart in the presence of the RN/UM #1. A review of the shift-to-shift NRCCSS revealed missing signatures on the following dates and shifts: 02/05/2025 for both incoming and outgoing nurse (3:00 PM - 11:00 PM), and 2/18/2025 for the outgoing nurse (7:00 AM - 3:00 PM). During an interview with surveyor on 02/26/2025 at 1:22 PM, the RN/UM #1 said that the nurses are required to sign the NRCCSS for accountability of narcotics. During an interview with surveyor on 02/28/2025 at 2:04 PM, the US FOIA (b)(6) said that the NRCCSS should be completed at the beginning and end of each shift to ensure accurate narcotic counts and prevent drug diversion. A review of the facility provided policy, with a review date of 2/28/2025, titled, "Counting Controlled Drugs and Drug Diversion" revealed under the section titled "Procedure" that, "All controlled drugs will be counted in the start and end of each shift by two (2) license nurses. Both parties sign the count sheet indicating that each controlled drug count is correct."	F 755	The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5 Completion date: March 27, 2025	
F 756 SS=D	NJAC 8:39-29.7(c) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		3/27/25

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F 756	Continued From page 33 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the Electronic Medical Record (EMR) and review	F 756	Criteria 1 On 12/22/24, resident #66's [redacted]	

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F 756	Continued From page 34 of other facility documentation, it was determined that the facility failed to follow through on recommendations made by the US FOIA (b)(6) [redacted]) during their monthly medication review regimen (MRR) in a timely manner. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident # 66) and was evidenced by the following: During the Initial Tour of the facility on 02/24/2025 at 10:57 AM, Resident #66 was observed in a NJ Exec Order 26.4b1 wheelchair in his/her room NJ Exec Orde and NJ Exec Order 26.4b1 Resident requested and received a cup of coffee. A review of the EMR on 02/24/2025 at 10:00 AM, revealed the following: According to the Admission Record, Resident #66 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]. According to the most recent quarterly Minimum Data Set, an assessment tool dated NJ Exec Order 26.4b1 revealed the resident had a Brief Interview for Mental Status of NJ /15 MDS which indicated severe NJ Exec Order 26.4b1. A review of the Order Summary Report revealed the following physician orders; NJ Exec Order 26.4b1 [redacted] Give 2 tablet by mouth every 6 hours for NJ Exec Orde [redacted] Do Not exceed NJ Exec Order 26.4b1 per day give NJ Exec Order 26.4b1 with order date of NJ Exec Order 26.4b1	F 756	NJ Ex Order 26.4(b)(1) recommendations were addressed. Criteria 2: All residents have the potential to be affected by this practice. Criteria 3: On March 18, 2025, the Director of Nursing and Supervisors of Nursing started educating all nurses on proper procedure for addressing monthly consultant pharmacy medication review in a timely manner. Plan to conclude in-service by March 27, 2025. Criteria 4 The unit managers will audit 10 charts per month for 6 months to ensure that the monthly Consultant Pharmacist medication recommendations are reviewed and followed up on in a timely manner. The director of nursing will review the audits monthly. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5 Completion date: March 27, 2025	

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F 756	Continued From page 35 NJ Exec Order 26.4b1) Give 2 tablet by mouth every 4 hours as needed for NJ Exec Order 26.4b1 Do Not exceed NJ Exec Order 26.4b1 per day dated NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 suggestion form dated NJ Exec Order 26.4b1 revealed the following: Routine order of NJ Exec Order 26.4b1 To avoid potentially going over maximum recommended daily dosing, consider decreasing the frequency of PRN (as needed) NJ Exec Order 26.4b1 or d/c (discontinue) PRN NJ Exec Order 26.4b1 On NJ Exec Order 26.4b1 the US FOIA (b)(6) hand wrote on the NJ Exec Order 26.4b1 suggestion form to NJ Exec Order 26.4b1 po (by mouth) q (every) 8 hours prn for NJ Exec Order 26.4b1 There was no documentation in the EMR that the facility followed up on the CP recommendations and the US FOIA (b) acceptance dated NJ Exec Order until NJ Exec Order 26.4b1 This was not addressed in 102 days. During an interview with the surveyor on 02/27/2025 at 10:24 AM, the US FOIA (b)(6) was asked what the process is when the CP has a NJ Exec Order 26.4b1 suggestion. The US FOIA (b) replied She comes in monthly and reviews all residents. She sends us a report after she leaves unless major issue that requires immediate attention. She then writes a note in chart she reviewed. If there is recommendation will document there is recommendation. She then emails and sends via regular mail the reports and the Unit Managers address them. When asked if there is a specific time frame of when the suggestion needs to be addressed. The US FOIA (b) replied If nursing recommendation we have to do	F 756		

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F 756	Continued From page 36 it right away. If it is a physician we send it to them and wait for their response. The [US FOIA (b)(6)] send back to the unit and the nurse addresses the changes and then gets filed in EMR under miscellaneous tab. The [US FOIA] is responsible to follow-up with physicians. The [US FOIA (b)] went on to say that she is not sure if there is a time frame in the policy. It should be done as soon as possible. On 02/27/2025 at 10:31 AM, a further review of the EMR under the miscellaneous tab indicated the [NJ Exec Order 26.4b1] recommendations form was uploaded into the record on [NJ Exec Order 26.4b1], however the facility did not address what was written by the [US FOIA (b)] During an interview with the surveyor on 02/28/2025 at 02:00 PM, the [US FOIA (b)] was asked what is the facility expectations of time frame for follow-up with cp recommendations and prescriber's orders. The [US FOIA (b)] replied as soon as possible. When asked if it was acceptable to wait 102 days to address the cp report, the [US FOIA (b)] said it is not acceptable to wait that long . On 02/27/2025 at 12:17 PM, a review of a facility policy titled Change of Status/Monthly Pharmacy Review with last reviewed date of 2/27/25, revealed under Procedure section 5. The Pharmacy Consultant recommendations will be reviewed with the attending physician. The policy did not include a specific time frame for addressing CP recommendations.	F 756		
F 812 SS=E	NJAC 8:39-29.3(a)(1) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/4/25

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F 812	Continued From page 37 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner designed to prevent food borne illness. This deficient practice was evidenced by the following: On 02/24/2025 from 09:43 to 10:09 AM, the surveyor, accompanied by the US FOIA (b)(6) [redacted], observed the following in the kitchen: 1. On the wall next to the solo standup solo freezer, a wall mounted knife container contained two knives with wooden handles. The wooden handles of the knives were exposed to the surveyor. They appeared to be old and had fine	F 812	Criteria 1a The food service manager (FSM) immediately removed and threw away all wooden handled cutlery in kitchen. There was no other wooden handled cutlery in the facility. Criteria 2a All residents have the potential to be affected by this deficient practice. To ensure no resident is affected by this deficient practice, the in servicing of staff is ongoing until April 4, 2025. The staff, residents and families are reminded not to bring wooden handled cutlery in the facility and are reminded to throw away any wooden handled cutlery found in the facility.	

