STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. BUILDING _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	**325 JERSEY STREET TRENTON, NJ 08611**

(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 Complaints # NJ 172764, 175812, 177341 Survey dates: 11/18/2024- 11/25/2024 Census: 127 Sample Size: 25+ 3 Closed Records THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		1/24/25

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

Electronically Signed | 12/23/2024

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

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 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 maintain an environment that protected and valued a residents' private space along with their personal property. This deficient practice was identified for 1 of 28 residents reviewed for Resident Rights (Resident #77). During initial tour of the [NJ Exec Order 2] Floor on 11/18/2024 at 10:55 AM, the surveyor observed a housekeeper wiping the inside of Resident #77's bedside drawer that was located across from the resident's bed. The surveyor immediately	F 550	Resident #77 was interviewed by the [US FOIA (b)] and had NJ Exec Order 26.4b1 from the deficient practice. All current residents have the potential to be affected by the deficient practice All housekeeping staff were educated by the Director of Housekeeping that no resident drawers should be opened/cleaned unless the room is on the list to be deep cleaned that day. Staff were also educated by the Director of Housekeeping that even if the room is on	

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F 550	Continued From page 2 requested the assistance of the Registered Nurse Unit Manager (RN/UM#1) and upon the return to the resident's room, the surveyor and RN/UM#1 heard Resident #77 [NJ Exec] to the housekeeper [NJ Exec Orde] and that they didn't give NJ Exec Order 26.4b1. The surveyor inquired if housekeeping has permission to go inside of resident's personal drawers. RN/UM #1 responded that they can open resident's drawers if the room was set to be carbolized (terminal cleaned). The surveyor inquired if Room [NJ Exec] was scheduled to be carbolized, to which RN/UM#1 denied and confirmed that housekeeping should not go into resident drawers without permission. The surveyor attempted to interview the housekeeper, but was unable due to language barrier. On the above date and time, the surveyor requested to speak with the US FOIA (b)(6) The [US FOI] confirmed that Room [NJ Exec] was not scheduled to be terminally cleaned and that it was common knowledge that Resident #77 [NJ Exec Order 26.4b1] for [NJ Exec] room to be cleaned or touched. [US FOI] also confirmed that housekeeping should not open and enter resident's personal drawers. The surveyor reviewed the medical record for Resident #77. A review of the Admission Record face sheet (an admission summary) reflected that Resident #77 was admitted to the facility with diagnosis that included, but not limited to [NJ Exec Order 26.4b1]	F 550	the deep clean schedule for the day, if a resident verbalizes that it is their preference to not have their drawers cleaned by houskeeping, they have the right to refuse, and they should report to the Unit Manager that the resident declined to have their drawers cleaned. To ensure compliance, the Housekeeping Director will audit staff while cleaning 10 rooms; weekly x 4, then monthly x 2. Results will be brought to the quarterly QAPI until compliance is achieved. The administrator is responsible for ensuring compliance	

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F 550	Continued From page 3 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [NJ Exec Order 26.4], reflected a brief interview for mental status (BIMS) score of [NJ Ex] out of 15, which indicated the resident is NJ Exec Order 26.4b1 On 11/21/2024 at 12:00 PM, the surveyor interviewed the US FOIA (b)(6) who advised that housekeeping should not be in resident drawers without permission. The [US FOIA (b)] further acknowledged that she is familiar with the Resident #77 and NJ Exec Order 26.4b1 On 11/22/24 at 11:45 AM, the US FOIA (b)(6) in the presence of the US FOIA (b)(6) and the survey team, acknowledged that residents have an expectation of privacy when it comes to personal property. A review of the facility's "Environmental Services Operational Manual" document, revised 6/2016, included under "Daily Patient Room Cleaning" section "Additional Information" included: "Remember, the housekeeper may be the major part of the Resident's social contact; be kind and courteous ..." A review of the facility's undated "Resident Rights" policy identified that "Employees shall treat all residents with kindess, respect, and dignity" and included: "Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity ...". NJAC 8:39-4.1(a)12	F 550		

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F 558	Continued From page 4	F 558		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 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 maintain the call bell within reach for 1 of 28 sampled residents, (Resident #90). This deficient practice was evidenced by the following: On 11/18/2024 at 10:49 AM, upon initial tour of the [redacted] Floor, the surveyor observed Resident #90's call bell on the floor under the bed. When asked about their call bell, Resident #90 was unsure where it was and if they had one. On 11/19/2024 at 11:17 AM, the surveyor observed the call bell on the floor underneath the resident's bed. On 11/20/2024 at 12:26 PM, the surveyor observed the call bell on the floor underneath the resident's bed. The surveyor reviewed the medical record for Resident #90. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [redacted]	F 558	Resident #90s call bell was immediately placed within reach of the resident. Resident #90 was interviewed by the [redacted] and had NJ Exec Order 26.4b1 for the deficient practice. All current residents have the potential to be affected by the deficient practice. All nursing staff were educated by the Director of Nursing/Designee on checking call bell location when they are doing their every 2 hour rounds to ensure that the call bells are within reach of all residents and that whenever staff is entering a room, they should ensure that the call bell is within reach of the resident. Staff was educated to put into TELs if a call bell is not working, or does not have a clip so that maintenance can replace. To ensure compliance, Unit Managers will audit their floors daily x 2 weeks, then weekly x 2 weeks, then monthly x 2 months. Results will be brought to the quarterly QAPI until compliance is achieved. DON is responsible for ensuring compliance.	1/24/25

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F 558	Continued From page 5 NJ Exec Order 26.4b1 [redacted].	F 558		

A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec out of 15, which indicated the resident's NJ Exec Order 26.4b1 [redacted].

A review of the resident's individual comprehensive care plan (ICCP) included a focus area, that the "Resident is at NJ Exec Order 26.4b1 related to: NJ Exec Order 26.4b1, NJ Exec Order 26.4b1" with interventions that included: "place call light within reach at all times" and "remind resident to use call light when attempting to NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 [redacted]

On 11/20/2024 at 12:48 PM, the surveyor interviewed the Certified Nursing Assistant (CNA#1) who confirmed that call lights are to be within resident's reach at all times.

On 11/20/2024 at 1:04 PM, the surveyor interviewed the Registered Nurse (RN#1) who stated that call bells are to be on the bed at all times.

On 11/20/2024 at 1:21 PM, the surveyor requested Registered Nurse Unit Manager (RN/UM#1) to accompany them to Resident #90's room. The surveyor inquired about the location of the call bell where RN/UM#1 located it on the floor under Resident #90's bed. RN/UM#1 confirmed that the call bell should be located within Resident #90's reach and it should not be on the floor under the bed.

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F 558	Continued From page 6 On 11/21/2024 at 12:00 PM, the surveyor interviewed the [redacted] who confirmed that call bells should be within reach of the resident and that the call bells have clips that secure them to the bed. On 11/22/24 at 11:45 AM, the [redacted], in the presence of the [redacted] and the survey team, acknowledged that call bells should be within reach of the resident. A review of the facility's "Call Lights, Accessibility and Timely Response" policy, revised 8/28/24, included "5. Staff will ensure he call light is within reach of the resident and secured, as needed [...]".	F 558		
F 584 SS=E	NJAC 8:39-31.8 (c) (9) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		1/24/25

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F 584	Continued From page 7 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. 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 to maintain the resident's environment, equipment, and living areas in a safe, sanitary, and homelike manner. This deficient practice was identified for 3 of 3 nursing units observed for environment. This deficient practice was evidenced by the following: The surveyor conducted a tour of the [redacted] Floor on 1/18/2024 at 9:42 AM. Surveyor # 1	F 584	1. In central bath on [redacted] floor, 2 washcloths and a hairbrush that were observed on a shower chair were removed immediately. [redacted] were noted for this deficient practice. All current residents have the potential to be affected by the deficient practice. All nursing staff were educated by the Director of Nursing and/or the Assistant Director of Nursing on ensuring that all	

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F 584	Continued From page 8 interviewed Registered Nurse/Unit Manager (RN/UM #1) who explained that the [NJ Exec Order 2] Floor consisted mostly of long term care residents. RN/UM #1 informed Surveyor # 1 that Housekeeping was responsible for cleaning/maintaining the resident rooms and daily touch surfaces and the certified nursing assistants (CNAs) were responsible for making beds, changing bed linens, and general cleanliness of the rooms. During the tour the surveyor observed the following: 1. In the central bath across from Room [NJ Exec O] Surveyor # 1 observed two dirty wash cloths or towels on top shower chair with a dirty hair brush underneath the shower chair. 2. In Room [NJ Exec Order 2] the surveyor observed Resident #77's mattress to have sections of blue plastic worn through to the white fibers. 3. In Room [NJ Exec O] Surveyor # 1 interviewed Resident #90 who stated that their bathroom light does not work. Surveyor # 1 observed Resident #90 enter the room and attempt to turn on the light with no success. Resident #90 also advised that their television does not work because they do not have a remote control. Resident #90 confirmed that they have made the staff aware of the light and television but nothing came of it. On 11/20/2024 at 12:48 PM, Surveyor # 1 interviewed the Certified Nursing Assistant (CNA#1) who stated that they were responsible for ensuring the general safety and condition of the resident's room. When asked if they would check to ensure the condition of the resident	F 584	personal items are removed from the shower rooms after showering each resident. Unit managers will audit their unit shower rooms weekly x 4, then monthly x 2 to ensure compliance. Results will be brought to Quarterly QAPI until compliance is achieved. DON is responsible to ensure compliance. 2. Resident # 90 was given a TV remote immediately upon notification that they were missing their remote, and bathroom light was fixed immediately by maintenance. Resident #90 was interviewed by DON and [NJ Ex Order 26.4b1] from the deficient practice. Resident #77's mattress was replaced immediately upon notification that it was worn. Resident was immediately interviewed by the DON and had no negative outcomes from the deficient practice. Room [NJ Ex Ord] was noted to have a missing drawer on their wardrobe. The drawer was replaced immediately upon notification to maintenance. On 11/20/24, in room [NJ Ex Or], it was observed that the plastic on the foot board of Resident #229's bed had separated. Upon notification, it was repaired immediately by Maintenance. Resident 229 was assessed by the DON and [NJ Ex Order 26.4b1] from this deficient practice. All current residents have the potential to be affected by the deficient practice. All staff were educated by the Director of	