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F 812	Continued From page 38 cracks in the handles on visual inspection, which would allow bacteria to remain in the wooden handles.When interviewed the [redacted] stated, "Ok. I know that." The [redacted] removed the wooden knives from the wall monted knife container/holder. 2. The high temperature dish machine was observed to be in use and actively washing dishware on 02/24/2025 at 10:01 AM. The surveyor asked the [redacted] to provide the surveyor the dish machine temperature log for observation. Review of the [facility name] Temperature Log revealed the following: No temperature was recorded for the breakfast meal on 2/24/2025 and the dish machine was observed to be in active operation at 02/24/25 10:03 AM. According to the [redacted] staff should document the temperatures of the dish machine prior to dishwashing to ensure the machine is operating at the correct minimum wash and rinse temperatures to ensure proper cleaning and sanitizing of dishware. Further review of the dish machine temperature log revealed the following: No breakfast temperatures were recorded on the following dates for February 2025: 2/3/2025, 2/12/2025, 2/13/2025, 2/15/2025, 2/17/2025, 2/20/2025. The facility failed to record dish machine temperatures at lunch on the following dates: 2/6/2025, 2/7/2025, 2/9/2025, 2/10/2025, 2/11/2025, 2/12/2025, 2/13/2025, 2/14/2025, 2/16/2025, 2/19/2025, 2/10/2025, 2/21/2025. The facility failed to record dish machine temperatures for dinner in February 2025 on the following dates: 2/1/2025, 2/2/2025, 2/3/2025, 2/4/2025, 2/6/2025, 2/7/2025, 2/8/2025, 2/9/2025, 2/10/2025, 2/11/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/18/2025, 2/20/2025, 2/21/2025, 2/22/2025, and 2/23/2025.	F 812	Criteria 3a The administrator sent an alert to the staff, residents, and family members reminding them not to bring in wooden handled cutlery into the facility. The administrator wrote a policy titled: “Wooden Cutlery (knives, spoons, forks etc.) is not allowed at Meadowview.” On 3/16/2025, the food service manager, food service supervisor and director of nursing started educating the staff about the policy and the risk of bacteria buildup on wooden handled cutlery. The in-service will be completed by April 4, 2025. In addition, the social workers will remind the families and residents about the policy during care conference meetings. On 3/24/25, the recreation director reminded the residents during resident council meeting that all types of wooden handled cutlery are prohibited in the facility. Criteria 4a The Food Service Manager (FSM) and Food Service Supervisor (FSS) will audit the kitchen daily for six months for the presence of wooden handled cutlery. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5a Completion date: April 4, 2025 Criteria 1b	

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F 812	Continued From page 39 On 02/28/2025 from 09:03 to 09:17 AM, the surveyor, accompanied by the [US FOIA (b)(6)] made the following observation in the dry storage room: 1. On an upper rack of a multi-tiered/rack canned good storage cart, a can of unsweetened applesauce had a significant dent on the bottom seam of the can. The [US FOIA (b)] agreed and removed the can from the storage rack and to the designated dented can area. The surveyor reviewed the facility provided policy titled Dish Machine Cleaning, revised 1/21/2023. The following was revealed under the section PROCEDURE: Daily - Prior to loading the dish machine. 2. The wash temperature is to be at 160 or above and the rinse temperature is to be at 180 or above. 3. Document the date, and meal period, the wash and rinse temperatures and initials in the dish machine logbook. The surveyor reviewed the facility provided policy with the subject Food Storage, Policy Number: 5010. The following was revealed under PROCEDURE: 13. Storage areas are monitored by supervisory staff. Leaking, bulging or severely damaged cans or jars with leaky lids and other items identified as damaged or unusable are isolated and disposed of according to unit policy. N.J.A.C. 18:39-17.2(g)	F 812	The food service manager immediately checked the temperature on the dishwashing machine to ensure the temperature of the dishwashing machine was in compliance. The temperature log of the dishwashing machine was moved closer to the dishwashing machine to remind the food service workers to record the temperature of the dishwashing machine in the dishwashing machine log before running the dishes through the dishwashing machine. Criteria 2b All residents have the potential to be affected by this deficient practice. To ensure no resident is affected by this deficient practice, the dish machine temperature log was moved to a visible area closer to the dishwashing machine as a reminder to the food service workers to record the temperature of the dishwashing machine in the dishwashing machine log before running the dishes through the dishwashing machine. Criteria 3b The dishwashing machine temperature log was moved to a visible area closer to the dishwashing machine. On 3/16/25, the food service supervisor started educating the staff about the importance of recording temperature of the dishwashing machine before running the dishes through the dishwashing machine to ensure that the temperature of the dishwashing machine was correct to kill any germs or bacteria. Reminders were placed in designated areas to	

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F 812	Continued From page 40	F 812	continuously remind the staff to check and record the dishwashing machine temperature in the dishwashing machine log. The food service supervisor plans to complete the in-service by March 31, 2025. Criteria 4b The food service manager and food service supervisor will audit the dish machine temperature log daily after every meal for 6 months to ensure that the dish machine temperature is being recorded prior to the dishwashing starting. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5b Completion date: March 31, 2025 Criteria 1c The food service manager removed the dented can and it placed in the proper designated dented can area. A more visible sign was posted in the designated dented can area making it easier to see. Policy for dented cans was revised and made visible in the designated areas. Criteria 2c All residents have the potential to be affected by this deficient practice. To ensure no resident is affected by this deficient practice, a more visible sign was posted in the designated dented can area	

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F 812	Continued From page 41	F 812	making it easier to see. Policy for dented cans was revised and made visible in the designated areas. Criteria 3c A more visible sign was posted in the designated dented can area making it easier to see. Policy for dented cans was revised and made visible in the designated areas. On 3/16/25, the food service supervisor started educating the staff on the revised dented cans policy and the purpose of the policy. The food service supervisor plans to complete the in-service by March 31, 2025. Criteria 4c The food service manager and food service supervisor will audit for dented cans daily for 6 months. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5c Completion date: March 31, 2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		3/27/25

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F 880	Continued From page 42 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 43 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of facility documentation, it was determined that the facility failed to follow [redacted], a set of infection control measures aimed at reducing the risk of [redacted]. This deficiency was observed for 1 of 1 resident (Resident #49) reviewed for [redacted]. This deficient practice was evidenced by the following: On 02/24/2025 at 10:38 AM, upon initial tour of the facility the surveyor observed the Home Health Aide (HHA#1) giving a bed bath to Resident #49 in their bedroom, while the resident was in bed, without wearing personal protective equipment (PPE), despite a sign on the outside of the door indicating [redacted] and the proper PPE	F 880	Criteria 1 Home Health Aide (HHA#1) was immediately reeducated in the proper procedure for [redacted]. HHA#1's agency was notified of deficient practice and agency reeducated HHA#1 on proper procedure for [redacted] on 3/3/2025. Criteria 2 All residents who are on Enhanced Barrier Precautions have the potential to be affected by this practice. Criteria 3 All Staff will be reeducated by the infection preventionist in proper procedure for Enhanced Barrier Precautions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315358	A. BUILDING _____ B. WING _____	C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	235 DOLPHIN AVE NORTHFIELD, NJ 08225