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F 584	Continued From page 9 mattresses and function of lights, CNA #1 confirmed. If they found something that was unsafe or broken in the room, CNA #1 stated that they would report it to the nurse and unit manager. On 11/20/2024 at 1:04 PM, Surveyor # 1 interviewed Registered Nurse (RN#1) who confirmed that they were responsible for safety checks, including the functionality of lights and condition of beds/mattresses. On 11/20/2024 at 1:13 PM, Surveyor # 1 conducted a follow-up interview with RN/UM#1 who stated that any resident room concerns would be submitted through a computerized system by the nurses. RN/UM#1 stated that the CNA's did not have access to the computer system. When asked about the functionality of resident bathroom lights or televisions, RN/UM#1 reported that he checks all the equipment in the room and would make a note if anything was out of order. On 11/20/2024 at 1:21 PM, Surveyor # 1 requested RN/UM#1 to Room [redacted] where he confirmed that the bathroom light cannot be easily turned on and that Resident# 90's television could not be turned on since there was no remote control. On 11/20/2024 at 1:27 PM, Surveyor # 1 showed a picture of Resident #77's mattress where the plastic was worn through to white fibers. RN/UM#1 stated, "I find it hard to believe the mattress [was] like that". Upon entering Room [redacted] and viewing the mattress RN/UM#1 responded, "Oh my God it is". RN/UM#1 indicated that the mattress should have been reported long	F 584	Nursing and/or the Assistant Director of Nursing on reporting issues immediately and putting them into TELs so that they can be addressed as soon as possible by Maintenance. To ensure compliance, Unit managers will perform weekly audits x 4, then monthly audits x 2 months on all rooms on their units. Results will be brought to the quarterly QAPI until compliance is achieved. DON is responsible for ensuring compliance. 3. housekeeping immediately placed a liner in the garbage can and the gloves were removed from the tub immediately on 2nd floor low side shower room. All current residents have the potential to be affected by the deficient practice. All nursing staff were educated by the Director of Nursing and/or ADON to remove all items from the shower rooms after showering residents. All housekeeping staff were educated by the Director of Housekeeping on ensuring that all trash cans have a liner after they empty the trash. To ensure compliance, Unit Managers will perform weekly audits x 4, then monthly audits x 2 to ensure that shower rooms are clean and free of personal belongings. Housekeeping director will perform audits weekly x 4, then monthly x 2 to ensure that housekeeping staff are placing liners	

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F 584	Continued From page 10 ago. On 11/21/2024 at 12:00 PM, Surveyor # 1 interviewed the US FOIA (b)(6)) who confirmed upon viewing the picture of the central bath that it should have been cleaned after resident use; Resident #77's mattress should have been reported by "housekeeping, CNAs, everyone"; and Resident #90's television and light should have been in working order. On 11/22/24 at 11:45 AM, the US FOIA (b)(6) , in the presence of the US FOIA (b)(6) the survey team, acknowledged that the central bath should have been cleaned after resident use; Resident #77's mattress should have been reported; and Resident #90's television and light should have been in working order. On 11/19/2024 at 11:17 AM during initial while doing rounds Surveyor # 2 observed a missing drawer on the wardrobe in room [redacted] During an interview on 11/21/2024 at 10:10 AM with Surveyor # 2, the US FOIA (b)(6) said when they notice broken or missing pieces of furniture, they would send a request to maintenance through the [redacted] system. When Surveyor # 2 showed the [redacted] the missing drawer the [redacted] said she didn't know the drawer was missing. During an interview on 11/22/2024 at 10:34 AM with Surveyor # 2 the US FOIA (b)(6) said they do room rounds every three to six months and that the last one was done in July of 2024. The [redacted] said there should be no broken furniture for the safety of the residents.	F 584	in every trash can after emptying the trash. Results will be brought to the quarterly QAPI until compliance is achieved. DON is responsible to ensure compliance. 4. Second floor low side shower room – sharps bin on the wall in the shower room was noted to be full and not emptied. Upon notification, the sharps bin was removed and replaced with a new, empty bin. All current residents have the potential to be affected by the deficient practice. All nursing staff were educated by the Director of Nursing and/or the Assistant Director of Nursing on checking and emptying all sharps containers when full. To ensure compliance, Unit Managers will perform weekly audits x 4, then monthly audits x 2 to ensure that all sharps containers are replaced when full on their units. Results will be brought to the quarterly QAPI until compliance is achieved. DON is responsible to ensure compliance. 5. On 11/20/24, it was observed that the medication cart on the high side of second floor had hair tangled in the wheels of the cart, and residual stains and wrappers were observed in the attached disposable glove holder on the side of the cart. It was also observed that the medication cart on the low side of second floor had hair	

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RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	325 JERSEY STREET TRENTON, NJ 08611

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F 584	Continued From page 11 During an interview on 11/22/2024 at 11:45 AM with Surveyor # 2, the [redacted] said there should be no missing or broken furniture in the rooms. The [redacted] then said the nurse had reported to maintenance that day after the surveyor had brought it to her attention, and the drawer had been replaced. On 11/18/2024 at 10:34 AM during the initial tour on the [redacted] floor in the low side shower room, Surveyor # 3 observed a trash can without a bag liner. The surveyor observed disposable gloves discarded in the whirlpool tub. The sharps bin on the wall was full and not emptied. The plastic lid indicated, "Full". On 11/20/2024 at 10:09 AM in the second floor shower room, Surveyor # 3 observed the sharps bin still indicating, "full". On 11/20/2024 at 10:10 AM in room 204, Surveyor # 3 observed the plastic on the foot board of Resident # 229's bed separated. Resident # 229 was asleep in the bed at that time. On 11/20/2024 at 10:13 AM, Surveyor # 3 observed the high side medication cart on the second floor. At that time, Surveyor # 3 observed hair tangled in the wheels of the cart. Surveyor # 3 observed residual stains and wrappers in the attached disposable glove holder on the side of the cart. On the same date at 10:15 AM, Surveyor # 3 observed the low side medication cart on the second floor. At that time, Surveyor # 3 observed hair tangled in the wheels of the cart. On 11/19/2024 at 11:49 AM, Surveyor # 4	F 584	tangled the wheels of the cart. Both medication carts were cleaned and the hair was removed from the wheels immediately upon notification. All current residents in the facility have the potential to be affected by the deficient practice. [redacted] was educated by the Director of Nursing and/or the Assistant Director of Nursing on cleaning medication and treatment carts, and a cleaning schedule was created to ensure that all carts will be deep cleaned as scheduled. To ensure compliance, Housekeeping director will perform weekly audits x 4, then monthly audits x 2 months on all medication and treatment carts to ensure they are being cleaned properly and that housekeeping staff are adhering to the cleaning schedule. Results will be brought to the quarterly QAPI until compliance is achieved. The administrator is responsible to ensure compliance. 6. [redacted] assessed Residents on [redacted] and [redacted] floor who eat in the Dining room, and there were no negative outcomes as a result of serving meals on their tray, without inquiring regarding personal preferences for serving the meal All current residents in the facility have the potential to be affected by the deficient practice.	

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F 584	Continued From page 12 observed lunch in the dining room on the [redacted] floor. Surveyor # 4 observed staff serve the residents on meal trays and not remove the items from the tray as well as not inquiring the residents' preferences. On 11/20/2024 at 1:27 PM, Surveyor # 4 observed lunch in the dining room on the [redacted] floor. Surveyor # 4 observed staff serve the residents on meal trays and not remove the items from the tray as well as not inquiring the residents' preferences. On 11/20/2024 at 1:29 PM, during an interview with the surveyor, the US FOIA (b)(6) [redacted]) on [redacted] floor said that normally, meals are served on the trays in the dining room area. On 11/20/2024 at 1:30 PM, during an interview with Surveyor # 4, the Certified Nurse Aide (CNA) said that meals are served on the trays to residents in the dining room area. A review of the facility's undated "Quality of Life-Homelike Environment" policy identified that "Residents are provided with safe, clean, comfortable and homelike environment [...]" and included: "2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. cleanliness and order; b. comfortable (minimum glare) yet adequate (suitable to the task) lighting [...]". A review of the facility's undated "Quality of Life-Dignity" policy identified that "Each resident shall be cared for in a manner that promotes and	F 584	All nursing staff were educated by the Director of Nursing and/or the Assistant Director of Nursing on removing items from the meal trays when serving all meals and asking all residents their preferences at the time they are serving their meals. To ensure compliance, Unit Managers will perform weekly audits x 4, then monthly audits x 2 months to ensure staff are removing all items from the trays during meal service and are asking the residents their preferences at each meal. Results will be brought to the quarterly QAPI until compliance is achieved. DON is responsible to ensure compliance.	

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F 584	Continued From page 13 enhances quality of life, dignity, respect and dignity" and included: "1. Resident shall be treated with dignity and respect at all times; 2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth [...]". NJAC 8:39-4.1 (a), 11, 12, 21.3 (a) (b), 27.2 (j), 31.2 (a-e), 31.3, 31.4 (a-f)	F 584		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review it was determined that the facility failed to maintain documentation and ensure that a complete and thorough investigation was conducted for residents that had a [redacted] This deficient practice was identified for 1 of 4	F 610	F610 A statement was obtained immediately by the [redacted] from the resident's assigned nurse at the time of the [redacted] There was [redacted] to the resident as a result of the missing statement.	1/24/25

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F 610	Continued From page 14 Residents (Resident #8) reviewed for accidents and was evidenced by the following: On 11/19/2024 at 12:PM, the surveyor requested all accidents and/or investigations during the timeframe of NJ Exec Order 26.4b1. The facility provided information related to Resident #8 sustaining a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. Upon review of the NJ Exec investigation titled, "NJ Exec Order 26.4b1" dated NJ Exec Order 26.4b1 at 2:19 PM revealed under Incident Description: "Heard a noise from the hall and got up to check and saw NJ Exec Order 26.4b1. There was an aide sitting in the hallway and NJ Exec Order 26.4b1. Per aide resident's NJ Exec Ord and she saw resident NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1. The surveyor reviewed the medical record for Resident #8. A review of the Admission Record face sheet (an admission summary) reflected that Resident #8 was admitted to the facility with diagnosis that included, but not limited to NJ Exec Order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4, reflected a brief interview for mental status (BIMS) score of NJ out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b A review of the electronic medical record	F 610	All current residents in the facility have the potential to be affected by the deficient practice. All nursing staff were educated by the Director of Nursing/ADON regarding proper policy and procedure for documentation post falls/incidents. Policies for proper Fall investigations were reviewed by the DON, and All Nursing staff including the DON, ADON, and Unit managers, were re-educated by the corporate educator, regarding conducting proper fall investigations including obtaining statements from the staff. DON to audit all incident reports to ensure that all proper documentation is completed properly weekly x 4, then monthly x 2 months. Results will be brought to the quarterly QAPI until compliance is achieved. DON is responsible to ensure compliance.	

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F 610	Continued From page 15 progress notes did not include a nurse's note for the [NJ Exec Order 26.4b1].	F 610		

On 11/19/2024 at 3:34 PM, the surveyor interviewed Licensed Practical Nurse Supervisor (LPN/S#1), who advised that they were familiar with Resident #8's [NJ Exec] on [NJ Exec Order 26.4b1] LPN/S#1 recounted that she was called to the floor by the nurse assigned to Resident #8 and that the [NJ Exec] was witnessed by the certified nursing assistant. LPN/S#1 confirmed that vital signs were obtained, and the resident was [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4] The LPN/S#1 acknowledged that the assigned nurse was responsible for entering the assessment into the progress notes.

On 11/21/2024 at 11:22 AM, the surveyor interviewed Licensed Practical Nurse Unit Manager (LPN/UM#1) who advised that they were familiar with Resident #8's [NJ Exec] on [NJ Exec Order 26.4b1] LPN/UM#1 explained that following a [NJ Exec D] everyone that was a witness is expected to write a statement including the assigned nurse and certified nursing assistant. LPN/UM#1 advised that the nurse assigned to the [NJ Exec Order 26.4b1] will start the investigation and gather all the statements. The supervisor was expected to then review everything for completeness and submit to the [US FOIA (b)(6)]).

The surveyor requested that LPN/UM#1 review the [NJ Exec Order 26.4b1] that was provided by the [US FOIA (b)] on [NJ Exec Order 26.4b1]. The LPN/UM#1 confirmed that Resident #8's assigned nurse did not provide a statement detailing the [NJ Exec]

On 11/21/2024 at 12:00 PM, the surveyor interviewed the [US FOIA (b)(6)] who confirmed that a thorough [NJ Exec Order 26.4b1] was

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F 610	Continued From page 16 not completed since all witness statements were not obtained and the lack of documentation in the progress notes. On 11/22/24 at 11:45 AM, the [US FOIA (b)(6)] [redacted], in the presence of the [US FOIA (b)(6)] [redacted] and the survey team, acknowledged that a thorough [NJ Exec] [redacted] investigation was not completed. A review of the facility's "Accidents and Supervision" policy, implemented 12/29/2022, did not provide guidance or specifics on how to conduct a thorough investigation. NJAC 8:39-9.4(f)	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Complaint # 172764 Based on observation, interview, and record review it was determined that the facility failed to accurately assess the status of a resident in the Minimum Data Set (MDS), an assessment tool used to facilitate care. This deficient practice was identified for 2 of 31 residents (Residents #98 and #41) reviewed and was evidenced by the following: 1.On 11/21/2024 at11:49 AM, the surveyor	F 641	[US FOIA (b)(6)] corrected the coding for residents #98 and #41 immediately to ensure accuracy. There were [NJ Exec Order 26.4b1] [redacted] for resident #98 and resident #41 as a result of the deficient practice. All current residents in the facility have the potential to be affected by the deficient practice. MDS nurses were educated by the Director of Nursing/designee on the requirement to ensure that all residents receive an accurate assessment reflective	1/24/25

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F 641	Continued From page 17 observed Resident #98 with a NJ Exec Order 26.4b1 to his/her NJ Exec Order 26.4b1. According to the Admission Record, Resident #98 was admitted to the facility with diagnoses including but not limited to NJ Exec Order 26.4b1. Resident #98 had a Physician Order (PO) dated NJ Exec Order 26.4b1 to apply a NJ Exec Order 26.4b1 to the NJ Exec A review of the NJ Exec Order 26.4b1 Medication Administration Record reflected that the NJ Exec Order 26.4b1 was signed out as completed. A review of the Quarterly MDS dated NJ Exec Order 26.4b1 for Resident # 98 reflected under Section NJ Exec Order 26 that the resident was coded as NJ indicating there was NJ Exec Order 26.4b1. A review of the Annual MDS dated NJ Exec Order 26.4b1 for Resident #98 reflected under Section NJ Exec Order 26 that the resident was coded as NJ indicating there was NJ Exec Order 26.4b1. During an interview on 11/22/2024 at 10:45 AM, the US FOIA (b)(6) stated that NJ Exec Order 26 are coded on the MDS. She confirmed that Resident has a PO for a NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1. The US FOIA (b)(6) further confirmed that the Quarterly MDS dated NJ Exec Order 26.4b1 and the Annual MDS dated NJ Exec Order 26.4b1 were coded incorrectly. During an interview with the US FOIA (b)(6) on 11/22/2024 at 11:54 AM, she acknowledged that Resident #98's NJ Exec Order 26.4b1 should have been coded on the MDS's.	F 641	of the resident's status at the time of the assessment. The MDS Director will monitor MDS assessments weekly x 4, then monthly x 2 months to ensure MDS assessments are completed correctly and coded correctly. Results will be brought to the quarterly QAPI until compliance is achieved. The Director of Nursing is responsible to ensure compliance.	

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F 641	Continued From page 18 NJAC 8:39-11.1 2. On 11/18/24 at 10:37 AM, the surveyor observed Resident #41 wearing [redacted] while walking in the hallway. On 11/19/24 at 11:11 AM, the surveyor observed Resident #41 laying in their bed. Resident #41 stated that they relied on [redacted] for [redacted] due to history of [redacted]. The surveyor reviewed the medical record for Resident #41. A review of the Admission Record face sheet (an admission summary) reflected that Resident #41 was admitted to the facility with diagnosis that included, but not limited to [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated the resident is [redacted]. Section [redacted] of the MDS for [redacted] was coded as [redacted] which identified that the resident did not use [redacted] A review of the Order Summary Report (OSR), dated as of [redacted], included the following physician orders (PO):	F 641		

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F 641	Continued From page 19 A PO, dated [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b] at [NJ Exec Order 26.4b1] every shift for [NJ Exec Order 26.4b1] A review of the resident's individual comprehensive care plan (ICCP) included a focus area, that the "[Resident is] on [NJ Exec Order 26.4b1] [related to] [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1]" with interventions that included: "[... [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] ...". On 11/22/24 at 10:44 AM, the survey team interviewed the [US FOIA (b)(6)] who confirmed that Resident #41 had a PO for [NJ Exec Order 26.4b1] since [NJ Exec Order 26.4b1] and acknowledged that the [NJ Exec Order 26.4b] MDS Quarterly Assessment was coded "[NJ Exec O]" for [NJ Exec Order 26] use. On 11/22/24 at 11:45 AM, the [US FOIA (b)(6)] in the presence of the [US FOIA (b)(6)] and the survey team, acknowledged that Resident #41 wears [NJ Exec Order 26] that it should have been identified as "[NJ Exec O]" in Section [NJ E] on the MDS. A review of the facility's "Conducting an Accurate Resident Assessment" policy, dated 10/22/2023, stated, "to assure that all residents receive an accurate assessment refeclective of the resident's status at the time of the assessment, by staff qualified to assesss relevant care areas". NJAC 8:39-11.1	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		1/24/25

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F 656	Continued From page 20 §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 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	F 656		

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F 656	Continued From page 21 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, record review, and pertinent facility documentation, it was determined that the facility failed to develop a comprehensive person-centered care plan that includes measurable objectives to meet the resident's medical, nursing, mental, and psychosocial needs specifically by failing to include what the Care Plan focuses are related to. The deficient practice was identified for 2 of 3 residents (Resident # 124 & 21) reviewed for Development/Implementation of Care Plans. A review of Resident # 124's Admission Record located in the Electronic Medical Record (EMR) revealed that he/she had a diagnoses including but not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident # 124's Order Summary Report located in the EMR revealed that he/she had physician's orders including but not limited to NJ Exec Order 26.4b1 [redacted], NJ Exec Order 26.4b1 [redacted] an NJ Exec Order 26.4b1 [redacted] A review of Resident # 124's Care Plans located in the EMR revealed an incomplete care plan focus for, "The resident is at risk for NJ Exec Order [redacted]". The focus did not specify what the risk for NJ Exec Order 26.4b1 was	F 656	US FOIA (b) interviewed resident #124 and there was NJ Exec Order 26.4b1 [redacted] to the incomplete care plan focuses. The care plan was updated immediately by the US FOIA (b) to reflect the resident #124s individual focus care plan. The US FOIA (b)(6) [redacted] updated resident #21's care plan immediately upon notification to reflect the NJ Exec Order 26.4b1 [redacted]. The US FOIA (b) assessed resident #21, there was NJ Exec Order 26.4b1 as a result of the deficient practice All current residents in the facility have the potential to be affected by the deficient practice. The Director of Nursing and/or ADON performed an audit of all current residents' care plans to ensure that they are personalized for all residents. The Registered Dietitian performed an audit of all residents with a significant unplanned weight loss or weight gain to ensure that care plans were personalized and updated All nursing staff were educated by the Director of Nursing and/or ADON on ensuring that all care plan focuses for all current residents are personalized. The Registered Dietitian was educated by the	

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F 656	Continued From page 22 related to. Further, the Care Plans revealed a focus for, "The resident uses NJ Exec Order 26.4b1 medications (SPECIFY medications) r/t [related to]". The focus did not specify what medications it was related to. Another Care Plan focus revealed, "The resident uses NJ Exec Order 26.4b1 medications (SPECIFY medications) r/t [related to] NJ Exec Ord related to [his/her] NJ Exec Order 26.4b1". The focus did not specify any medications. Lastly, the Care Plans revealed a focus for, "The resident uses NJ Exec Order 26.4b1 medication (SPECIFY medications) r/t [related to]". The focus did not specify any medications and what it was related to. On 11/20/2024 during an interview with the surveyor, Resident # 124 stated he/she could not recall if the facility ever discussed his/her care plan with him/her. On 11/22/2024 at 11:45 AM during an interview with the surveyor, the US FOIA (b)(6)) replied, "Detail oriented about behaviors, non-pharmaceutical interventions, activities, and food preferences." after the surveyor asked how should comprehensive care plans be individualized. The US FOIA (b) replied, "No" when asked by the surveyor if she would consider a care plan complete if a focus for NJ Exec Order 26.4b1 medications did not specify the medications. A review of the facility policy titled, "Comprehensive Care Plans" with an implemented date of 06/10/2024 revealed, "1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by	F 656	Director of Nursing/ADON on ensuring that all residents' comprehensive care plans are updated in a timely manner to reflect any weight losses or gains. Unit Managers will perform audits weekly x 4, then monthly x 2 of residents' care plans to ensure compliance with personalized focused care plans. The DON or Designee will perform audits weekly x 4, then monthly x 2 of all care plans for current residents with significant weight loss or weight gain to ensure that care plans are updated by the RD. Results will be brought to the quarterly QAPI until compliance is achieved. Director of Nursing is responsible to ensure compliance.	