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F 880	Continued From page 44 required for [redacted] A review of Resident #49's Order Summary Report located in the [redacted] Medical Record revealed an order to maintain [redacted] due to the presence of a [redacted]. During an interview with the surveyor on 02/24/2025 at 10:40 AM, HHA #1 said that no one at the facility had informed her that PPE was required when performing a bed bath, though it should be worn for infection control purposes. During an interview with surveyor on 02/26/2025 at 09:38 AM, the Infection Preventionist said that [redacted] are implemented for residents with [redacted] which are [redacted] or [redacted] as well as for those with medical devices, such as a [redacted]. Healthcare providers must wear PPE when performing tasks like [redacted]. A review of a facility policy, with a review date of 01/16/2025 titled, "Infection Prevention Policy and Procedure Manual", revealed under definitions, that "Enhanced Barrier Precaution: This is an approach using PPE (ie. gowns and gloves) during high contact resident care, design to reduce the transmission of colonized MDROs." N.J.A.C.8:39-19.4(a)	F 880	Criteria 4 The Infection Preventionist will observe 5 staff members per week for 6 months to ensure proper use of PPE during care of residents on Enhanced Barrier Precautions. Any corrections will be made immediately. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI Team. Criteria 5 Completion date: March 27, 2025	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060101	A. BUILDING: _____ B. WING _____	C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATIC	235 DOLPHIN AVE NORTHFIELD, NJ 08225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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, for 4 of 14 day shifts in the 2 weeks of staffing prior to the recertification survey dated 3/3/2025. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	Criteria 1 The facility will ensure all avenues and resources are exhausted. The facility implemented immediate on the spot interview for qualified candidates. The facility advertised for the following positions: registered nurse, licensed practical nurse, and certified nursing assistant. Criteria 2 All residents have the potential to be affected by this deficient practice. Facility will follow the staffing plan by utilizing overtime, mandatory overtime, and	3/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060101	A. BUILDING: _____ B. WING _____	C 03/03/2025

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S 560	Continued From page 1 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: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer 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 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. As per the Nurse Staffing Report (AAS-11) completed by the facility, the staffing to resident ratios that did not meet the requirements of 1 CNA to 8 residents for the day shift were as documented below: For the 2 weeks of staffing prior to survey from 02/9/2025 to 02/22/2025, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: - 2/11/25 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. - 2/12/25 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. - 2/14/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. - 2/22/25 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.	S 560	agency staff to meet minimum staffing requirements. Criteria 3 Facility will continue to advertise for new hires. Facility will follow the staffing plan by utilizing overtime, mandatory overtime, and agency staff to meet minimum staffing requirements. Facility will curtail admissions of new residents if staffing needs cannot consistently be met. Criteria 4 A review of staffing level will be conducted by the Director of Nursing 5 days a week and review of the weekend staffing level to ensure compliance with the state minimum staffing level required for each shift. The review of state minimum staffing level will be discussed in the daily management meeting. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5 Completion date: March 27, 2025	

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	060101	A. BUILDING: _____ B. WING _____	C 03/03/2025

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S 560	Continued From page 2 During an interview with the surveyor on 02/27/2025 at 10:30 AM, the Staffing Coordinator (SC) stated that she was aware of the minimum direct care staffing ratio requirements which were 1:8 for day shift, 1:10 for evening shift, and 1:14 for night shift. When asked if they were consistently meeting the requirements, the SC stated that they were meeting them often. During an interview with the surveyor on 3/3/2025 at 8:44 AM, the Assistant Director of Nursing (ADON) stated she was aware of the minimum direct care staffing ratio requirements which were 1:8 for day shift, 1:10 for evening shift, and 1:14 for night shift. When asked if they were consistently meeting the requirements, the ADON stated that they were consistently meeting the requirements. A review of the facility provided policy titled "Posting Direct Care Daily Staffing Numbers" dated 12/1/2022, revealed under Procedure #11: Staffing will have at least the minimal requirements currently set at: a. CNA staffing for day shift 1 to 8 b. Direct care staff for evening shift is 1 to 10 c. Direct care staff for night shift is 1 to 14	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315358 Y1	A. Building B. Wing Y2	5/8/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	235 DOLPHIN AVE NORTHFIELD, NJ 08225

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0582	Correction	ID Prefix F0656	Correction	ID Prefix F0657	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	03/28/2025	LSC	03/27/2025	LSC	03/27/2025
ID Prefix F0658	Correction	ID Prefix F0688	Correction	ID Prefix F0690	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	03/27/2025	LSC	03/27/2025	LSC	03/27/2025
ID Prefix F0695	Correction	ID Prefix F0755	Correction	ID Prefix F0756	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed
LSC	03/27/2025	LSC	03/27/2025	LSC	03/27/2025
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	04/04/2025	LSC	03/27/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/3/2025	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060101 Y1	A. Building B. Wing Y2	5/8/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	235 DOLPHIN AVE NORTHFIELD, NJ 08225

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/27/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/3/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315358	A. BUILDING **01** B. WING _____	**03/03/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	**235 DOLPHIN AVE** **NORTHFIELD, NJ 08225**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 2/25/25 and 2/26/25 and Meadowview Nursing and Rehabilitation was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Meadowview Nursing and Rehabilitation is a three-story, Type I Fire Resistant building that was built in January 1988. The facility is divided into 18 smoke zones.	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 by: Based on observations and interviews on 2/26/25	K 211	Criteria 1a	4/18/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/24/2025

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

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K 211	Continued From page 1 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure means of egress exits were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101: 2012 Edition, Sections 7.1.10.1, 7.2 19.2.1 and NFPA 80: 2010 Edition. The deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:50 AM revealed the second floor stairwell 5 exit fire door had panic hardware that did not positive latch when closed in its door frame. The latch was stuck in the hardware and remained retracted when operated. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the observation. An observation at 1:50 PM of clothing storage room number 117 revealed an exit sign above an exterior exit door. The door was locked and could not be opened. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the observation and the US FOIA (b) stated it was locked to prevent people from coming in from the loading dock area outside. An observation at 2:10 PM of exit stairwell number 3's landing between the first and ground floor where the exit door to the outside at ground level was located, revealed the exit door to the outside for all three floor level corridors did not	K 211	The Director of Environmental Services (DES) immediately contacted Atlantic County Facilities Management representative concerning the stairwell 5 exit fire door did not positive latch when closed in its door frame. Atlantic County Facilities Management contacted our locksmith with the issue. On 2/28/25, our locksmith fixed the latch of stairwell 5 exit fire door. On 3/11/25 our locksmith installed a new doorknob on stairwell 5 exit fire door. The administrator advised the environmental supervisor and the assistant environmental supervisor about the importance of inspecting the doors and ensuring that all doors are working according to regulatory guidelines. Criteria 2a All residents have the potential to be affected by this deficient practice when doors are not properly operational. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of stairwell 5 exit fire door is part of the monthly maintenance monitoring program. Criteria 3a The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of stairwell 5 exit fire door is part of the monthly maintenance monitoring program. On 2/28/25, our locksmith corrected the deficient practice.	