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F 656	Continued From page 23 the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed." § 8:39-11.2 A review of Resident #21's admissions record revealed that, Resident #21 was admitted with but not limited to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 A review of the Resident #21's admission Minimum Data Set (MDS) dated NJ Exec Order 26.4b1 revealed under section NJ E that the resident had a NJ Exec Order 26.4b1 or NJ Exec Order in a NJ Exec Order or NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1. A review of the current Care Plan (CP) for Resident #21 did not include documentation of a CP focus area or interventions for a NJ Exec Order 26.4b1. During an interview on 11/21/2024 at 11:45 AM with the surveyor the US FOIA (b)(6) said if a resident has a NJ Exec Order 26.4b1 change there would be a focus added to their care plan. The US FOIA (b)(6) who is writing the note on the change would also be responsible for updating the care plan. When asked to look at Resident #21's CP the RD stated, "it doesn't look like there is one" When asked if there should be a CP focus for NJ Exec Order 26.4b1 for Resident # 21 the US FOIA replied, NJ Exec Orde During an interview on 11/22/2024 at 11:45 AM with the surveyor US FOIA (b)(6) stated,	F 656		

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F 656	Continued From page 24 "Yes, the [US FOM] should be adding that focus to the CP", when asked if there should be a focus for [NJ Exec Order 26.4b1] on a resident's care plan. A review of a facility provided policy titled "Comprehensive Care Plans" implemented on 06/12/2024 revealed under section "Policy" that, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental psychosocial needs that are identified in the resident's comprehensive assessment." The policy also revealed under "Policy Explanation and compliance Guidelines:" That, "3. The comprehensive care plan will describe, at a minimum the following: a. The service that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." NJAC 8:39-11.2	F 656		
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 interview, record review and document review it was determined that the facility failed to maintain thorough documentation following a [NJ Exec Order 26.4b1] according to professional standards of clinical practice. This deficient practice was	F 658	A progress note was completed by the [NJ Exec] floor cart nurse immediately, to reflect Resident #8s [NJ Exec] There were [NJ Exec Order 26.4b1] [redacted] to resident #8 due to the missing progress note.	1/24/25

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F 658	Continued From page 25 identified for 1 of 4 Residents (Resident #8) reviewed for accidents and 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 state: "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." On 11/19/2024 at 12:16 PM, the surveyor requested all accidents and/or investigations during the timeframe of NJ Exec Order 26.4b1 [redacted]. The facility provided information related to Resident #8 NJ Exec Order 26.4b1 [redacted] Upon review of the NJ Exec investigation titled, NJ Exec Order 26.4b1 [redacted] dated NJ Exec Order 26.4b1 at 2:19 PM revealed	F 658	All current residents in the facility have the potential to be affected by the deficient practice. All nursing staff were educated by the Director of Nursing and/or the Assistant Director of Nursing on completing the required documentation post falls. The assigned cart nurse was disciplined on missing documentation post resident #8's fall. The Director of Nursing and/or the Assistant director of nursing will audit weekly x 4, then monthly x 2 all falls/incidents to ensure that proper documentation has been completed. Results will be brought to quarterly QAPI until compliance is achieved. Director of Nursing is responsible to ensure compliance.	

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F 658	Continued From page 26	F 658		

under Incident Description: "Heard a noise from the hall and got up to check and saw [redacted] There was an aide sitting in the hallway and [redacted]. Per aide resident's [redacted] and she saw [redacted] and the [redacted]".

The surveyor reviewed the medical record for Resident #8.

A review of the Admission Record face sheet (an admission summary) reflected that Resident #8 was admitted to the facility with diagnosis that included, but not limited to [redacted]

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted].

A review of the electronic medical record progress notes did not include a nurse's note for the [redacted]

On 11/19/2024 at 3:34 PM, the surveyor interviewed Licensed Practical Nurse Supervisor (LPN/S#1), who advised that they were familiar with the Resident #8's [redacted] on [redacted]. LPN/S#1 recounted that she was called to the floor by the nurse assigned to Resident #8 and that the [redacted] was [redacted] by the certified nursing assistant. LPN/S#1 confirmed that vital signs were

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F 658	Continued From page 27 obtained, and the resident was [redacted] for [redacted] The LPN/S#1 acknowledged that the assigned nurse was responsible for entering the assessment into the progress notes. On 11/20/2024 at 1:04 PM, the surveyor interviewed Registered Nurse (RN#1) who advised that it was the facilities' expectation that every patient encounter has a resident note. When asked what encounter would require a nursing note RN#1 reported, [redacted] such a [redacted] RN#1 explained that the nursing note should include: [redacted], the time of the [redacted] where it happened, what happened, [redacted], what [redacted] the resident was in, if the resident was taking [redacted], the name/time the physician was contacted, and name/time family was contacted. RN #1 confirmed that all parties who [redacted] the [redacted] were to provide statements. On 11/21/2024 at 11:22 AM, the surveyor interviewed Licensed Nurse Unit Manager (LPN/UM#1) who advised that they were familiar with Resident #8's [redacted] on [redacted]. LPN/UM#1 confirmed that following a resident [redacted] the cart nurse should enter a progress note that included documentation of any [redacted] approximation of time when [redacted] occurred, time physician was contacted, location of the [redacted] The surveyor requested that LPN/UM#1 review the progress notes for the [redacted] that occurred on [redacted]. The LPN/UM#1 confirmed that there was no documentation of the [redacted]	F 658		

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F 658	Continued From page 28 On 11/21/2024 at 12:00 PM, the surveyor interviewed the [redacted]) who confirmed that there was no progress note or electronic medical documentation from the Resident #8's assigned nurse that detailed [redacted] fall that occurred on [redacted]. On 11/22/24 at 11:45 AM, the [redacted], in the presence of the [redacted] and the survey team, acknowledged there should have been progress note or documentation that fully detailed Resident #8's [redacted] A review of the facility's "Falls-Clinical Protocol" document, revised 10/2010, included under "Assessment and Recognition" section included: " ...the nurse shall assess and document/report the following: a. vital signs; b. recent injury, especially fracture or head injury; c. musculoskeletal function, observing for change in normal range of motion, weight bearing, etc; d. change in cognition or level of consciousness; e. neurological status; f. pain; g. frequency and number of falls since last physician visit; h. precipitating factors, details on how fall occurred; i. all current medications, especially those associated with dizziness or lethargy; j. all active diagnosis ...". A review of the facility's "Assessing Falls and their Causes" document, revised 10/2010, included under "Steps in the Procedure" section included: "f. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and over all function. It will note the presence or absence of	F 658		

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F 658	Continued From page 29 significant findings.	F 658		
F 690 SS=D	NJAC 8:39-9.4(f) 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 (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	F 690		1/24/25

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F 690	Continued From page 30 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to ensure that residents with NJ Exec Order 26.4b1 received appropriate treatment and services to prevent NJ Exec Order 26.4b1 to the extent possible specifically by leaving the NJ Exec Order 26.4 in contact with the floor, unsecured to a bed, resting on top of a mattress while a resident was lying in bed, and failing to document whether the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 as ordered by the physician. The deficient practice was identified for 2 of 2 residents (Resident # 120 & 21). The deficient practice was evidenced by the following: A.) A review of Resident # 120's Electronic Medical Record (EMR) revealed a physician's order to maintain a NJ Exec Order 26.4b1 . The EMR further revealed a physician's order to document catheter output every shift, every 8 hours for NJ Exec Order 26.4b1 care. A review of Resident # 120's Care Plan located in the EMR revealed a focus that the resident has a NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. The focus revealed an intervention to, "monitor/record/report to US FOIA (b)(6)] for s/sx [signs and symptoms] NJ Exec Order 26.4b1 NJ Exec Order 26.4 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 ..."	F 690	Resident #120s NJ Exec Order 26.4b1 was immediately NJ Exec Order 26.4 to the bed and placed in a NJ Exec Order 26.4b1. Resident #21 NJ Exec Order 26.4 was immediately placed in a NJ Exec Order 26.4b1 and NJ Exec Order 26.4 to the bedframe. US FOIA (b) assessed resident #120 and #21 with NJ Exec Order 26.4b1 as a result of the missing TARs for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. All current residents in the facility with foley catheters have the potential to be affected by the deficient practice. All nursing staff were educated by the Director of Nursing and/or the Assistant Director of Nursing on ensuring proper foley catheter policies are maintained, and care planning any residents non-compliant with the catheter policy . All nursing staff were educated by the Director of Nursing and/or the Assistant Director of Nursing on ensuring that all documentation/signing of MARs and TARs is completed for every resident/every shift. The Director of Nursing and/or the Assistant Director of Nursing will audit all residents with foley catheters weekly x 4, then monthly x 2 to ensure staff is following foley catheter policies and that all documentation is completed. Unit Managers were educated to check daily that all MARs and TARs are completed. Results will be brought to quarterly QAPI	

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F 690	Continued From page 31 A review of Resident # 120's Treatment Administration Record located in the EMR revealed blank administration sections for the following dates and times: [redacted] at 06:00 (6:00 AM) [redacted] at 14:00 (2:00 PM) [redacted] at 14:00 (2:00 PM) On 11/20/2024 at 9:59 AM, the surveyor observed Resident # 120 in bed. At that time, the surveyor observed the [redacted] not secured to the bed and resting on the floor. There was also a disposable glove on the floor near the door. On the same date at 10:18 AM while in the resident's room during an interview with the surveyor, Licensed Practical Nurse # 1 said the [redacted] should not be on the floor. At that time, LPN # 1 secured the [redacted] to the bed frame. ON 11/22/2024 at 11:45 AM during an interview with the surveyor, the [redacted] replied, "The little clip on the bed frame." when the surveyor asked how should a [redacted] when a resident is in bed. Secondly, the [redacted] replied "Absolutely not..." after the surveyor asked if the [redacted] should be in contact with the floor and unsecured to the bed. Lastly, the [redacted] replied, "For [redacted]." when the surveyor asked, "Why?" During the same interview, the [redacted] replied, "Absolutely not." after the surveyor asked if there is an order to document [redacted] every shift, should there be blanks on the administration record. The surveyor then asked if there is no	F 690	until compliance is achieved. Director of Nursing is responsible to ensure compliance.	

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documentation, would you consider it administered. The [US FOIA (b)] replied, "No."

§ 8:39-27.1 (a)

B. During the initial tour of the unit on 11/18/2024 at 09:45 AM, Resident #21 was in bed with a [NJ Exec Order 26.4b1] in laying on top of the bed with [NJ Exec Order 26.4b1], and visible from the hallway. It was not secured to the bed frame.

On 11/19/2024 at 11:13 AM Resident #21 was observed in the activities room. Resident #21's [NJ Exec Order 26.4b1] was observed hooked on to the right arm of the resident's wheelchair located above the resident's [NJ Exec Order 26.4b]

A review of Resident # 21's admissions record revealed that, Resident # 21 was admitted with diagnoses but not limited to [NJ Exec Order 26.4b1]).

A review of the Resident #21 admission Minimum Data Set (MDS) dated [NJ Exec Order 26.4b1] revealed under section [N] that the resident had an [NJ Exec Order 26.4b1]

A review of Resident # 21's Treatment Administration Record (TAR) revealed 3 blanks for the order to [NJ Exec Order 26.4b1] output every shift.
[NJ Exec Order 26.4b1] night shift
[NJ Exec Order 26.4b1] night shift
[NJ Exec Order 26.4b1] evening shift

During an interview on 11/21/2024 at 10:10 AM with the surveyor, the [NJ Exec] floor [US FOIA (b)(6)]

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F 690	Continued From page 33 ([redacted] said that [redacted] should be below the NJ Exec Order 26.4b1 so that they don't [redacted] back into the [redacted] and cause an [redacted] The [redacted] also said there should always be a [redacted] on the NJ Exec Order 26.4b1. Lastly the [redacted] stated," If it wasn't signed out it wasn't done" referring to blanks on the TAR. During an interview on 11/21/2024 at 11:14 AM with the surveyor, the US FOIA (b)(6) said the [redacted] should be [redacted] than the [redacted] and in [redacted] to [redacted] and not cause an [redacted] A review of a facility policy title "Catheter Care "implemented on 04/12/2023 revealed under "Policy Explanation" that, "2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use, and 9. Ensure drainage bag is located below the level of the bladder to discourage back flow of urine." A review of a facility policy titled "Wound Treatment Management" implemented on 02/12/2023 revealed that "7. Treatments will be documented on the Treatment Administration Record or in the electronic health record." N.J.A.C. 8:39-27.1 (a)	F 690		
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	F 695		1/24/25

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F 695	Continued From page 34 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 pertinent facility documents, it was determined that the facility failed to properly store NJ Exec Order 26.4b1 equipment, specifically a NJ Exec Order 26.4b1 in accordance with professional standards of practice by leaving it NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. The deficient practiced was identified for 2 of 3 residents (Resident # 72 & 19) investigated under NJ Exec Order 26.4b1 Care. The deficient practice was evidenced by the following: A review of Resident # 72's Order Summary located in the Electronic Medical Record (EMR) revealed an order for, 'NJ Exec Order 26.4b1 : Please NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Orde weekly for NJ Exec Order 26.4b1 and patency. Label and date." On 11/19/2024 at 11:18 AM while in Resident # 72's room, the surveyor observed a NJ Exec Order 26.4b1 in an opened drawer not secured in a NJ Exec O and NJ Exec Order 26.4b1. On 11/20/2024 at 10:03 AM while in Resident # 72's room, the surveyor observed the NJ Exec Order 26.4b1 NJ Exec Order 2 extending into a close drawer. No date was observed on the NJ Exec Orde or NJ Exec Order 2 at that time. On the same date at 10:07 AM during an interview with the surveyor while in Resident # 72's room, the US FOIA (b)(6)	F 695	Resident #72s NJ Exec Order 26.4b1 was immediately placed in a bag and labeled properly. Resident #19s NJ Exec Order 26.4b1 was immediately placed in a bag. Resident #72 and #19 were assessed by the US FOIA (b)(6) and had NJ Ex as a result of the deficient practice. All current residents in the facility with respiratory equipment have the potential to be affected by the deficient practice. Director of Nursing performed an audit of all current residents in the facility with respiratory equipment to ensure proper storage and labeling. All nursing staff were educated by the Director of Nursing and/or the Assistant Director of Nursing on respiratory equipment policy – proper storage and labeling. The Director of Nursing and/or the Assistant Director of Nursing will audit all residents with respiratory equipment weekly x 4, then monthly x 2 to ensure proper storage and labeling of all respiratory equipment. Results will be brought to quarterly QAPI until compliance is achieved. Director of Nursing is responsible to ensure compliance	

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	315235	A. BUILDING _____ B. WING _____	C 11/25/2024

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F 695	Continued From page 35 stated, "[Resident # 72] NJ Exec Order 26.4b1 [redacted] Normally, it should be in a [redacted] On the same date at 12:46 PM during an interview with the surveyor, the US FOIA (b)(6) [redacted] said the bag for the NJ Exec Order 26.4b1 was in the back of the drawer. On 11/22/2024 at 11:45 AM during an interview with the surveyor, the US FOIA (b)(6) [redacted] replied, "Everything should be in a bag. everything should be stored that way." when the surveyor asked how should a NJ Exec Order 26.4b1 be stored when not in use. A review of the facility policy titled, "Administering Medications through a Small Volume Nebulizer" with a revised date of October, 2010 under section, "Steps in the Procedure" revealed, "29.When equipment is completely dry, store in a plastic bag with the resident's name date on it." § 8:39-27.1 (a) On 11/18/2024 at 10:00 AM during initial tour the surveyor observed in Resident #19's room, a NJ Exec Order 26.4b1 [redacted] on the nightstand not secured in a [redacted] and NJ Exec Order 26.4b1 [redacted]. The surveyor also observed a NJ Exec Order 26.4b1 [redacted] hanging from the NJ Exec Order 26.4b1 not secured in a [redacted] and NJ Exec Order 26.4b1 On 11/18/2024 at 11:00 AM while in Resident # 19's room, the surveyor observed a NJ Exec Order 26.4b1 [redacted] laying on the floor not secured in a [redacted]	F 695		

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F 695	Continued From page 36 On 11/20/2024 Resident #19 was observed sitting in front of their room. The NJ Exec Order 26.4b1 was NJ Exec Order 26.4b from the back if the resident's chair not secured in a NJ Exec O and NJ Exec Order 26.4b1 A review of Resident # 19's Admission Record revealed the resident was admitted to the facility with the diagnoses which included but were not limited, NJ Exec Order 26.4b1 A review of Resident # 19's Order Summary located in the Electronic Medical Record (EMR) revealed orders for, " NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1 two times a day for NJ Exec Order 26 and NJ Exec at NJ Exec Order 26.4b1 via NJ Exec every shift related to NJ Exec Order 26.4b During an interview on 11/21/2024 at 10:10 AM with the surveyor, the US FOIA (b)(6) said that when NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 are not in use they should be placed in NJ Exec Orde When asked if NJ Exec Order 2 or NJ Exec Order 26 should be NJ Exec Order 26.4b1 or on the floor, the US FOIA replied, "No". During an interview on 11/21/2024 at 11:14 AM with the surveyor, the US FOIA (b)(6) stated, "In bags closed and dated when they were last changed", when asked where NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 should be kept when not in use. During an interview on 11/22/2024 at 11:45 AM with the surveyor, the US FOIA (b)(6) stated,	F 695		

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F 695	Continued From page 37 "Absolutely not", when asked if [redacted] and [redacted] should be left open to are or laying on the floor. A review of the facility policy titled, "Administering Medications through a Small Volume Nebulizer" with a revised date of October 2010 under section, "Steps in the Procedure" revealed, "29. When equipment is completely dry, store in a plastic bag with the resident's name date on it."	F 695		
F 756 SS=D	§ 8:39-27.1 (a) 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 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	F 756		1/24/25

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F 756	Continued From page 38 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 interview, record review, and review of pertinent facility documents, it was determined that the facility failed to address the recommendations made by the US FOIA (b)(6) [redacted]) in a timely manner. This deficient practice was identified for 1 of 5 residents (Resident # 81). reviewed for medication management. The deficient practice was evidenced by the following: A review of the Admission Record for Resident # 81 revealed the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]	F 756	Resident #81 was assessed by US FOIA (b)(6) [redacted] and there were NJ Exec Order 26.4b1 [redacted] secondary to the deficient practice. All current residents in the facility have the potential to be affected by the deficient practice. Director of Nursing educated US FOIA (b)(6) [redacted] who is responsible for reviewing pharmacy consultant reports monthly, regarding completing pharmacy recommendations in a timely manner per facility policy and disciplinary action was given. The Director of Nursing will audit pharmacy consultant reports monthly x 3 months to ensure that all recommendations are carried out as recommended in a timely fashion. Results will be brought to quarterly QAPI until compliance is achieved. Director of	

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F 756	Continued From page 39 The facility-provided CP Recommendation dated NJ Exec Order 26.4b1, indicated to clarify the Resident # 81's NJ Exec Order 26.4b1 rder to include NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 The order needing clarifaction was written, NJ Exec Order 26.4b1 by mouth one time a day for NJ Exec Order 26.4b1 The same recommendation was also noted on the CP Recommendation dated NJ Exec Order 26.4b1. This recommendation was not completed or acted upon by the facility until NJ Exec Order 26.4b1, when the orignal order was discontinued and a new order was written stating 'NJ Exec Order 26.4b1, give NJ Exec Orde by mouth one time a day for NJ Exec Order 26.4b1 During an interview on 11/21/2024 at 10:22 AM with the surveyor, the US FOIA (b)(6) said that she was responsible for completing the CP recommendations. The US FOIA (b)(6) said when the recommendations come in, she immediately sends them to the doctor to review, and they are completed with in a day or two. The US FOIA (b)(6) said the recommendation should have been done in NJ Exec O but did not remember why they weren't completed. During an interview on 11/22/2024 at 11:45 AM with the surveyor, the US FOIA (b)(6) said they [the facility] try to complete the recommendations as soon as possible, and that they try to get them done within the week. The US FOIA (b) acknowledged that the CP recommendation for Resident # 81 should have been completed sooner. A review of a facility provided policy titled,	F 756	Nursing is responsible to ensure compliance.	