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K 211	Continued From page 2 open when force was applied. The exterior exit door was not operational. The end of the corridor on all three levels had exit signs directing egress to the stairwell as 1 of the 2 remote exits from each of the levels corridors in that wing. In an interview at the time, the US FOIA (b)(6) confirmed the observation and the US FOIA (b)(6) stated the door was rusted shut. The facility's US FOIA (b)(6) informed of the deficient practice at the Life Safety Code exit conference at 4:17 PM. NJAC 8:39-31.2 (e) NFPA 80	K 211	Criteria 4a The director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the stairwell 5 exit fire door 3 times a week for 6 months. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5a Completion date: March 11, 2025 Criteria 1b The director of environmental services contacted Atlantic County Facilities Management representative concerning the clothing storage room 117 exit sign above exterior exit door. The door was locked and could not be opened. The exit door leads out on to the back loading dock which would allow individuals easy access into the building. The Atlantic County Fire Marshall assessed the door and confirmed that this was not an exit. On 3/4/25, the exit sign was removed. Criteria 2b All residents have the potential to be affected by this deficient practice when doors are not properly operational. The Atlantic County Fire Marshall assessed the clothing storage room 117 exit door and confirmed that this was not an exit. On 3/4/25, the exit sign was removed. The Director of Environmental Services (DES) and or Assistant Supervisor of	

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K 211	Continued From page 3	K 211	Maintenance, Housekeeping and Laundry (ASMHL) will ensure that there is no exit sign in storage room 117 and the loading dock door are part of the monthly maintenance program. Criteria 3b The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure that there is no exit sign in storage room 117 and the loading dock door are part of the monthly maintenance program. On 3/4/25, the exit sign was removed. Criteria 4b The director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit 3 times a week for 6 months the clothing storage room 117 for no exit sign above exterior exit door and ensure that the loading dock door is secured. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5b Completion date: March 4, 2025 Criteria 1c Regarding the stairwell 3 exit door not opening with force applied, the administrator notified Atlantic County Facilities Management representatives	

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K 211	Continued From page 4	K 211	and the director of environmental notified the Atlantic County Fire Marshall. Our door vendor was contacted. The vendor planned to replace the stairwell 3 exit door by April 18, 2025. Criteria 2c All residents have the potential to be affected by this deficient practice when doors are not properly operational. The Atlantic County Fire Marshall, and the Atlantic County Facilities representative assessed stairwell 3 exit door. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure that the checking of stairwell 3 exit door is part of the monthly maintenance monitoring program. Criteria 3c The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure that the checking of stairwell 3 exit door is part of the monthly maintenance monitoring program. Stairwell 3 exit door will be replaced by April 18, 2025. Criteria 4c The director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit stairwell 3 exit door 3 times a week for 6 months. For two quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315358	A. BUILDING **01** B. WING _____	**03/03/2025**

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MEADOWVIEW NURSING AND REHABILITATION CENTER	**235 DOLPHIN AVE** **NORTHFIELD, NJ 08225**

(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 211	Continued From page 5	K 211	meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5c Completion date: April 18, 2025	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/26/25 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to ensure required illumination was arranged so that the failure of any single lighting unit did not result in an illumination level of less than 0.2 ft-candle in any designated area in accordance with NFPA 101: 2012 Edition, Section 7.8 and 7.8.1.4. The deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 2:48 PM of the exterior exit discharge from stairwell number 6 revealed there was one light fixture with one bulb. An observation at 2:55 PM of the exterior exit discharge from stairwell number 7 revealed there was one light fixture with one bulb.	K 281	Criteria 1a The Director of Environmental Services (DES) immediately contacted Atlantic County Facilities Management representative concerning the exterior exit discharge from stairwell number 6 revealed there was one light fixture with one bulb. Atlantic County Facilities Management contacted our electrician vendor. On April 1, 2025, the vendor corrected the deficiency by installing a new light fixture with two bulbs for brighter illumination of the exterior exit discharge from stairwell number 6. Criteria 2a All residents have the potential to be affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry	4/1/25

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K 281	Continued From page 6 In interviews at the times, the US FOIA (b)(6) [redacted] confirmed the observations. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:17 PM. NJAC 8:39-31.2 (e)	K 281	(ASMHL) will ensure the checking of the exterior exit discharge from stairwell number 6 has one light fixture with two bulbs. This monitoring will be part of the monthly maintenance program. Criteria 3a The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the exterior exit discharge from stairwell number 6 has one light fixture with two bulbs. This monitoring will be part of the monthly maintenance program. On April 1, 2025, the vendor corrected the deficiency by installing a new light fixture with two bulbs for brighter illumination of the exterior exit discharge from stairwell number 6. Criteria 4a Once a month for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the exterior exit discharge from stairwell number 6 to ensure that the light fixture with two bulbs is in place. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5a Completion date: April 1, 2025 Criteria 1b	

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K 281	Continued From page 7	K 281	The Director of Environmental Services (DES) immediately contacted Atlantic County Facilities Management representative concerning the exterior exit discharge from stairwell 7 revealed there was one light fixture with one bulb. Atlantic County Facilities Management contacted our electrician vendor. On April 1, 2025, the vendor corrected the deficiency by installing a new light fixture with two bulbs for brighter illumination of the exterior exit discharge from stairwell number 7. Criteria 2b All residents have the potential to be affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the exterior exit discharge from stairwell 7 light fixture is part of the monthly maintenance monitoring program. Criteria 3b The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the exterior exit discharge from stairwell number 7 has one light fixture with two bulbs. This monitoring will be part of the monthly maintenance program. On April 1, 2025, the vendor corrected the deficiency by installing a new light fixture with two bulbs for brighter illumination of the exterior exit discharge from stairwell number 7.	

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K 281	Continued From page 8	K 281	Criteria 4b Once a month for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the exterior exit discharge from stairwell 7 to ensure that the light fixture with two bulbs is in place. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5b Completion date: April 1, 2025	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321		3/19/25

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K 321	Continued From page 9 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/26/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure hazardous areas were protected by doors that were self closing or automatic closing all the way into their door frame in accordance with NFPA 101: 2012 Edition, Section 8.7, 19.3.2, and 19.3.2.1.3. The deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a facility tour from 11:30 AM to 3:12 PM revealed: 1. The kitchen dry storage room had combustible storage and was greater than 50 square feet. The storage room door to the corridor did not close all the way into its door frame when released from the fully open position. The door stopped when its leading edge met the corner of the door frame and required excessive force to pull to latch. 2. The laundry room door to the corridor did not	K 321	Criteria 1a The Director of Environmental Services (DES) contacted Atlantic County Facilities Management representative concerning the kitchen dry storage room door required excessive force to pull to latch. Atlantic County Facilities Management contacted our door vendor. The vendor corrected the deficiency on March 19, 2025 Criteria 2a All residents have the potential to be affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the kitchen dry storage room is working properly. This monitoring will be part of the monthly maintenance program. Criteria 3a The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry	