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F 756	Continued From page 40 "Documentation and Communication of Consultant Pharmacist Recommendations", implemented 08/2020 reflected, "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion."	F 756		
F 812 SS=F	NJAC 8:39-29.3 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 812	The two outdated egg salad sandwiches	1/24/25

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F 812	Continued From page 41 other facility documents, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 11/18/2024 from 9:25 AM to 10:14 AM, the surveyor, accompanied by the US FOIA (b)(6) and observed the following: 1.) In the refrigerator referred to as the "reach in cooler," there were two egg salad sandwiches labeled with a use by date of 11/16/2024, but no made on date. The US FOIA said that egg salad sandwiches should be discarded because sandwiches can cause illness. 2.) In the dry storage area, there were four bags of unopened marshmallows with a manufacture's expiration date of 07/2024. The US FOIA said that marshmallows should be discarded because of the expiration date. 3.) In the overstock storage area, there were 70 cases (6 gallon per case) of water with a manufacture's expiration date of 07/31/2024. The US FOIA said that the NJ Exec Order 26.4b1 is aware of the expired overstock water supply and is working on obtaining a new supply. On 11/20/2024 at 11:35 AM, the surveyor observed the US FOIA (b)(6) in the kitchen area. The US FOIA was not wearing a hair restraint. When interviewed by the surveyor at that time, the US FOIA said that she is required to wear a hairnet while in the kitchen.	F 812	were immediately discarded. The 4 bags of expired marshmallows were immediately discarded. The 70 gallons of expired water were immediately replaced with a new 70 gallon emergency water supply. No food was affected by the 2 staff entering the kitchen without hairnets. All current staff have the potential to be affected by the deficient practice. The US FOIA (b)(6) and the kitchen staff was in serviced by the Administrator regarding ensuring all food is labeled and dated, and discarded once the expiration date is up. A large sign was posted at the kitchen door reminding staff to wear a hairnet before entering the kitchen. All dietary staff, the Pediatric day care staff and the Activities staff, were inserviced regarding wearing hairnets/beardnets in the kitchen. The Dietary Manager or designee will audit food in refrigerators and storage weekly x4 than monthly x3 to ensure there is no outdated food. Results will be brought to the quarterly QAPI meeting until compliance is achieved.	

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F 812	Continued From page 42 On 11/20/2024 at 11:49 AM, the surveyor observed the US FOIA (b)(6) [redacted] in the kitchen area. The US FOIA (b)(6) was not wearing a hair restraint. When interviewed by the surveyor at that time, the US FOIA (b)(6) said that she is required to wear a hairnet while in the kitchen. On 11/20/2024 at 11:50 AM, during an interview with the surveyor, the US FOIA (b)(6) [redacted]) said that the staff should have worn hair restraints while in the kitchen. The US FOIA (b)(6) always comes to the kitchen without a hairnet, and he will provide reeducation to the staff. A review of the undated facility policy titled, "HCSG Label and Date In-Service", revealed under labeling food "All products should be marked with a made on and use by date." A review of the facility policy dated 02/2017 titled, "Food Storage and Retention Guide", revealed "Specialty Items Dry Storage Manufacturer Guideline."	F 812		
F 880 SS=E	N.J.A.C 8:39-17.2 (g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		1/24/25

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F 880	Continued From page 43 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 disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 44 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, interview, record review, and review of pertinent facility documents it was determined that the facility staff failed to use appropriate infection control practices specifically by 1). failing to wear a gown when providing [redacted] care, and 2). Performing hand hygiene for residents and staff during meal service. The deficient practice was identified for 1 of 1 (Resident # 22) residents reviewed for [redacted], and 1 of 3 floors observed for dining. ([redacted]) The deficient practice was evidenced by the following: 1.) A review of Resident # 22's diagnoses located in the Electronical Medical Record (EMR), revealed a diagnosis of but not limited to a [redacted]. A review of Resident # 27's physician's orders	F 880	1. Resident #22 was assessed by [redacted] and had [redacted] secondary to the deficient practice. All current residents in the facility that are on enhanced barrier precautions have the potential to be affected by the deficient practice. The Director of Nursing and/or Assistant Director of Nursing educated all nursing staff on proper Enhanced Barrier Precautions infection control policies. The Director of Nursing and/or the Assistant Director of Nursing will audit wound care for residents that are on enhanced barrier precautions weekly x 4, then monthly x 2. Results will be brought to quarterly QAPI until compliance is achieved. Director of Nursing is	

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F 880	Continued From page 45 located in the EMR revealed that he/she was receiving NJ Exec Order 26.4b1 applied every day shift for NJ Exec Order 26.4b1. The order further revealed to NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1, apply NJ Exec Order 26.4b and NJ Exec Orde with NJ Exec Order 26.4b1 . On 11/22/2024 at 08:55 AM, with permission from Resident # 22, the surveyor observed their wound care provided by the US FOIA (b)(6) . At that time, the surveyor observed an orange sign on the room door that read, 'NJ Exec Order 26.4b1 ". The sign revealed that, "Everyone Must: clean their hands including before entering and when leaving the room. Providers and Staff must also: Wear gloves and a gown for following high-contact resident care activities: Dressing Bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting device care or use: central line, urinary catheter, feeding tube, tracheostomy, NJ Exec Order 26 care: NJ Exec Order 26.4b1 " The US FOIA entered the room without wearing a gown. During the observation of the NJ Exec Order 2 care, the US FOIA did not wear a gown throughout the entire process. At the time the NJ Ex Order 26.4b1 concluded, the surveyor asked the US FOIA whether Resident #22 was on NJ Exec Order 26.4b1 . The US FOIA replied saying "I should have worn a gown." The surveyor did not observe a bin outside of the room containing any personal protective equipment such as gowns. During an interview on 11/22/2024 at 09:52 AM with the surveyor, the US FOIA (b)(6)	F 880	responsible to ensure compliance. 2. Residents on NJ Exec floor were assessed by the US FOIA (b) with NJ Exec Order 26.4b1 secondary to the deficient practice. All current residents in the facility have the potential to be affected by this deficient practice. The Director of Nursing and/or the Assistant Director of Nursing educated all nursing staff on performing proper hand hygiene before passing trays and offering hand hygiene to residents before, during, and after meals are served. Nursing Managers will audit their units during meal times weekly x 4, then monthly x 2 to ensure compliance with proper hand hygiene policies . Results will be brought to quarterly QAPI until compliance is achieved. Director of Nursing is responsible to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. BUILDING _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	325 JERSEY STREET TRENTON, NJ 08611

(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 880	Continued From page 46 said staff should be wearing gowns when ever doing [NJ Ex Order 26.4b1] or any direct care on residents that are on [NJ Exec Order 26.4b1]. During an interview on 11/22/24 at 11:45 AM with the surveyor, when asked if a gown is to be worn when [NJ Exec Order 26.4b1] care on a resident on [NJ Exec Order 26.4b1], the [US FOIA (b)(6)] "Absolutely, and when providing any [NJ Exec Orde] care". A review of the facility provided policy titled, "Enhanced Barrier Precautions" implemented 12/23/2022 revealed" Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with multi-drug resistant organisms (MDROs) as well as those at risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." The policy also revealed under "4. High-contact ace activities include h. Wound care: any skin opening requiring a dressing." § 8:39-19.4 (a) 2.) On 11/19/2024 at 11:49 AM, Surveyor # 2 observed 3 Certified Nurse Aides (CNAs) on the 4th floor distributing meal trays to residents during lunchtime without performing hand hygiene beforehand, and the CNAs did not assist residents with hand hygiene before, during, or after the meal. On 11/19/2024 at 11:55 AM, during an interview with the Surveyor # 2, CNA # 1 said that she should have performed hand hygiene before passing out meal trays to residents. On 11/19/2024 at 12:00 PM, during an interview	F 880		

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	315235	A. BUILDING _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 880	Continued From page 47 with Surveyor # 2, the Registered Nurse Unit Manager (RNUM # 1) on [redacted] floor said that CNAs should be performing hand hygiene before passing out meal trays to residents and residents should have been provided hand hygiene to prevent infection. On 11/21/2024 at 11:14 AM, during an interview with Surveyor # 2, the US FOIA (b)(6) [redacted] said that staff should wash their hands before delivering trays to residents and after any contact with residents or food. Staff should assist residents with hand hygiene before meals. On 11/23/2024 at 11:51 AM, during an interview with the surveyor, the US FOIA (b)(6) [redacted] said that staff should wash their hands before delivering trays to residents. On 11/23/2024 at 11:51 AM, during interviews with Surveyor # 2, the US FOIA (b)(6) [redacted] said that staff should wash their hands before delivering trays to residents and the US FOIA (b)(6) [redacted]) added that staff should assist residents with hand hygiene before meals if they are unable to do so independently. A review of the dated facility policy 12/23/2022 titled, "Hand Hygiene", revealed under Hand Hygiene Table "before and after eating." A review of the dated facility policy 10/2009 titled, "Assistance with Meals", revealed under Training in Safe Food Handling Practices that, "All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. BUILDING _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 48 safe food handling." A review of the dated facility policy 11/29/2023 titled, "Serving a Meal", revealed under 1, "Prepare the room or serving area for mealtime (decrease noise level, provide lighting, position comfortably) and make sure hands and face are clean."	F 880		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that the resident call bell system properly functioned by a.) ensuring the call bell system volume was set to a level to be heard and b.) devices used to identify call bell notifications were functioning properly. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at on 12/20/2024 at 12:55 PM revealed the call bell light outside of room NJ Exec turned on when tested by the US FOIA (b)(6) but there was no audible notification and the activation did not	F 919	1. The call bells in room NJ Exec Order 26:4(f) and NJ Exec were repaired on 11/25/24. 2. All current residents have the potential to be affected by the deficient practice 3. A facility audit on call bells was done by the Maintenance director to ensure all call bells are functioning properly. The ADON educated all nursing staff to report any call bell issues identified in the electronic NJ Exec Order system. The US FOIA (b)(6) Was educated to prioritize call bell work order requests. 4. The maintenance director will audit facility call bells in at least 6 rooms per floor, weekly x4, than monthly x3 to	1/24/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 919	Continued From page 49 register at the nurse's station call bell annunciator. An observation at 1:00 PM revealed the call bell light outside of room [NJ Exec D] turned on when tested by the [US FOIA (b)(6)] but there was no audible notification and the activation did not register at the nurse's station call bell annunciator. Additionally, visual notification of the activation is not possible from the nurse's station because it is being blocked by the hallway wall. One of 2 residents were in the room at the time of testing. An observation on 11/21/2024 at 10:47 AM revealed the call bell in room [NJ Exec D] did not function when tested by the [US FOIA (b)(6)] In an interview at the time, the [US FOIA (b)(6)] confirmed that the call bell did not function and stated that the call bell box had broken pins. The resident in room [NJ Exec D] was in the bed at the time of the testing. NJAC 8:39-31.2(e), 31.8(c) 9	F 919	ensure proper functioning. Results will be brought to the Quarterly QAPI meeting until compliance is achieved. The administrator is responsible ensuring compliance.	

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
	061112	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CE	325 JERSEY STREET TRENTON, NJ 08611

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. Staffing reviewed for the referenced dates/shifts. No residents were negatively affected. 2. All residents have potential to be affected. 3. Daily review of staffing by DON (or designee) to ensure compliance with NJSA 30:13-18 minimum staffing requirements for nursing homes for all shifts. Call-out policy reviewed. Agency engaged as needed. 4. The DON (or designee) to have weekly meetings to determine upcoming schedules to anticipate staffing needs and will report findings to the Administrator	1/24/25

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

Electronically Signed | 12/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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. 1. For the 2 weeks of AAS-11 staffing from 11/03/2024 to 11/16/2024, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -11/03/24 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs. -11/04/24 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -11/06/24 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -11/08/24 had 10 CNAs for 125 residents on the day shift, required at least 16 CNAs. -11/09/24 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -11/10/24 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -11/11/24 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs.	S 560	weeky x4 ; monthly x 3 months with results reported to the Quarterly QAPI meeting.	

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S 560	Continued From page 2 During an interview on 11/22/2024 at 9:47 AM with the surveyor, the Staffing Coordinator (SC) was asked if she felt they were meeting the staff requirements. The SC replied, "We try to meet the staffing requirements". The facility was unable to provide any policy regarding CNA staffing.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility	S1405	1. Employees #1 thru #10 received a	1/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVERSIDE HEALTH AND REHABILITATION CE	325 JERSEY STREET TRENTON, NJ 08611

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S1405	Continued From page 3 documentation, it was determined that the facility failed to ensure that employees received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. This deficient practice was identified for 10 of 10 employee files reviewed and was evidenced by the following: On 11/21/2024 at 12:03 PM, the surveyor reviewed the employee files of ten random recently hired individuals. Employee #1 was hired on [NJ Exec Order 26.4b] and an employee health examination could not be located. Employee #2 was hired on [NJ Exec Order 26.4b] and an employee health examination could not be located. Employee #3 was hired on [NJ Exec Order 26.4b] and an employee health examination could not be located. Employee #4 was hired on [NJ Exec Order 26.4b] and an employee health examination could not be located. Employee #5 was hired on [NJ Exec Order 26.4b] and an employee health examination could not be located. Employee #6 was hired on [NJ Exec Order 26.4b] and an employee health examination could not be located. Employee #7 was hired on [NJ Exec Order 26.4b] and an employee health examination could not be located.	S1405	Physical examination by the facility MD. No residents were negatively affected by the deficient practice 2. All current residents have the potential to be affected by the deficient practice 3. The HR director was educated by the Administrator regarding the requirement to ensure all new hires receive a Physical exam by a Licensed Physician upon employment. An audit was conducted by the HR director of previous 2 months of new hires to ensure Physical exams were completed. 4. An audit will be done by the Administrator of all new hires monthly x4 to ensure physical exams on completed. Results of the audit will be brought to the Quarterly QAPI meeting until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 4 Employee #8 was hired on [NJ Exec Order 26.4b1] and an employee health examination could not be located. Employee #9 was hired on [NJ Exec Order 26.4b1] and an employee health examination could not be located. Employee #10 was hired on [NJ Exec Order 26.4b1] and an employee health examination could not be located. During an interview with the surveyor on 11/22/2024 at 9:53 AM, the Human Resources Director (HRD) reported that during the onboarding process a medical evaluation would consist in the form of a [NJ Exec Order 26.4b1]. The HRD stated, "I was told we don't need to ask for a physical, in the past we were required". During an interview with the surveyor on 11/22/2024 at 10:05 AM, the Infection Preventionist advised that she was unaware of any employee health examination that needed to be completed and confirmed that a physician does not review any new employee health forms. On 11/22/24 at 11:45 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the (Director of Nursing) DON and the survey team, acknowledged that the facility did not complete employee health examinations. The facility was unable to provide any policy reqarding Employee Health Evaluations.	S1405		

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
315235 Y1	A. Building B. Wing Y2	1/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	325 JERSEY STREET TRENTON, NJ 08611

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 F0550	Correction	ID Prefix F0558	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	01/24/2025	LSC	01/24/2025	LSC	01/24/2025
ID Prefix F0610	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	01/24/2025	LSC	01/24/2025	LSC	01/24/2025
ID Prefix F0658	Correction	ID Prefix F0690	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	01/24/2025	LSC	01/24/2025	LSC	01/24/2025
ID Prefix F0756	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	01/24/2025	LSC	01/24/2025	LSC	01/24/2025
ID Prefix F0919	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(g)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/24/2025	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?
11/25/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061112 Y1	A. Building B. Wing Y2	1/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	325 JERSEY STREET TRENTON, NJ 08611

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	Correction	ID Prefix S1405	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. #	Completed
LSC	01/24/2025	LSC	01/24/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/25/2024	☐ 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
	315235	A. BUILDING **01** B. WING _____	**11/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	**325 JERSEY STREET** **TRENTON, NJ 08611**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Riverside Health and Rehabilitation Center 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 11/20/2024 and 11/21/24 . Riverside Health and Rehabilitation Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Riverside Health and Rehabilitation Center's construction was stated to be 1980's with no current major renovations or noted additions. It was a two story building Type I (222) construction and was fully sprinklered. The facility has 2-diesel generators, one 150 KW interior and one 25 KW exterior. The 25 KW does the 4th floor only. The generators do approximately 80% of the facility. The facility has 15-smoke zones. The facility has four stories and attached to an unused section that was vacant on floors 4, 3 and 2. Floor 1 was attached to a Pediatric Day Health Service Program. The building utilizes an electric fire pump to support the fire sprinkler system.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/16/2024

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

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	315235	A. BUILDING **01** B. WING _____	**11/25/2024**

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K 000	Continued From page 1 There was supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility has 141 certified beds. The census was 127.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler	K 222		1/24/25

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K 222	Continued From page 2 system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that doors provide with delayed egress locking	K 222	1. The 4th floor deadzone delayed egress door sign was corrected to read Pull instead of Push. The 3rd floor deadzone egress door sign was corrected to read Pull instead of Push. The delayed	

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K 222	Continued From page 3 arrangements were installed in accordance with NFPA 101:2012 Edition, Sections 7.2.1.6.1 and 19.2.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/20/2024 at 1:16 PM revealed the delay egress door to the 4th floor dead end zone contained a sign that read "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". The door needs to be pulled to be opened. An observation at 2:04 PM revealed the delay egress door to the 3rd floor dead end zone contained a sign that read "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". The door needs to be pulled to be opened. An observation on 11/21/2024 at 12:02 revealed the delay egress locking arrangement on the north stairway did not function when tested by the US FOIA (b)(6) The door did unlock when the code was entered. In interviews at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/21/24 at 2:00 PM.	K 222	egress lock on 3rd floor North Stairwell repaired immediately 11/21/24 2. All residents have the potential to be affected by the deficient practice. 3. A facility audit of delayed egress doors was done by the maintenance director to ensure proper signage. The Administrator educated the Maintenance Staff regarding ensuring all delayed egress locks are checked at least weekly to ensure proper functioning. 4. The Maintenance director will audit delayed egress door signage and proper function monthly X3 and report results to the Quarterly QAPI meeting until compliance is achieved. Administrator is responsible to ensure compliance.	
K 223 SS=F	N.J.A.C 8:39-31.2(e) Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices	K 223		1/24/25

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K 223	Continued From page 4 Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that doors in all exit stairway enclosure including the dead zone stairway enclosures were equipped with smoke-resistant doors that were positive latching and either self-closing or automatic-closing in accordance with NFPA 101 (2012) Sections 19.2.2.2.7, 7.2.1.8.2 and NFPA 80 Section 5.2.4.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/20/2024 at 1:20 PM revealed the fourth-floor dead end zone stairway enclosure was not provided with latching hardware. An observation on 11/20/2024 at 1:28 PM revealed the fourth-floor central stairway enclosure was not provided with latching hardware.	K 223	1. The 4th floor deadzone end stairway door had latching hardware installed. The 4th floor central stairway door had latching hardware installed. The south stairway basement door had latching hardware installed. The North stairway basement door had latching hardware installed. 2. All residents have the potential to be affected by the deficient practice. 3. The US FOIA (b)(6) was educated by the Administrator regarding the need for all smoke doors to self-close and positively latch. 4. The maintenance director will audit facility self closing, smoke doors monthly x3 to ensure proper latching exists. Results will be brought to the Quarterly QAPI, until compliance is achieved. Administrator is responsible to ensure compliance	

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K 223	Continued From page 5 An observation on 11/21/2024 at 11:33 AM revealed the south stairway enclosure in the basement was not provided with latching hardware. An observation at 11:55 AM revealed the north stairway enclosure in the basement was not provided with latching hardware. This condition would prevent the doors from closing and positive latching in the event of an emergency when the controlled access device is de-energized by the fire alarm system. In an interview at the time the [redacted] confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/21/24 at 2:00 PM.	K 223		
K 293 SS=F	N.J.A.C 8:39-31:2(e) Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on	K 293	1. An exit signed was installed by the	1/24/25

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K 293	Continued From page 6 11/20/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that exit signs were installed above doors through which the egress path leads in accordance with NFPA 101:2012 Edition, Section 7.10.1.2.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:11 PM revealed an exit sign was not provided on either side of the fire/smoke barrier doors near room 14. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/21/24 at 2:00 PM.	K 293	Maintenance director at the 4th floor corridor fire-doors near room 414. 2. All residents have the potential to be affected by the deficient practice 3. A facility audit was conducted by the maintenance director to ensure that proper signage was installed at all emergency exits. The Administrator Educated the maintenance department regarding ensuring exit signs with continuous lighting, are present at emergency exits. 4. Maintenance director will Audit all emergency exits to ensure proper signage is in place monthly x3 or until compliance is achieved. Results will be brought to the Quarterly QAPI meeting. The Administrator is responsible for ensuring compliance.	
K 321 SS=F	N.J.A.C 8:39-31:2(e) 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	K 321		1/24/25

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K 321	Continued From page 7 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler 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 observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure hazardous areas were equipped with smoke-resistant partitions and doors that are positive latching and either self-closing or automatic-closing. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/20/2024 at 1:00 PM revealed the laundry chute room door on the 4th floor did not positive latch when tested by the US FOIA (b)(6) An observation at 1:39 revealed the soiled utility room on the fourth floor was missing a 2-foot by 2-foot ceiling tile. An observation at 1:48 revealed the south utility room near elevator 1 on the third floor did not	K 321	1. The 4th floor laundry chute door was repaired immediately to positively latch. The missing ceiling tile in 4th floor soiled utility room was relaced immediately. The 3rd floor utility room door was repaired immediately to positively latch. The 2nd floor soiled utility room door gap was repaired. The emergency generator fuel storage room was repaired to self-close a positively latch. The basement boiler room door was repaired to positively latch. 2. All residents have the potential to be affected by the deficient practice. 3. The Maintenance staff was educated by the Administrator regarding ensuring hazardous areas have a self-closing and positively latching door, and ensuring no gaps greater than ¿ inch exist in smoke protected doors or ceilings. 4. The maintenance director or designee will audit hazardous area doors and ceiling tiles monthly x4 , to ensure proper	

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K 321	Continued From page 8 positive latch. An observation on 11/21/2024 at 11:04 AM revealed the second-floor soiled utility room door contained a gap larger than 1/4-inch from the top of the door and the door frame when the door was in the closed position. An observation at 11:27 AM revealed the emergency generator fuel storage room door was not self-closing or automatic-closing and the door did not positive latch. An observation at 11:37 AM revealed the boiler room door did not positive latch. In an interview at the time, the [redacted] confirmed the observation. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 11/21/24 at 2:00 PM. N.J.A.C 8:39-31:2(e)	K 321	self-closure and latching, and no gaps greater than ¿ inch exist. Results will be brought to the Quarterly QAPI meeting until compliance is achieved. Administrator is responsible to ensure compliance	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the [redacted]), it was	K 355	1. The Class K fire extinguisher in the kitchen was provided with an instruction placard for proper use.	1/24/25

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K 355	Continued From page 9 determined that the facility failed to ensure that Class K portable fire extinguishers were provided with the required instructional placard in accordance with NFPA 101:2012 Edition, Sections 9.7.4, NFPA 10:2010 Edition, Sections 5.5.5.3, and A 5.5.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/24/2024 at 11:44 AM revealed the Class K fire extinguisher in the kitchen area was not provided with an instruction placard that stated that the fire protection system shall be actuated prior to using the portable fire extinguisher. In an interview at the time, the [redacted] confirmed the observation. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 11/21/24 at 2:00 PM. N.J.A.C 8:39-31:2(e) NFPA 10, 96	K 355	2. All residents have the potential to be affected by the deficient practice. 3. The Maintenance director educated the Kitchen staff regarding proper usage of Class K fire extinguisher in case of a fire. 4. The maintenance director will audit Class K fire extinguishers monthly x3 to ensure they are in good working order and have proper instructions placed near them. Results will be brought to the quarterly QAPI meeting until compliance is achieved. Administrator is responsible to ensure compliance.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372		1/24/25

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K 372	Continued From page 10 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/20/2024 at 12:41 PM revealed, a 1-inch by 1-inch and a 2-inch by 2-inch unprotected penetration through the fire/smoke barrier wall near room 414. An observation on 11/21/2024 at 10:27 AM revealed a 5-inch by 2-inch unprotected penetration through the fire/smoke barrier wall on floor 2. In interviews at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/21/24 at 2:00 PM.	K 372	1. The two penetrations found in the 4th floor fire/smoke barrier wall near room 414 were repaired immediately. The penetration found in the 2nd floor fire/smoke barrier wall was repaired immediately. 2. All residents have the potential to be affected by the deficient practice. 3. The maintenance director conducted an audit of Smoke barrier facility walls to ensure that no other penetrations were present. The Administrator inserviced the maintenance department regarding ensuring no penetrations exist in fire/smoke barrier walls. 4. The Maintenance Director or designee will audit facility Fire/smoke barrier walls Monthly x3 to ensure compliance with penetrations. Results of the audit will be brought to the quarterly QAPI meeting until compliance is achieved. The Administrator is responsible to ensure compliance	
K 741 SS=F	N.J.A.C 8:39-31:2(e) Smoking Regulations CFR(s): NFPA 101	K 741		1/24/25

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K 741	Continued From page 11 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that ashtrays of noncombustible materials and safe design, and metal containers with self-closing cover devices were readily available to all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This	K 741	1. The two plastic ashtrays in the smoking area were replaced with non-combustible ashtrays. A metal container with a self-closing cover was placed in the smoking area for ashtrays to be emptied into. 2. All residents have the potential to be affected by the deficient practice. 3. Smoking aides were educated	

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	315235	A. BUILDING 01 B. WING _____	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 741	Continued From page 12 deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/21/2024 at 12:52 PM revealed the resident smoking area contained 2 outdoor smoker receptacle ashtrays constructed of combustible plastic material. Additionally, a metal container with a self-closing cover device into which ashtrays can be emptied was not provided or readily available to the area. In an interview at the time, the [redacted] confirmed the observation. N.J.A.C 8:39-31.2(e)	K 741	regarding ensuring ashtrays and metal container are always present in the smoking area and to empty ashtrays or any cigarette butts found, into the metal container. 4. Maintenance Director or designee will audit resident smoke area weekly x4 than monthly x3 to ensure compliance with cigarette disposal. Results will be brought to the quarterly QAPI meeting until compliance is achieved. The Administrator is responsible to ensure compliance	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review and interviews on 11/20/2024 and 11/21/2024 in the presence of the [redacted] it was	K 761	1. An inspection was immediately conducted of fire doors to all stairways, including the deadzones to ensure proper	1/24/25

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	315235	A. BUILDING **01** B. WING _____	**11/25/2024**

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K 761	Continued From page 13 determined that the facility failed to ensure that fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed monthly inspections of fire doors consisted of only inspecting for the latching and the gap of the doors. Annual inspections in accordance with NFPA 80: 2012 Edition, Section 5.2.4.2 were not conducted and the list did not include the fire doors to All stairway enclosures including the dead zones. In an interview at the time the [redacted] confirmed the observation. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 11/21/24 at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 761	compliance with NFPA 80 section 5.2.4.2. The Monthly inspection sheet was updated to include inspection of stairway fire doors including the dead zone. 2. All residents have the potential to be affected by the deficient practice. 3. The [redacted] was educated by the Administrator regarding ensuring stairway fire doors throughout the facility are included in the monthly door inspection. 4. The Administrator will audit the monthly door inspection report monthly x3 to ensure that all stairway doors are properly inspected for compliance with Lifesafety regulations. Results will be brought to the quarterly QAPI meeting until compliance is achieved.	
K 917 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the [redacted] it was	K 917	1. The 4th floor almond colored emergency power outlets were immediately replaced with red covers.	1/24/25

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	315235	A. BUILDING 01 B. WING _____	11/25/2024

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K 917	Continued From page 14 determined that the facility failed to ensure that electrical receptacles or cover plates supplied from the life safety and critical branched were provided with a distinctive color or marking in accordance with NFPA 99 sections 6.4.2.2.6, 6.5.2.2.4.2 and 6.6.2.2.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/20/2024 at 1:30 PM revealed all the electrical receptacles and cover plates in the corridor on the fourth floor were almond colored. In an interview at the time, the surveyor asked the [redacted] if any of the electrical receptacle in the corridor were supplied from the generator in cases of emergency. The [redacted] stated that the receptacles with red cover plates were provided emergency power. Upon further review, the [redacted] confirmed that there were no distinctive color or markings on any of the outlets in the fourth-floor corridor and stated that someone must have changed the cover plate to the receptacles. N.J.A.C 8:39-31.2(e) NFPA 99	K 917	2. All residents have the potential to be affected by the deficient practice. 3. The administrator educated the maintenance staff regarding ensuring to only use red colored outlet covers for the emergency power outlets. 4. The maintenance director or designee will audit emergency power outlets monthly x3 to ensure they have red covers. Results of the audit will be brought to the quarterly compliance meeting until compliance is achieved. The Administrator is responsible to ensure compliance	
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	K 918		1/24/25

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K 918	Continued From page 15 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 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 observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that maintenance and testing of generators in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, NFPA 110, NFPA 111 and NFPA 70. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 918	1. The standard lead acid battery in the generator was tested for proper voltage. 2. All residents have the potential to be affected by the deficient practice 3. The US FOIA (b)(6) was inserviced by the Administrator regarding ensuring monthly testing for the standard lead acid battery in the generator 4. The Administrator will audit the	

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	315235	A. BUILDING **01** B. WING _____	**11/25/2024**

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K 918	Continued From page 16 An observation at 11:44 AM revealed the generator utilized a standard lead-acid battery. In an interview at the time, the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid batteries. The US FOIA (b)(6) confirmed that the battery was a standard, not a sealed lead-acid battery and stated that monthly testing is not conducted. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/21/24 at 2:00 PM. N.J.A.C 8:39-31:2(e) NFPA 70, 99, 110, 111	K 918	generator battery tests monthly x3 to ensure compliance. Results will be brought to the Quarterly QAPI meeting until compliance is achieved.	
K 928 SS=F	Gas Equipment - Labeling Equipment and Cylind CFR(s): NFPA 101 Gas Equipment - Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL." Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting.	K 928		1/24/25

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K 928	Continued From page 17 11.5.3.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/20/2024 and 11/21/2024 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that when empty and full oxygen cylinders were stored in the same enclosure, empty cylinders were marked to avoid confusion and delay in accordance with NFPA 99:2010 Edition, Sections 11.6.5.2 and 11.6.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/20/2024 at 1:40 PM revealed the oxygen storage area on the 4th floor contained 2 racks for oxygen cylinder storage. In an interview at the time, the surveyor asked the US FOIA (b)(6) if full and empty oxygen cylinders were held in the room for storage. The US FOIA (b)(6) stated that both full and empty oxygen cylinders were held in the room and confirmed that there were no markings of empty and or full cylinders to avoid confusion and delay in case of emergency. N.J.A.C 8:39-31:2(e) NFPA 99	K 928	1. Signage for the oxygen storage area on 4th floor was immediately placed to indicate which tanks were Full and which were Empty 2. All residents have the potential to be affected by the deficient practice. 3. Don or designee educated staff regarding storing oxygen tanks in the correct place for full and empty tanks. 4. Maintenance Director or designee will audit oxygen tank storage areas weekly x4, than monthly x2 to ensure proper signage and placement of tanks. Results of the audit will be brought to the quarterly QAPI meeting until compliance is achieved. The Administrator is responsible to ensure compliance.	

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
315235 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/27/2025 Y3

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	01/24/2025	LSC K0223	01/24/2025	LSC K0293	01/24/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	01/24/2025	LSC K0355	01/24/2025	LSC K0372	01/24/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0741	01/24/2025	LSC K0761	01/24/2025	LSC K0917	01/24/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	01/24/2025	LSC K0928	01/24/2025	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?
11/25/2024	☐ YES ☐ NO