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K 321	Continued From page 10 close all the way into its door frame when released from the fully open position. The door stopped 3/4 of an inch from its place in the door frame. 3. The basement storage room G08 had combustible storage and was greater than 50 square feet. The storage room door to the corridor did not close all the way into its door frame when released from the fully open position. The door stopped when the door strike hit the edge of the door frame. 4. The basement storage room G11 had combustible storage and was greater than 50 square feet. The storage room door was not equipped with a self closing device. 5. The clean linen storage room G47 had combustible storage and was greater than 50 square feet. The storage room door to the corridor did not close all the way into its door frame when released from the fully open position. The door stopped 3/4 of an inch from its place in the door frame. 6. Resident room 177 corridor door didn not close to latch on its own and would not latch when pulled because it was rubbing on the door frame. In interviews at the times, the US FOIA (b)(6) [redacted] confirmed the observations. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:17 PM. NJAC 8:39-31.2(e)	K 321	(ASMHL) will ensure the checking of the kitchen dry storage room door is working properly. This monitoring will be part of the monthly maintenance program. The vendor corrected the deficiency on March 19, 2025 Criteria 4a Once a week for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the kitchen dry storage room door. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5a Completion date: March 19, 2025 Criteria 1b The Director of Environmental Services (DES) contacted Atlantic County Facilities Management representative concerning the laundry room door to the corridor did not close all the way into its door frame when released from the fully open position. Atlantic County Facilities Management contacted our door vendor. The vendor corrected the deficiency on March 19, 2025. Criteria 2b All residents have the potential to be affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of	

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K 321	Continued From page 11	K 321	Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the laundry room door is working properly. This monitoring will be part of the monthly maintenance program. Criteria 3b The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the laundry room door is working properly. This monitoring will be part of the monthly maintenance program. The vendor corrected the deficiency on March 19, 2025 Criteria 4b Once a week for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the laundry room door. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5b Completion date: March 19, 2025 Criteria 1c The Director of Environmental Services (DES) contacted Atlantic County Facilities Management representative concerning the basement storage room door G08 did not close all the way into its door frame when released from the fully open	

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K 321	Continued From page 12	K 321	position. Atlantic County Facilities Management contacted our door vendor. The vendor corrected the deficiency on March 19, 2025. Criteria 2c All residents have the potential to be affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the basement storage room door G08 is working properly. This monitoring will be part of the monthly maintenance program. Criteria 3c The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the basement storage room door G08 is working properly. This monitoring will be part of the monthly maintenance program. The vendor corrected the deficiency on March 19, 2025 Criteria 4c Once a week for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the basement storage room door G08. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team.	

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K 321	Continued From page 13	K 321	Criteria 5c Completion date: March 19, 2025 Criteria 1d The Director of Environmental Services (DES) contacted Atlantic County Facilities Management representative concerning the basement storage room door G11 was not equipped with a self-closing device. Atlantic County Facilities Management contacted our door vendor. The vendor corrected the deficiency on March 19, 2025. Criteria 2d All residents have the potential to be affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the basement storage room door G11 is working properly. This monitoring will be part of the monthly maintenance program. Criteria 3d The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the basement storage room door G11 is working properly. This monitoring will be part of the monthly maintenance program. The vendor corrected the deficiency on March 19, 2025 Criteria 4d Once a week for 6 months, the director of	

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K 321	Continued From page 14	K 321	environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the basement storage room door G11. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5d Completion date: March 19, 2025 Criteria 1e The Director of Environmental Services (DES) contacted Atlantic County Facilities Management representative concerning the clean linen storage room door G47 did not close all the way into its door frame when released from the fully open position. Atlantic County Facilities Management contacted our door vendor. The vendor corrected the deficiency on March 19, 2025. Criteria 2e All residents have the potential to be affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the clean linen storage room door G47 is working properly. This monitoring will be part of the monthly maintenance program. Criteria 3e The Director of Environmental Services	

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K 321	Continued From page 15	K 321	(DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the clean linen storage room door G47 is working properly. This monitoring will be part of the monthly maintenance program. The vendor corrected the deficiency on March 19, 2025 Criteria 4e Once a week for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the clean linen storage room door G47. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5e Completion date: March 19, 2025 Criteria 1f The Director of Environmental Services (DES) contacted Atlantic County Facilities Management representative concerning the resident room door 177 did not close to latch on its own and would not latch when pulled because it was rubbing on the door frame. Atlantic County Facilities Management contacted our door vendor. The vendor corrected the deficiency on March 19, 2025. Criteria 2f All residents have the potential to be	

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K 321	Continued From page 16	K 321	affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the resident room door 177 is working properly. This monitoring will be part of the monthly maintenance program. Criteria 3f The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the resident room door 177 is working properly. This monitoring will be part of the monthly maintenance program. The vendor corrected the deficiency on March 19, 2025 Criteria 4f Once a week for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit resident room door 177. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5e Completion date: March 19, 2025	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities	K 324		3/28/25

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K 324	Continued From page 17 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 by: Based on observation and interview on 2/26/25 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to perform monthly owners inspections of the range-hood fire wet chemical suppression systems in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect all	K 324	Criteria 1 The Director of Environmental Services (DES) contacted Atlantic County Facilities Management Representative regarding the kitchen range hood fire suppression system. Our vendor was contacted and the vendor performed the semi-annual inspection of the kitchen range hood fire suppression system on March 19, 2025. The maintenance staff performed and documented the monthly owner's inspections of the range-hood fire wet	

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K 324	Continued From page 18 residents and was evidenced by the following: An observation at 1:20 PM of the kitchen range-hood fire suppression system wet chemical inspection tag revealed the semi-annual inspection was performed in September 2024 and there were no monthly inspections listed. The facility did not have monthly inspection documentation indicating the monthly owners inspection had been performed for the previous 12 months. No further documentation was provided. In an interview at the time, the US FOIA (b)(6) confirmed the observation and stated they didn not do an owners inspection. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 4:17 PM. NJAC 8:39-31.2(e) NFPA 17 A, 96	K 324	chemical suppression system for February 2025 and March 2025. Criteria 2 All residents have the potential to be affected by this deficient practice. The facility corrected the deficiency as it relates to the individual by having our maintenance staff performed and documented the February 2025 and March 2025 monthly owner's inspections. The facility will continue to record the monthly owner's inspection regularly. This practice will ensure the facility keeps all individuals safe. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the monthly inspection of the kitchen range hood fire suppression system. This monitoring will be part of the monthly maintenance program. Criteria 3 On March 28, 2025, the Director of Environmental Services (DES) educated the maintenance staff to ensure the staff performs monthly inspections and documents the monthly inspections. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the kitchen range hood fire suppression system is inspected monthly and the inspection is documented. This monitoring will be part of the monthly maintenance program. The vendor completed the semi-annual	

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K 324	Continued From page 19	K 324	inspection of the kitchen range hood fire suppression system on March 19, 2025. The maintenance staff performed and documented the monthly owner's inspections of the range-hood fire wet chemical suppression system for February 2025 and March 2025. Criteria 4 Once a month for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the kitchen range hood fire suppression system for monthly inspection and ensure that the inspection is documented. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5 Completion date: March 28, 2025	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced	K 345		3/19/25

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K 345	Continued From page 20 by: Based on record review and interview on 2/25/25 and 2/26/25 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to ensure sensitivity testing of smoke detectors in accordance with NFPA 101:2012 Edition, NFPA 70:2011 Edition and NFPA 72:2010 Edition. The deficient practice had the potential to affect all residents and was evidence by the following: A record review on 2/25/25 at 10:45 AM of the fire alarm inspection, testing and maintenance reports revealed there were no documents that sensitivity testing was conducted on the facilities 223 smoke detectors. In an interview on 2/25/25 at 2:17 PM, the surveyor reviewed concerns from the record review and requested fire alarm smoke detector sensitivity testing reports from the US FOIA (b)(6) in the presence of the US FOIA (b)(6) . No further documentation was provided. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 2/26/25 at 4:17 PM. NJAC 8:39-31.2 (e) NFPA 70, 72	K 345	Criteria 1 The Director of Environmental Services (DES) contacted Atlantic County Fire Marshall regarding the fire alarm inspection, testing and maintenance reports revealed that there were no documents that sensitivity testing was conducted on the facilities 223 smoke detectors. The vendor was contacted, and the vendor provided the sensitivity report on March 19, 2025. Criteria 2 All residents have the potential to be affected by this deficient practice. Atlantic County Fire Marshall contacted the vendor for the sensitivity report. On March 19, 2025, the facility corrected the deficiency as it relates to the individual by having our vendor completed and provided the sensitivity report. Criteria 3 On 3/20/25, The Director of Environmental Services educated the staff to verify that the vendor provides the sensitivity report with its fire alarm inspection, testing and maintenance reports. The Director of Environmental Services (DES) and/or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will inspect the vendors log monthly. This monitoring will be part of the monthly maintenance program. The vendor submitted the sensitivity report on March 19, 2025.	

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K 345	Continued From page 21	K 345	Criteria 4 Once a quarter for the next two quarters, the director of environmental services will remind the vendor to provide the next sensitivity report along with the fire alarm inspection, testing and maintenance reports. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5 Completion date: March 19, 2025.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		4/17/25

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K 353	Continued From page 22 by: Based on observations and interviews on 2/26/25 in the presence of the U.S. FOIA (b) (6) [redacted] it was determined the facility failed to ensure fire sprinkler system components and smoke barriers were maintained in accordance with NFPA 13: 2010 Edition, NFPA 25: 2011 Edition, and NFPA 101: 2012 Edition. The deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a facility tour from 11:30 AM to 3:12 PM revealed: 1. The electrical room by activities had 3-inch metal conduit and bx wire penetrating through the drop ceiling above the electrical panels in 12 places where the openings were not sealed to prevent the passage of smoke. The openings in the drop ceiling smoke barrier containing sprinkler heads would allow the smoke and hot gasses to escape into the space above the drop ceiling delaying sprinkler activation. 2. Resident room 253 had 1 sprinkler head escutcheon positioned inside the plane of a bulging ceiling tile and had a half inch space around the escutcheon open to the space above. 3. Electrical room 240 had 3 electrical panels and 1 box with 3-inch metal conduit bx wire and other wire pipes penetrating through the drop ceiling above the electrical panels in 11 places where the openings were not sealed to prevent the passage of smoke.	K 353	Criteria 1 The Director of Environmental Services (DES) contacted Atlantic County Facilities Representative regarding the following: 1. Electrical room by activities had 3-inch metal conduit and bx wire penetrating through the drop ceiling. 2. Resident room 253 had 1 sprinkler head escutcheon positioned inside the plane of a bulging ceiling tile and had a half inch space around the escutcheon open to the space above. 3. Electrical room 240 had 3 electrical panels and 1 box with 3-inch metal conduit bx wire and other wire pipes penetrating through the drop ceiling above the electrical panels in 11 places where the openings were not sealed to prevent the passage of smoke. 4. Equipment storage room 142 had 2 insulated pipes going through a 5-inch by 8-inch hole in the drop ceiling. Also, a phone box and PA system had wires penetrating through the drop ceiling above the panels where the openings were not sealed to prevent the passage of smoke. 5. Fire panel electrical room 140 had wires and 3-inch metal tubes in 32 places penetrating through the drop ceiling above the panels where the openings were not sealed to prevent the passage of smoke. 6. Janitors closet room 141 had two 5 inch and two 6 inch pipes penetrating through the drop ceiling where the openings were not sealed to prevent the passage of smoke. 7. The first floor main dining room ceiling had 8 of 13 sprinkler head escutcheons	

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K 353	Continued From page 23 4. Equipment storage room 142 had 2 insulated pipes going through a 5-inch by 8-inch hole in the drop ceiling. Also, a phone box and PA system had wires penetrating through the drop ceiling above the panels where the openings were not sealed to prevent the passage of smoke. 5. Fire panel electrical room 140 had wires and 3-inch metal tubes in 32 places penetrating through the drop ceiling above the panels where the openings were not sealed to prevent the passage of smoke. 6. Janitors closet room 141 had two 5 inch and two 6 inch pipes penetrating through the drop ceiling where the openings were not sealed to prevent the passage of smoke. 7. The first floor main dining room ceiling had 8 of 13 sprinkler head escutcheons coming down from their proper installation location and not flush with the ceiling. 8. Kitchen storage room 107C had openings in the sheet rock wall by the ceiling. There was 3-foot by 5-inch opening on left wall, a 5-inch by 5-inch hole around a drain pipe, a 23-inch by 7-inch hole next to duct work and a 23-inch by 12-inch hole next to duct work on the adjacent wall. 9. A kitchen storage room was missing two 2-inch by 2-foot and one 8-inch by 2-foot ceiling tile next to a sprinkler head on the ceiling. 10. Two kitchen sprinkler heads by the dishwasher were loaded with dust.	K 353	coming down from their proper installation location and not flush with the ceiling. 8. Kitchen storage room 107C had openings in the sheet rock wall by the ceiling. There was 3- foot by 5-inch opening on left wall, a 5-inch by 5- inch hole around a drain pipe, a 23-inch by 7-inch hole next to duct work and a 23-inch by 12- inch hole next to duct work on the adjacent wall. 9. A kitchen storage room was missing two 2- inch by 2-foot and one 8-inch by 2-foot ceiling tile next to a sprinkler head on the ceiling. 10. Two kitchen sprinkler heads by the dishwasher were loaded with dust. 11. The first floor family and friends room drop ceiling had 2 of 4 sprinkler heads with a half inch space around the side of the escutcheons. 12. The first floor electrical closet across from elevator #3 had unsealed wire penetrations through the ceiling. 13. Electrical room G40 had wires, conduit and metal pipe penetrating through the concrete ceiling where the spaces created were not fire stopped in 8 of the 12 locations. The vendor was contacted. The vendor corrected all 13 listed issues on April 17, 2025. Criteria 2 All residents have the potential to be affected by this deficient practice. On April 17, 2025, the facility corrected the deficiency as it relates to the individual by having our vendor corrected all 13 listed issues. The Director of Environmental	

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K 353	Continued From page 24 11. The first floor family and friends room drop ceiling had 2 of 4 sprinkler heads with a half inch space around the side of the escutcheons. 12 The first floor electrical closet across from elevator #3 had unsealed wire penetrations through the ceiling. 13. Electrical room G40 had wires, conduit and metal pipe penetrating through the concrete ceiling where the spaces created were not fire stopped in 8 of the 12 locations. In interviews at the times, the US FOIA (b)(6) [redacted] confirmed the observations. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 4:17 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure to inspect all 13 listed issues monthly. This monitoring will be part of the monthly maintenance program. Criteria 3 On April 4, 2025, the Director of Environmental Services (DES) provided in-service training to the maintenance staff about all 13 listed issues. The Director of Environmental Services (DES) and/or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will inspect all 13 listed issues monthly. This monitoring will be part of the monthly maintenance program. The vendor corrected all 13 listed issues on April 17, 2025. Criteria 4 Once a month for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit all 13 listed issues. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5 Completion date: April 17, 2025.	
K 531 SS=F	Elevators CFR(s): NFPA 101	K 531		4/4/25

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K 531	Continued From page 25 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 2/25/25 and 2/26/25 in the presence of the[US FOIA (b)(6) [redacted], it was determined that the facility failed to conform with Firefighter's Service Requirements of ASME/ANSI A17.3 and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4.2 and 9.4.3. This included firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation for 3 of 3 devices. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 531	Criteria 1 The Director of Environmental Services (DES) contacted Atlantic County Facilities Management Representative regarding the firefighter's service was not conducted for 10 of the last 12 months for 2 of the elevators and not conducted for 12 of the last 12 months for the other one of the elevators and incomplete documentation of elevator services and reports. Atlantic County Facilities Management Representative reminded the vendor regarding firefighter's service and incomplete documentations. On March 31, 2025, the vendor completed and documented the fire fighter's service on all three elevators. On March 31, 2025, the	

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K 531	Continued From page 26 Observations on 2/25/25 revealed there were 3 elevators that each served the three levels of the facility. A record record review showed that the firefighters service was not conducted for 10 of the last 12 months for 2 of the elevators and not conducted for 12 of the last 12 months for the other one of the elevators. The documents provided demonstrated that the elevator service company that performed the monthly service filled out two " Hydraulic Elevator Maintenance Check Chart" forms for 2024 and did not fill out the elevator number indicating which elevator was being tested. January, February and March were the only months filled out on the two forms, The columns and rows on the two forms for the months of April to December 2024 were blank. There was no 2025 " Hydraulic Elevator Maintenance Check Chart" form for any of the 3 elevators. In an interview on 2/25/25 at 2:17 PM, the surveyor reviewed the missing Phase I and Phase II firefighters monthly recall documentation for the 3 passenger elevators with the facility. No further firefighters service test documents were provided. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 4:17 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	vendor provided the annual hydraulic pressure tests report completed on 12/4/2024. Criteria 2 All residents have the potential to be affected by this deficient practice. The facility corrected the deficiency as it relates to the individual by having our vendor completed and documented the fire fighter's service for all three elevators on March 31, 2025. On March 31, 2025, the vendor provided the annual hydraulic pressure tests report completed on 12/4/2024. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the monthly elevators' reports for proper documentation. This monitoring will be part of the monthly maintenance program. Criteria 3 By April 4, 2025, the Director of Environmental Services (DES) will educate the maintenance staff to ensure the staff knows how to check the monthly elevator inspection reports for accuracy and ensure that the inspection is documented properly. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the checking of the monthly elevators' reports for proper documentation. This monitoring will be part of the monthly maintenance program. On March 31, 2025, the vendor corrected	

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K 531	Continued From page 27	K 531	the deficient practice. The vendor completed and documented the fire fighter's service on all three elevators. On March 31, 2025, the vendor provided the annual hydraulic pressure tests report completed on 12/4/2024. Criteria 4 Once a month for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will audit the monthly elevator inspection reports for accuracy and ensure that the inspection is documented properly. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5 Completion date: April 4, 2025.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		4/24/25

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K 761	Continued From page 28 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 2/25/25 and 2/26/25 in the presence of the Administrator, it was determined that the facility failed to ensure that fire and smoke door assemblies were inspected and tested annually with written record in accordance with NFPA 80: 2010 Edition Sections 5.2.1, 5.2.3, 5.2.4.2 (1) through (11), NFPA 105:2010 Edition, and NFPA 101: 2012 Edition, Sections 7.2.1.15.1 to 7.2.1.15.8, 8.3.3.1, and 19.7.6. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 02/25/25 and 02/26/25 revealed there was no documentation that annual inspections of fire door assemblies were conducted and no documentation that inspections of smoke door assemblies were conducted as part of the facilities maintenance program. In an interview on 2/26/25 at 9:20 AM, the surveyor informed the US FOIA (b)(6) that during the record review on 2/25/25 there were no records that the fire doors were inspected annually and no record that the smoke doors were inspected as part of a facility maintenance program at least annually. The surveyor requested inspection reports for the facility's fire and smoke doors at the time. The US FOIA (b)(6) wrote down the request and stated that another department did the inspections and he will get them. No further documentation was provided. The facility's US FOIA (b)(6) was informed that	K 761	Criteria 1 The Director of Environmental Services (DES) contacted Atlantic County Facilities Management Representative regarding no annual inspection of the fire and smoke door assemblies. Atlantic County Facilities Management Representative contacted the vendor. On April 7, 2025, the vendor completed and provided the report for the annual inspection of fire and smoke door assemblies. Criteria 2 All residents have the potential to be affected by this deficient practice. On April 7, 2025, the facility corrected the deficiency as it relates to the individual by having our vendor completed and provided the report for the annual inspection of fire and smoke door assemblies. The Director of Environmental Services (DES) and/or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) are responsible for performing monthly inspections of all fire and smoke door assemblies. This monitoring will be part of the monthly maintenance program. Criteria 3 On April 4, 2025, the Director of Environmental Services (DES) in-serviced the maintenance staff regarding the fire and smoke door assemblies. The Director	

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K 761	Continued From page 29 documentation of the fire and smoke door inspections were required on 2/26/25 at the 9:20 AM interview. The facility's[US FOIA (b)(6) redacted] were informed of the deficient practice at the Life Safety Code exit conference on 2/26/25 at 4:17 PM. NJAC 8:39-31.2 (e) NFPA 80, 105	K 761	of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure that the vendor conducts the required annual inspection, while the maintenance staff is responsible for performing monthly inspections of all fire and smoke door assemblies. This monitoring will be part of the monthly maintenance program. On April 7, 2025, the vendor completed and provided the report for the annual inspection of fire and smoke door assemblies. Criteria 4 Once a month for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will inspect and audit the fire doors. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5 Completion date: April 24, 2025.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not	K 914		3/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315358	A. BUILDING 01 B. WING _____	03/03/2025

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K 914	Continued From page 30 listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation record review and interview on 2/25/25 and 2/26/25 in the presence of the[US FOIA (b)(6) [redacted]), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, blade tension and physical integrity in accordance with NFPA 99: 2012 Edition, Section 6.3, and 6.3.3.2, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations and interview on 2/26/25 confirmed that the facility had non-hospital grade outlets installed in resident rooms. A documentation review on 2/25/25 between 10:00 AM and 3:00 PM revealed there was an	K 914	Criteria 1 The Director of Environmental Services (DES) contacted Atlantic County Facilities Management Representative regarding the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, blade tension and physical integrity. Atlantic County Facilities Management Representative contacted the vendor. On March 21, 2025, the vendor provided the detailed report of the annual electrical receptacles tests in the residents' rooms. In the annual report, the four electrical outlet tests completed in the residents' rooms were as follows: grounding, polarity, blade tension and physical integrity. Criteria 2 All residents have the potential to be	

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K 914	Continued From page 31 annual inspection report from an electrical service company that checked the facility's electrical panels and did not include checking outlets in resident rooms. There was no documentation that the required resident bed side electrical outlets inspections and tests for: physical integrity, grounding, polarity and blade tension were performed in the last 12 months. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the documentation review. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 2/26/25 at 4:17 PM. NJAC 8:39-31.2(e) NFPA 99	K 914	affected by this deficient practice. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the visual checking of the electrical outlets in the residents' rooms. This monitoring will be part of the monthly maintenance program. The facility corrected the deficiency as it relates to the individual by getting the completed electrical outlets in residents' rooms report for grounding, polarity, blade tension and physical integrity. On March 21, 2025, the vendor provided the detailed report of the annual electrical outlets' tests in the residents' rooms. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure the grounding, polarity, blade tension and physical integrity tests are included in the electrical report. They will ensure the monthly visually inspection the electrical outlets in the residents' rooms. This monitoring will be part of the monthly maintenance program. Criteria 3 By March 28, 2025, the Director of Environmental Services (DES) will educate the maintenance staff to ensure the staff visually inspects the electrical outlets in the residents' rooms and contact the electrical vendor for further assistance. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) or designee will ensure the monthly visually	

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K 914	Continued From page 32	K 914	inspection the electrical outlets in the residents' rooms. This monitoring will be part of the monthly maintenance program. The continuous monitoring will ensure the safety of our residents. On March 21, 2025, the vendor provided the detailed report of the annual electrical outlets in the residents' rooms. Criteria 4 Once a month for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will visually inspect the electrical outlets in residents' rooms. For two quarters, the audit results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5 Completion date: March 28, 2025.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		4/24/25

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K 918	Continued From page 33 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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 2/25/25 and 2/26/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure: 1. the generators' monthly load test was performed for 9 of the last 12 months, 2. the transfer time of power from the primary source to the secondary source was within 10 seconds during the monthly load tests, 3. the diesel generator set was exercised at a load of 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual	K 918	Criteria 1 The Director of Environmental Services (DES) contacted Atlantic County Facilities Management Representative and the county representative contacted the vendor. The facility addressed the following five concerns: 1. The generators' monthly load test was performed for 9 of the last 12 months. The facility addressed the generators' monthly load test concern by contacting the vendor. On 4/24/25, the vendor completed the load tests for both the 300kw and 600kw generators.	

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K 918	Continued From page 34 load bank test, 4. a annual fuel sample was analyzed and 5. a 36 month 4 hour load test or load bank test (if load bank is required) was performed, in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Sections: 8.1.1, 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7, These deficient practices had the potential to affect all residents and were evidenced by: In an interview on 2/25/25 at 2:17 PM, the US FOIA (b)(6) stated that a service from the county performed the Inspections, Tests and Maintenance (ITM) of the facility's generators. The facility has a 300 Kilowatt (kW) and a 600 kW generator. The 300 kW serves the HVAC chillers and the 600 kW serves the emergency power to the building. A record review on 2/25/25 and 2/26/25 of the emergency power generator monthly ITM service reports revealed the facility's documents: 1. Showed no document of a monthly ITM performed for January 2025 and March 2024. Additionally, there was No load or N/A listed under the load present row on the monthly ITM reports for the months of: December, November, October, September, August, July and June of 2024. 2. Did not have any time recorded for the time it took for the power to transfer from utility to the generator power to indicate if this was done within the 10 second requirement. 3. Did not record the percentage of the EPS nameplate KW rating that the generator was	K 918	2. The transfer time of power from the primary source to the secondary source was within 10 seconds during the monthly load tests. The facility addressed the transfer time of power from the primary source to the secondary source within 10 seconds by contacting the vendor, and the vendor completed the transfer time of power from the primary source to the secondary source within 10 seconds on 4/1/2025 and again during the Aprils Inspections, Tests and Maintenance (ITM) of the facility's generators. 3. The diesel generator set was exercised at a load of 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test. The facility addressed the 90 minute annual load bank test concern by contacting the vendor, and the vendor completed the 2 hour annual load bank test for the 600kw generator on 3/11/2025 and completed the load test for the 300kw generator on 3/12/2025. 4. An annual fuel sample was analyzed. The facility addressed the annual fuel sample concern by contacting the vendor, and the vendor completed the annual fuel sample test on 4/24/2025. 5. A 36-month 4-hour load test or load bank test (if load bank is required). The facility addressed the 36-month 4-hour load test concern by contacting the vendor, and the vendor completed the 36-month 4-hour load test on 4/1/2025. Criteria 2 All residents have the potential to be affected by this deficient practice. On April	

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K 918	Continued From page 35 exercised monthly to determine if the load met the 30% of the nameplate rating requirement or perform a 90 minute annual load bank test for the last 12 months. 4. Did not take a fuel sample to be analyzed to ensure the fuel was not contaminated. 5. Had no document that a 36 month, 4 hour load test or load bank test (if load bank is required) was performed in the last 3 years. In an interview on 2/26/25 at 11:12 AM, the surveyor reviewed the generator records that were still required. The US FOIA (b)(6) stated he will call the department that services the generator. No further documents that applied were provided. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 4:17 PM. NJAC 8:39-31.2 (e) NFPA 99, 110	K 918	24, 2025, the facility corrected the deficiency as it relates to the individual by having our vendor completed and provided the generator reports for the five issues identified. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will ensure that the facility has all the necessary monthly, annual and triannual testing completed and documented. This monitoring will be part of the monthly maintenance program. Criteria 3 On April 4, 2025, the Director of Environmental Services (DES) provided in-service training to the maintenance staff about all 5 listed issues. The Director of Environmental Services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) or designee will verify that the vendor conducts and documents monthly, annual and triannual generator testing according to established schedules. This monitoring will be part of the monthly maintenance program. The vendor corrected the deficiency on April 24, 2025. Criteria 4 Once a month for 6 months, the director of environmental services (DES) and or Assistant Supervisor of Maintenance, Housekeeping and Laundry (ASMHL) will review the generator log to verify that the monthly, annual, and triannual testing has been completed and properly documented. For two quarters, the audit	

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K 918	Continued From page 36	K 918	results will be reported and reviewed in QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team. Criteria 5 Completion date: April 24, 2025.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315358 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/8/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	235 DOLPHIN AVE NORTHFIELD, NJ 08225

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	04/18/2025	LSC K0281	04/01/2025	LSC K0321	03/19/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	03/28/2025	LSC K0345	03/19/2025	LSC K0353	04/17/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	04/04/2025	LSC K0761	04/24/2025	LSC K0914	03/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	04/24/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/3/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO