STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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	F 000		

Survey Date: 5/2/22

Census: 124

Sample: 24 + 3 + 2

A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.

F689 s/s of K:
During the Standard Recertification Survey from 4/19/22 through 5/2/22, the survey team identified that the facility failed to ensure the puree consistency diet was free of large particles of food which was likely to promote an aspiration risk for residents who were on a pureed diet for 1 of 1 main lunch entree meals observed on 4/26/22. The facility's failure to ensure the puree consistency diet was free of large particles of food posed a serious and immediate threat for adverse effects, including choking and aspiration which is likely to result in serious harm, impairment, or even death. This resulted in an Immediate Jeopardy (IJ) situation for all residents on a pureed diet.

The Immediate Jeopardy situation began on 4/26/22 at 12:20 PM. The facility was notified of the IJ on 4/26/22 at 3:40 PM. An acceptable Removal Plan was received on 4/27/22 at 12:21 PM. The Removal Plan was verified by the survey team on 4/27/22 and removed on 4/27/22.

The non-compliance remained on 4/28/22 for no

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/26/2022

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

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F 000	Continued From page 1 actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.	F 578		6/13/22

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F 578	Continued From page 2 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure life-sustaining treatment wishes were reviewed with the resident or their representative and documented consistently within the medical record. This deficient practice was identified for 1 of 26 residents (Resident #121) reviewed for Advance Directive (AD) planning and was evidenced by the following: On 4/19/22 at 10:57 AM, the surveyor observed Resident #121 seated near the nurse's station with his/her eyes closed. The surveyor reviewed the medical records for Resident #121. A review of the Face Sheet (an admission summary) reflected the resident was admitted to the facility in [redacted] with diagnoses that included EX Order 26 § 4b1 [redacted]. The record indicated the resident was responsible for him/herself, and the section for "Code Status" was blank. A review of the electronic Medical Record (eMR) under the resident's profile section, a section to enter the resident's life-sustaining treatment wishes (i.e., full code, do not resuscitate (DNR), do not hospitalize (DNH), do not intubate (DNI)] was blank.	F 578	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Social Worker contacted the Responsible Party/Representative of Resident #121 to review and discuss Advanced Directives. Resident□s Representative acknowledged receipt of the Advanced Directives information and expressed no changes in resident□s Advanced Directives. Resident #121 continues to be on Full Code Status. In addition, resident□s life-sustaining treatment wishes were reviewed and a POLST (Physician□s Order for Life Sustaining Treatment) was completed and signed by resident□s representative and physician. Resident was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents are at risk for the same deficient practice. Social Worker or designees reviewed the medical records of all residents to ensure that Advanced Directives and resident□s wishes for life-sustaining treatments were	

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F 578	Continued From page 3 The physician's Order Summary Report for April 2022 did not address the resident's life-sustaining treatment wishes. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/8/22, reflected that the resident had [redacted] cognition. A review of the resident's hybrid Medical Record and eMR included no documentation that indicated the resident's end-of-life wishes had been discussed with the resident or the resident's family. On 4/19/22 at 12:43 PM, the surveyor interviewed the Registered Nurse (RN) on the [redacted] Floor nursing unit, who stated she had reviewed Resident #121's MR and was unable to locate the resident's AD or code status. The RN stated that the "Code Status should be listed on the profile screen directly under the resident's room number, but it's not there." On 4/19/22 at 12:54 PM, the surveyor interviewed the Social Worker (SW), who stated that she was responsible for discussing AD with residents and their families upon admission and quarterly during the Interdisciplinary Care Plan meetings (IDCP). The SW stated that she was unable to provide any evidence that AD information had been discussed on admission or during each IDCP meeting. On 4/19/22 at 1:10 PM, the SW provided the surveyor with an Interdisciplinary Care plan note (IDCP) dated 8/5/21 that reflected the SW	F 578	reviewed with the resident or resident□s representative and documented in the resident□s medical record. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All staff were in-serviced on the Facility□s Policy re: Resident□s Rights - Advanced Directive Tracking Program to ensure that: (a) the facility honors the Advanced Directives of all residents; (b) to make information available to the residents or residents□ representatives on how to prepare such directives should the resident not have them in place, or (c) to change existing directives in accordance with resident□s wishes. Review and Discussion of Advance Directives and resident□s life-sustaining wishes will be done upon admission and at least quarterly during each IDCP (Interdisciplinary Care Plan) Meeting. ¿ Training on Advanced Directives and honoring residents□ life-sustaining wishes will be provided to health care staff during initial orientation and will be incorporated in the facility's annual education plan. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Director of Social Worker or designee will review the Medical Records of 2 residents per week x 4 weeks, and 6 residents monthly thereafter x 3 months. Audit will consist of the following: (a) For New Admissions: Advanced Directives and life-sustaining treatment	

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F 578	Continued From page 4 reviewed the AD forms with Resident #121's son. The SW acknowledged that she had not discussed any AD information and should have reviewed it during the quarterly IDCP meetings. On 5/2/22 at 10:25 AM, the Licensed Nursing Home Administrator, in the presence of the Director of Nursing, Assistant Director of Nursing, Corporate Human Resources/Payroll, and survey team, acknowledged there was no AD. A review of the the facility's "Resident Right - Advanced Directive Tracking Program" policy dated 2/1/22 included it is the policy of the facility to honor the advance directives of all residents and to make information available to the resident on how to prepare such directives, should the resident not have them in place or change existing directives. During the admission process, the Social Services Director or designee will discuss with each resident and/or the person accompanying the resident the following: whether they have an advance directive such as a surrogate designation, living will, or durable power of attorney... the resident and or the person accompanying them will be given a copy of the advance directives information, including the forms used by the facility, whether they have completed advance directives or not. The resident or the person accompanying them should sign that they have received this information... Social Services or the appropriate designee should visit the resident and discuss advance directives with them to ensure that he/she has executed the advance directives he/she would want... ensure that the information was given to the resident. Social Services will advise the resident that at any time, he/she may amend, revoke or write a new advance directive,	F 578	wishes were reviewed with the resident or their representative during the admission process. Should the resident not have them in place, information regarding Advanced Directives is made available to the residents or residents representatives on how to prepare such directives or on changing existing directives (b) For Current Long-Term Care Residents: Review documentation to ensure that Advanced Directives and life-sustaining treatment wishes were reviewed and discussed with the resident or resident s representative on at least quarterly basis during the Interdisciplinary Care Plan Meeting. Should the resident not have them in place, information regarding Advanced Directives is made available to the residents or residents representatives on how to prepare such directives or on changing existing directives ¿ Findings will be reported to the Director of Nursing and Administrator monthly and will be presented at the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plans	

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F 578	Continued From page 5 and staff will assist.... NJAC 8:39-4.1 (a)(2)	F 578		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow a physicians order for a [redacted] consultation for a resident receiving an [redacted] medication in accordance with professional standards of nursing practice for 1 of 5 residents (Resident #9) reviewed for unnecessary medications. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #9 was seen and examined by psychiatrist. Resident to continue with medications and with current Treatment Plan, as per psychiatrist. All nurses were in-serviced on facility□s policy re: Following Physician□s Orders as prescribed. Focus was made on ensuring that all Orders for Psychiatry Consults are completed as ordered. If physician orders are not followed, the reason should be recorded on the resident□s medical record. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents with MD Orders for Psychiatry Consults are at risk for the same deficient practice.	7/1/22

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F 658	Continued From page 6 Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: On 4/28/22 at 9:50 AM, the surveyor observed Resident #9 sitting in their wheelchair in their room. The resident stated that he/she had trouble sleeping at night, so the physician had prescribed a EX Order 26 § 4b1 to take as needed. The resident stated that the medication was effective. The surveyor reviewed the medical record for Resident #9. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated	F 658	Director of Nursing and Assistant Director of Nursing reviewed Physician□s Orders of current residents on psychotropic medications to ensure that no other residents were affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All nurses were in-serviced and educated on the facility□s policy re: Following Physician□s Orders as prescribed. Emphasis was made on ensuring that all Orders for Psychiatry Consults are completed as ordered. If physician orders are not followed, the reason should be recorded on the resident□s medical record. Facility contracted with a new Psychiatry Provider Group to ensure that Physician orders for Psychiatry Consults are followed and completed as prescribed. IV. MONITORING OF CORRECTIVE ACTIONS: Director of Nursing or designee will review 5 charts weekly x 4 weeks, and monthly thereafter x 3 months, to ensure that Psychiatry Consults are completed in accordance with physician□s orders. Findings will be reported to the Director of Nursing and Administrator monthly and will be presented at the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plans	

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F 658	Continued From page 7 4/8/22, reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out 15, which indicated a [redacted]. A further review in Section N. Medications, reflected that during a seven day look back period, the resident received an [redacted] daily. A review of the Physicians Orders reflected a physician order (PO) dated 7/27/21 for [redacted] A further review of the Physicians Orders reflected a PO dated 12/3/21 for [redacted] consultation. A review of the Physician Consultations did not include a [redacted] consultation. On 4/28/22 at 10:00 AM, the surveyor requested from the Director of Nursing (DON) a copy of all Resident #9's [redacted] consultations and notes. On 4/28/22 at 1:13 PM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that Resident #9 was being seen by the [redacted] today; that the resident had not seen the [redacted] since admission at the facility. The LNHA stated that there was a PO in December (2021) for a [redacted] consultation that was never followed through with. On 4/28/22 at 1:25 PM, the surveyor interviewed the DON who stated that there was a PO from December (2021) for Resident #9 for [redacted] consultation, that should have been added to the [redacted] list of residents to visit. The DON stated that she could not speak to why the resident was not seen, but the PO was put into	F 658	V. COMPLETION DATE: 7/01/2022	

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F 658	Continued From page 8	F 658		

the electronic medical record. The DON stated that the facility was trying to get a new [redacted] since the current [redacted] lived far away and traveling to the facility was difficult. The DON continued that until March, the previous Assistant Director of Nursing (ADON #1) was following up with the [redacted] weekly via email to update the list and would look into why the resident was not seen.

On 4/29/22 at 10:20 AM, the surveyor re-interviewed the DON who stated that she could only view the PO from December 2021 for the [redacted] consultation and could not access the list to verify if the resident was ever added to the list to be seen and could not speak to why the resident was not seen by the [redacted] until surveyor inquiry.

On 4/29/22 at 10:29 AM, the surveyor interviewed the resident's Registered Nurse (RN) who stated that she was a per diem nurse but was familiar with Resident #9. The RN stated that the resident had difficulty sleeping and took [redacted] as needed which helped them [redacted] The RN stated that physician orders were put into the electronic medical record by the nurse who took the order and followed.

On 5/2/22 at 10:25 AM, the DON in the presence of the LNHA, current ADON #2, Corporate Human Resource/Payroll, and survey team, acknowledged that the PO for Resident #9's [redacted] consultation should have been followed through. The DON stated that the previous ADON #1 was responsible for putting physician orders into the electronic medical record and following up, but all nurses were responsible. The DON stated that it was a

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F 658	Continued From page 9 nursing standard of practice to follow a PO. A review of the facility's "Physician Services" policy dated 2/1/22 included...All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift... NJAC 8:39-11.2(b); 27.1(a)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; 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 a resident who was dependent on staff for assistance with activities of daily living was provided oral care consistent with their needs and preferences. This deficient practice was identified for 1 of 3 residents (Resident #40) reviewed for activities of daily living and was evidenced by the following: On 4/19/22 at 10:48 AM, the surveyor observed Resident #40 in bed with their eyes closed. The resident did not respond to the surveyor. On 4/20/22 at 12:02 PM, the surveyor observed the resident in bed. The surveyor asked the resident about the care they received with their activities of daily living (ADLs). Resident #40 stated that they were assisted with showers, shaving, and bed baths but were never assisted	F 677	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Assistant Director of Nursing immediately ensured that Resident #40 was provided with oral care by his/her assigned CNA. The facility CNA and the Hospice Aide who were involved in the care of Resident #40 were counseled regarding the need to provide oral care to resident. Director of Nursing contacted the Hospice Agency to establish a written communication system between the Facility CNA□s and the Hospice Aides. An ADL Communication and Accountability Form for Resident #40 was developed to ensure that ADL assistance is provided to resident, that is consistent	7/8/22

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F 677	Continued From page 10 with [redacted]. The resident further stated that he/she needed assistance with setting up their supplies as it was too challenging to do themselves, and no one had ever assisted them. The surveyor reviewed the medical record for Resident #40. A review of the Face Sheet (an admission summary) reflected the resident was admitted to the facility in [redacted] with diagnoses that included EX Order 26 § 4b1 [redacted] A review of the most recent significant change Minimum Data Set (MDS), an assessment tool dated 2/14/22, reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted], which indicated a fully EX Order 26 § 4b1. A further review of the MDS, [redacted] Status, reflected that the resident required one-person extensive physical assistance for personal hygiene. A review of the resident's individualized care plan (ICP) initiated on 2/28/22 included that the resident received [redacted] services related to [redacted] Interventions included assisting with ADL care as needed; provide routine ADL care desired; and to work cooperatively with [redacted] staff to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. The care plan did not specifically address [redacted] A review of the resident's electronic Certified Nursing Aide (CNA) Care Log, a communication tool used by CNAs with specific resident care	F 677	with his/her needs and preferences. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents on Hospice who are unable to carry out some activities of daily living have the potential to be affected by the same deficient practice. All Hospice residents were checked by the Assistant Director of Nursing to ensure that they received proper assistance with ADL□s consistent with their needs and preferences. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: An ADL Accountability Form for Hospice Residents was developed by the Director of Nursing to document completion of ADL assistance, as attested to by the Facility CNA and the Hospice Aide. This is to minimize miscommunication and to ensure that proper assistance with activities of daily living is provided to Hospice residents. Facility Nursing Staff and Hospice Aides were in-serviced on the form. All nursing staff and Hospice Aides were in-serviced on making sure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Emphasis was made on Oral Care.	

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F 677	Continued From page 11 needs and preferences, including mouth care, reflected the facility CNA documented that they provided oral care for Resident #40 from 2/9/22 to 4/26/22. On 4/27/22 at 12:45 PM, the surveyor interviewed the resident's CNA, who stated that she had never assisted Resident #40 with their [redacted] because she assumed the resident's [redacted] Aide did it. The surveyor asked the CNA why she had documented she had assisted Resident #40 with [redacted], but the CNA did not respond. On 4/27/22 at 12:50 PM, the surveyor interviewed the resident's Hospice Aide, who stated that she "sometimes" provided mouth care for Resident #40. The surveyor informed the [redacted] Aide that Resident #40 said he/she had never been assisted with [redacted]. The [redacted] Aide threw up her hands and replied, "sometimes I forget." On 4/27/22 at 12:55 PM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated it was the facility CNA's responsibility to communicate with the [redacted] Aide to ensure all ADL care was rendered. On 4/28/22 at 11:50 AM, the surveyor interviewed the Director of Nursing (DON), who stated the CNA was ultimately responsible for providing ADL care. The CNA should have communicated with the [redacted] Aide and should not have just assumed [redacted] was being done by the [redacted] Aide. On 4/29/22 at 1:00 PM, the surveyor interviewed Resident #40, who stated that his/her CNA had	F 677	IV. MONITORING OF CORRECTIVE ACTIONS: The Charge Nurses or designee will conduct Grooming Observation audits on Hospice Residents weekly x 1 month, then quarterly thereafter x 3 months. Audit will focus on ensuring that proper oral care has been provided to the residents. Findings will be reported to the Director of Nursing monthly and presented in the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plans V. COMPLETION DATE: 07/08/2022	

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F 677	Continued From page 12 set them up with all the necessary supplies needed to brush their teeth. The resident smiled and stated, "my mouth feels much better." On 4/29/22 at 1:52 PM, the DON, in the presence of the Licensed Nursing Home Administrator (LNHA), ADON, and survey team, acknowledged that the facility CNA and Hospice Aide should have communicated with each other to ensure Resident #40 was receiving oral care. A review of the facility's updated CNA Job Description included: maintain a safe homelike environment; assist residents with ADL needs and promote maximal independence...perform all duties as assigned. NJ 8:39-27.1(a)	F 677		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of other pertinent documentation, it was determined that the facility failed to ensure that the puree consistency diet was free of large particles of food which could promote aspiration risk for residents who were on pureed diets. This deficient practice was identified for 1 of 3	F 689	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #383 was not adversely affected by the deficient practice. Resident was out of the facility when	7/8/22

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F 689	Continued From page 13 residents (Resident #383) for 1 of 1 [redacted] lunch entree [redacted] on 4/26/22. On 4/26/22 at 11:42 AM, the surveyor observed the Daytime Cook puree meatballs for the lunch meal without following a standard recipe or manufacturer instructions for puree consistency. Upon interview, the Daytime Cook reported that she "eyeballed" what the puree consistency should be. The surveyor observed the Daytime Cook plate the [redacted], which contained chunks of [redacted] dispersed in the puree dish and placed them on the dining cart for Resident #383 (who had a history of [redacted]). At this time, the surveyor, accompanied by the [redacted] the [redacted] confirmed that the puree texture was inappropriate and would lead to "[redacted]" and a "[redacted] if a resident with a history of [redacted] ate it. The Food Service Director (FSD) stated that there were no standard recipes or instructions for puree texture food and stated that he "eyeballed" the consistency to know if he needed to add thickener or if the food was the appropriate consistency. On 4/26/22 at 12:35 PM, despite the [redacted] confirming the inappropriate texture of the puree diet in the kitchen, the dining cart that contained the [redacted] for Resident #383 was delivered to the nursing floor. Both the [redacted] and [redacted] acknowledged that Resident #383's meal tray should not have been delivered to the nursing floor after the [redacted] confirmed the texture was inappropriate.	F 689	his/her meal tray was delivered. Facility immediately replaced the Dietary Management Company and contracted with a Dietitian Consulting Company to assist in promptly correcting the deficient practice. Standardized menus for pureed diets were implemented. The Cooks, the Food Service Director and the Dietary Staff were in-serviced on these menus and on how to properly ensure that the pureed consistency diets are free of large particles of food. A new food processor was immediately purchased to ensure appropriate consistency in preparing mechanically altered diets. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents on pureed diet have the potential to be affected by the same deficient practice. The Director of Nursing and Dietitian checked on these residents to ensure that none of them were adversely affected by the deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Facility immediately replaced the Dietary Management Company and contracted with a Dietitian Consulting Company to assist in promptly correcting the deficient practice. Standardized	

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F 689	Continued From page 14 Interview with Certified Nursing Aide (CNA #1) revealed that on occasion, she found "chunks" in the food of the [redacted] and reported it to the nurse who reported it to the FSD. The facility's failure to ensure the [redacted] consistency diet was free of EX Order 26 § 4b1 [redacted] This resulted in an Immediate Jeopardy (IJ) situation that began on 4/26/22. The facility's administration notified the IJ on 4/26/22 at 3:40 PM. The facility submitted an acceptable written Removal Plan on 4/27/22 at 12:23 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 4/27/22. The non-compliance remained on 4/27/22 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The evidence was as follows: On 4/26/22 at 11:34 AM, the surveyor observed the Daytime Cook operating a blender. At this time, the surveyor, in the presence of the FSD, asked the Daytime Cook what she was preparing, and the Daytime Cook replied pureed meatballs. The surveyor asked the Daytime Cook how she prepared the pureed meatballs. She stated that she took a "little pan" (1/6 cambro deep) and filled it approximately three-quarters with meatballs. The Daytime Cook stated that the sauce was already mixed with the meatballs, so she added no additional sauce. When asked if she used any	F 689	menus for pureed diets were implemented. The Cooks, the Food Service Director and the Dietary Staff were in-serviced on these menus and on how to properly ensure that pureed consistency diets are free of large particles of food. All staff in the facility were in-serviced on pureed textured foods, specifically on how to ensure that the puree consistency diets are free of large particles of food, which could promote aspiration risk for residents who were on pureed diets. Competency Skills Checks were conducted on the cooks and Food Service Director by the Regional Dietary Supervisor of the new Dietary Company to ensure that they are competent in the proper preparation of pureed consistency diets. A PIP (Performance Improvement Plan) was developed on Pureed Consistency Diets and incorporated in the facility□s Facility Assessment and QAPI Program to promote the safety of residents who are at risk for aspiration. IV. MONITORING OF CORRECTIVE ACTIONS: The Regional Dietary Consultant or designee will conduct observation audits for breakfast, lunch and dinner once a week x 4 weeks, then monthly thereafter x 6 months to ensure that the cooks are compliant in preparing pureed consistency meals. A Pureed Consistency Audit Log was developed for the Food Service Director or Designee to complete weekly x 4	

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F 689	Continued From page 15 thickener (an added agent to thicken purees), the Daytime Cook stated that it was unnecessary because the meatball had "breadcrumbs" in it to thicken. When asked if the Daytime Cook followed a recipe to puree foods, she replied no. When asked how she knew the puree was okay, she replied that you have to look at the consistency meaning not liquidy, not shiny, and not too thick. The surveyor observed the Daytime Cook transfer the pureed meatballs from the blender directly into a 1/6 cambro deep. The surveyor observed large particles of food being transferred in that mixture. The Daytime Cook then took the pureed meatballs and directly placed them on the steam table for lunch service. The surveyor did not observe the Daytime Cook check the consistency of the meatballs. On 4/26/22 at 12:00 PM, the surveyor requested another surveyor to ask the [redacted] to join them in the kitchen. On 4/26/22 at 12:09 PM, the surveyor interviewed the [redacted], who stated that she usually did not come downstairs to the kitchen unless she was ordering a trial meal tray. The [redacted] stated that pureed foods should be the consistency of applesauce, meaning "no consistency, no grains, no food particle because it was a choking hazard for people on puree [foods] therefore [redacted] The [redacted] stated that usually, the kitchen would follow guidelines, so no texture. On 4/26/22 at 12:20 PM, the surveyor observed the Dietary Aide check the meal tray for Resident	F 689	weeks, then monthly thereafter x 6 months to ensure compliance. Results of the above audits will be reported to the Administrator monthly and presented in the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plan. quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plan. V. COMPLETION DATE: 07/08/2022	

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#383, which contained pureed meatballs, pureed pasta, and pureed vegetables. The surveyor interviewed the Dietary Aide, who stated that she was verifying that the meal ticket matched the tray.

The surveyor asked the SLP if the pureed food on Resident #383's meal tray was the appropriate consistency. The SLP confirmed that the puree looked appropriate and the Dietary Aide, at this time, placed the lid on the meal and placed it into the dining cart that she confirmed was for the [redacted] Floor nursing unit.

On 4/26/22 at 12:23 PM, the surveyor, in the presence of the FSD, asked the SLP to verify if the consistency of the pureed meatballs on the steam table was appropriate. The SLP asked the Daytime Cook to plate a sample of the pureed meatballs. The SLP, using the back of a plastic spoon, began gently spreading the pureed meatballs on the plate, which she stated she was looking for any texture or large particles. The SLP identified large particles of food in the pureed meatballs and pushed them to the side of the plate. The SLP stated, "cannot bring up meatballs; someone on puree is an [redacted] risk."

The SLP informed the FSD that the pureed meatballs contained "chunks." The texture was a "mechanical soft" diet. The Daytime Cook stated that she should have pureed the food longer. The FSD confirmed that the pureed meatballs were not the appropriate consistency and instructed the pureed meatballs to be taken off the food service line and be reblended.

On 4/26/22 at 12:27 PM, the surveyor observed

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the Evening Cook at the blender, blending the meatballs. The surveyor interviewed the Evening Cook who stated that he was just blending the meatballs more and added no additional ingredients to the blender. The Evening Cook stated that he did not follow a standardized recipe for blending foods but stated that when he pureed food, he placed it in the blender and "walked away" to allow the food to blend. The Daytime Cook stated that pureed food was the correct consistency when it contained no "chunks" and could be scooped.

On 4/26/22 at 12:29 PM, the surveyor interviewed the FSD, who stated that a contracted [name redacted] Food Service Company took over in January 2022, and they provided no recipes for pureed foods. The FSD stated that both cooks have been at the facility for years, longer than him (who started in October 2021), and the cooks taught him how the consistency of pureed food should be. The FSD stated that pureed foods should be the consistency of mashed potatoes so the food can be scooped without running on the plate, and the texture should be smooth.

On 4/26/22 at 12:35 PM, the surveyor interviewed the Dietary Aide who was still with the lunch dining cart and confirmed all the lunch trays were now in the cart and no lunch trays had been removed from the cart. At this time, the Porter, in the presence of the surveyor, left the kitchen with the lunch meals and proceeded to the First Floor nursing unit.

On 4/26/22 at 12:38 PM, the lunch meal truck arrived on the First Floor nursing unit. The surveyor observed Licensed Practical Nurse (LPN #1) locate CNA #1 to assist in passing out

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food trays.

On 4/26/22 at 12:42 PM, the surveyor interviewed CNA #1, who stated that she checked the meal trays prior to delivering them to the residents to ensure that the meal ticket matched each tray. CNA #1 grabbed Resident #383's meal tray and then placed it back into the food cart. CNA #1 stated that the resident had left the facility that morning, so they would not receive that tray. At this time, the surveyor asked CNA #1 to place that tray at the nurse's station. The surveyor informed the FSD and the SLP that Resident #383's pureed meal tray had been plated prior to reblending the meatballs and was never taken off the truck.

On 4/26/22 at 12:46 PM, the SLP, in the presence of the surveyor and FSD, used the back of a spoon to verify the consistency of the pureed meatballs. The SLP separated large particles and placed them on the side of the plate. The SLP confirmed that the consistency was not appropriate and stated, "if the resident was served, this would have caused [redacted]." The FSD confirmed that this meal should not have been delivered.

The surveyor reviewed the medical record for Resident #383.

A review of the Face Sheet (admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted]

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A review of the Nurses' Notes reflected a Skilled Nurses Note dated 4/14/22 that the resident was at risk for EX Order 26 § 4b1

A review of the Physician Documentation reflected a History and Physical dated 4/15/22 for [redacted]

On 4/26/22 at 1:11 PM, the surveyor interviewed LPN #1, who stated that Resident #383 was admitted to the facility on [redacted] with a primary diagnosis of EX Order 26 § 4b1. LPN #1 stated in the beginning, the resident was not EX Order 26 § 4b1, so they were seen by SLP and placed on a puree diet and fed by CNA #1. LPN #1 stated that she was unaware of any instances that Resident #383 EX Order 26 § 4b1 at the facility.

On 4/26/22 at 1:20 PM, the surveyor interviewed CNA #2, who stated that pureed food needed to be smooth because solid food could cause aspiration. CNA #2 stated that there were [redacted] residents on a [redacted] on this nursing unit, and one of those residents was confused but fed themselves.

On 4/26/22 at 1:51 PM, the surveyor interviewed CNA #1, who stated that residents were put on a pureed diet if they had difficulty swallowing food, so the physician and SLP ordered that diet [pureed]. CNA #1 stated that pureed food was supposed to look like "baby food smooth" and not have "chunks" in it. When asked, CNA #1 stated that every once in a while, mostly at breakfast, she would see "chunks" in the puree because it's dry. CNA #1 stated that "when I see the chunks in puree, I smash it with milk and syrup." CNA #1 stated that she also informed LPN #1 to call the

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kitchen and let them know to check the pureed food prior to serving.

On 4/26/22 at 2:21 PM, the surveyor interviewed CNA #3, who stated that that pureed food texture should be completely smooth, or it needed to be sent back to the kitchen. When asked if there was ever pureed food that was an inappropriate consistency, CNA #3 stated that sometimes, she would tell the nurse, and the nurse would call the kitchen. When asked which nurse she informed, CNA #3 stated that she could not recall since the nursing unit had mainly Agency nurses.

On 4/26/22 at 2:54 PM, the surveyor interviewed the FSD regarding the nursing staff informing him that the pureed foods were an inappropriate consistency. The FSD denied ever being informed of pureed food with inappropriate consistency. The FSD now informed the surveyor that the cooks usually used a food processor first to break down the food prior to adding it to the blender. However, the FSD stated that since the food processor was broken, they only used the blender today, so he had never seen pureed food that consistency before.

On 4/26/22 at 2:58 PM, the surveyor re-interviewed CNA #1, who confirmed that she had in the past observed "chunks" in the pureed food, so she informed LPN #1, who called the kitchen. CNA #1 stated that she was unsure who LPN #1 spoke to in the kitchen but confirmed that LPN #1 was aware.

On 4/26/22 at 2:59 PM, the surveyor re-interviewed LPN #1, who confirmed that in the past, there had been "chunks" in the pureed food, and she called the kitchen and spoke directly with

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the FSD to let him know. LPN #1 confirmed the FSD was aware of the pureed food not being the appropriate consistency.

On 4/26/22 at 3:36 PM, the surveyor, in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, interviewed the Director of Nursing (DON), who stated that pureed food texture should be smooth with "no chunks" because residents on pureed diets might not be able to chew, so they just swallow. The DON confirmed that food needed to be smooth in texture to prevent aspiration. When asked what aspiration was, the DON stated that "food goes down the wrong pipe," meaning the lungs versus the stomach. The DON also confirmed that large particles in pureed food was a "choking hazard."

The facility's failure to ensure the puree consistency diet was free of large particles of food posed a serious and immediate threat for adverse effects, including choking and aspiration, which is likely to result in serious harm, impairment, or even death.

This resulted in an Immediate Jeopardy situation. The IJ was identified on 4/26/22, and the LNHA and DON were notified of the IJ at 3:40 PM. An acceptable written Removal Plan was accepted on 4/27/22. The Removal Plan included in-servicing all staff involved in cooking, preparing, delivering, and feeding residents the correct texture of the puree diet, free of large food particles. A log was created to check the appropriate consistency of puree foods. A new food processor was purchased, and a consultant [name redacted] was onboarded to educate kitchen staff on textured food preparation.

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F 689	Continued From page 22	F 689		

On 4/27/22 at 11:08 AM, the surveyor observed the Daytime Cook with the Consultant Certified Food Manager (CFM) preparing pureed vegetables. The Consultant CFM stated that he began in-servicing the kitchen staff yesterday on how to prepare pureed food, including how the consistency should be and how to test to ensure the appropriate consistency properly. The Consultant CFM stated that prior to breakfast being served that morning, he checked the pureed eggs that were on the steam table for services and identified that the eggs were an inappropriate consistency because they were too liquidy. The Consultant CFM stated that he had the staff remove the eggs for the steam table, add additional eggs, and blend them to be the appropriate consistency. The Consultant CFM confirmed this occurred prior to any service.

On 4/27/22 at 11:19 AM, the surveyor interviewed the Daytime Cook, who stated the facility purchased a [redacted] (food processor) yesterday to puree foods. The Daytime Cook stated the facility's other food processor was broken since at least Saturday (4/23/22). The Daytime Cook stated that she had not worked on Friday (4/22/22), and when she started work on 4/23/22, the food processor did not work, so she assumed it broke the day before. The Daytime Cook stated that she thought the FSD was aware that the food processor was broken and did not inform the FSD until Tuesday that the machine was broken, and since Saturday (4/23/22), only the blender was used to puree foods. The Daytime Cook stated that she had been in-serviced on how to prepare and check the consistency of puree foods and that the FSD now checked the texture of each puree item prior to

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F 689	Continued From page 23 service. On 4/27/22, the survey team verified the implementation of the facility's Removal Plan through observation and interview. On 4/28/22 at 12:14 PM, the surveyor re-interviewed the FSD, who stated that since he has been at the facility (October 2021), he has not in-serviced his staff or conducted competencies on anything related to the kitchen, food safety, food temperatures, etcetera. The FSD stated that the staff had been in-serviced on infection control. A review of the facility's "Food and Nutrition Services" policy dated 2/1/22 included: the facility will provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional needs and special dietary needs...the facility will employ sufficient staff with the appropriate competencies and skills set to carry out the functions of the food and nutrition services...the residents will receive and consume foods in the appropriate form and/or appropriate nutritive content as prescribed by the physician and/or assessed by the interdisciplinary team...the facility will store, prepare, distribute and serve food in accordance with professional standards for food and safety...	F 689		
F 712 SS=E	NJAC 8:39-17.1(a); 17.4(a)(1)(2); 27.1(a) Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a	F 712		7/8/22

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F 712	Continued From page 24 physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission. b.) Ensure all residents were seen by the physician or nurse practitioner every thirty days with a physician visit at least every sixty days. This deficient practice was identified for 4 of 4 residents (Resident #4, #9, #92, and #109) reviewed for physician visits and evidenced by the following: On 4/28/22 at 9:50 AM, the surveyor observed Resident #9 sitting in their wheelchair in their room. The resident stated that he/she had trouble sleeping at night, so the physician had prescribed a sleep medication to take as needed.	F 712	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The attending physician of Residents #4, Resident #9, Resident #92 and Resident #109 was notified about the deficient practice. All 4 residents will be seen and examined by a physician in their next monthly visit. The 4 residents were not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents who were under the care of the physician who was not compliant	

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F 712	Continued From page 25 The resident stated that the medication was effective. The surveyor reviewed the medical record for Resident #9. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses that included EX Order 26 § 4b1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/8/22, reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out [redacted] which indicated a EX Order 26 § 4b1 cognition. A review of the Physician Progress Notes reflected the following: 7/28/21 The History and Physical completed by NP #2 7/30/21 Physician Progress Note completed by NP #1 8/06/21 Physician Progress Note completed by NP #1 8/13/21 Physician Progress Note completed by NP #1 8/25/21 Physician Progress Note completed by NP #2 9/01/21 Physician Progress Note completed by NP #2 9/08/21 Physician Progress Note completed by Physician	F 712	with the frequency of Physician□s Visits are at risk for the same deficient practice. These residents were identified and will be seen and examined by a physician in their next monthly visit. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator will send out a Memorandum to all Attending Physicians, reminding them of the regulations and facility policy related to the frequency and timeliness of Physician□s Visits. Non-compliance will result in the physician□s loss of privileges in supervising the care of residents in the facility. All nurses were in-serviced on the regulations and facility policy related to the frequency and timeliness of Physician□s Visits. Emphasis was made on the following: Ensure that the physician responsible for supervising the care of residents conduct face-to-face visits and write progress notes at least every thirty days for the first ninety days of admission. Ensure that all residents are seen by the physician or nurse practitioner every thirty days with a physician visit at least every sixty days. IV. MONITORING OF CORRECTIVE ACTIONS: The Director of Nursing or Designee will review the Medical Records of 2 residents per unit per week x 4 weeks,	

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F 712	Continued From page 26 9/10/21 Physician Progress Note completed by NP #2 9/15/21 Physician Progress Note completed by NP #2 9/29/21 Physician Progress Note completed by NP #2 11/19/21 Physician Progress Note completed by NP #2 12/26/21 Physician Progress Note completed by Physician 2/23/22 Physician Progress Note completed by NP #2 3/07/22 Physician Progress Note completed by NP #1 4/04/22 Physician Progress Note completed by NP #1 There was no documented evidence that the resident was seen at least every thirty days for the first ninety days by the physician. The physician did not see the resident upon admission or in August 2021. The physician saw the resident on 9/8/21. There was no Physician or NP visit for October 2021 or January 2022. The last Physician visit was 12/26/21. There was no evidence of a Physician visit for February or April 2022. On 4/29/22 at 11:22 AM, the surveyor re-interviewed Resident #9, who stated that he/she only knew the physician they saw in the community and were unsure who their physician was at the facility. The resident stated that he/she did not see the physician here. On 4/19/22 at 11:41 AM, the surveyor observed Resident #4 sitting in their wheelchair watching television. The surveyor interviewed the resident, who stated they were happy with the facility and	F 712	and monthly thereafter x 3 months. Audit will consist of reviewing the Physician□s H&P□s (History and Physical Exam) and Monthly Progress Notes to ensure compliance with the frequency and timeliness of Physician□s Visits. Findings will be reported to the Administrator and Medical Director monthly and presented in the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and or action plans on a quarterly basis. V. COMPLETION DATE: 07/08/2022	

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F 712	Continued From page 27 had no concerns. The surveyor reviewed the medical record for Resident #4. A review of the Face Sheet reflected that the resident was admitted to the facility in January of 2019 with diagnoses which included [redacted]. A review of the most recent quarterly MDS dated 1/7/22 reflected a BIMS score of [redacted] out of 15, which indicated a [redacted]. A review of the Physician Progress Notes from April 2021 through April 2022 reflected the following: 4/30/21 Physician Progress Note completed by NP #1 5/27/21 Physician Progress Note completed by NP #1 6/25/21 Physician Progress Note completed by NP #1 8/9/21 Physician Progress Note completed by NP #1 9/11/21 Physician Progress Note completed by NP #2 10/15/21 Physician Progress Note completed by NP #2 11/19/21 Physician Progress Note completed by NP #2 12/31/21 Physician Progress Note completed by Physician 2/5/22 Physician Progress Note completed by NP	F 712		

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F 712	Continued From page 28 #2 3/21/22 Physician Progress Note completed by NP #1 4/18/22 Physician Progress Note completed by NP #1 There was no evidence of a physician visit for July of 2021 and no evidence that the physician saw the resident at least every sixty days. On 4/29/22 at 1:12 PM, the surveyor observed the resident in their room. The surveyor asked the resident if they knew who their physician was or if they seen their physician. The resident responded that they did not know who their physician was and had not seen their physician. On 4/22/22 at 11:25 AM, the surveyor observed Resident #109 in the sixth-floor dayroom sitting in a [redacted]. Resident #109 stated he/she was doing good but was going to his/her room to use the bathroom. A review of the Face Sheet reflected that the resident was admitted to the facility in February of 2018 with diagnoses which included [redacted] A review of the most recent annual MDS dated 4/15/22, reflected that the resident had a BIMS score of [redacted] out of 15, which indicated a [redacted]. The surveyor reviewed the medical record for Resident #109.	F 712		

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F 712	Continued From page 29 The Physician's Progress Notes from [redacted] to [redacted], reflected Resident #109 was seen once by his/her primary physician on [redacted]. A further review of the Physician's Progress Notes reflected the physician's nurse practitioner (NP) completed the other monthly visits. On 4/29 at 1:26 PM, the surveyor interviewed RN #2, who stated that she was a per diem nurse that floated to each floor but was the nurse for the fifth floor that day. She stated the Medical Director came at least three (3) times a week, but for Resident #109, NP #1 conducted the visits. RN #2 further stated she was unsure if Resident #109's Physician came in because the physician could have visited when she was not there. RN #2 confirmed she has "always" seen NP #1, and that NP #1 came in once or twice a week which would be documented in the electronic medical record. On 4/29/22 at 1:32 PM, the surveyor observed Resident #109 eating his/her lunch in the sixth-floor dayroom. On 4/29/22 at 1:33 PM, the surveyor interviewed RN #1, who stated the Medical Director visited the facility on Monday, Wednesday, and Friday. One physician comes to the facility once a month. As for Resident #109's physician stated she had "not seen this year," RN #2 confirmed she had "only seen the NP #1" completing the monthly physician visits. 4. On 4/19/22 at 10:55 AM, the surveyor observed Resident #92 [redacted] and seated on a mechanical lift pad in a [redacted] in the activity room.	F 712		

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On 4/22/22 at 11:51 AM, the surveyor observed Resident #92 seated in a wheelchair in the day room, [redacted], listening to music played on the television for a music therapy activity, was frowning and appeared to be upset.

The surveyor reviewed the medical record for Resident #92.

A review of the Face Sheet reflected that the resident was originally admitted to the facility in [redacted] and readmission in [redacted] of [redacted] with diagnoses that included [redacted].

A review of the most recent quarterly MDS dated 3/11/22 reflected that the resident had a BIMS score of [redacted] out of [redacted] which indicated a [redacted].

A review of the Physician's Progress Notes from April 2021 through April 2022 reflected that the physician last saw the resident on 8/28/21. The physician had not seen the resident in 2022.

On 4/28/22 at 1:17 PM, the surveyor called the resident's physician's office to speak with the physician. The Receptionist answered the telephone and put the surveyor on a brief hold to speak with the physician. The Receptionist informed the surveyor that they spoke with the physician, who stated that they no longer go to that facility and the surveyor would need to speak with the Nurse Practitioner (NP #1). The Receptionist informed the surveyor that she would leave a message for NP #1 to call the surveyor.

On 4/29/22 at 10:36 AM, the surveyor interviewed

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NP #1 via telephone, who stated that she came to the facility twice a month to see residents and saw all the assigned residents at least once a month. NP #1 stated that the physician came if necessary; otherwise, NP #2 was also seeing residents. NP #1 stated that the physician did not have a schedule to go to the facility.

On 4/29/22 at 1:28 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that she had only met the physician for this resident a few times in the past year and was unsure if the physician came in during days or times that she was not working.

On 5/2/22 at 10:25 AM, the DON, in the presence of the LNHA, ADON, Corporate Human Resource/Payroll, and survey team, stated that she spoke to NP #1 today and told her that the physician must come to the facility and see the residents at least every sixty days.

A review of the facility's "Physician Services" policy dated 2/1/22, included... the residents must be seen by a physician at least once every thirty days for the first ninety days after admission, and at least once every sixty days thereafter; a physician visit is considered timely if it occurs not later than ten days after the visit was required; all required visits will be made by the physician personally; at the option of the physician, required visits in [SNFs] skilled nursing facilities, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance to federal and state law.

NJAC 8:39-23.2(d)

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F 759	Continued From page 32	F 759		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure all medications were administered without error of 5% or more. During the medication pass on 4/21/22, the surveyor observed two (2) nurses administer medications to four (4) residents. There were 25 opportunities and four (4) errors observed, which calculated a medication administration error rate of 16.0%. The deficient practice was identified for 1 of 2 nurses administering medications to 2 of 4 residents (Resident #131 and #78) and was evidenced by the following: 1. On 4/21/22 at 8:03 AM, the surveyor observed the Licensed Practical Nurse (LPN) during the medication pass administer five (5) medications, including one EX Order 26 § 4b1 [redacted] The surveyor with the LPN observed Resident #131 sitting in a EX Order 26 § 4b1, and the LPN stated that the resident had not had their breakfast yet. The LPN offered Resident #131 a cookie, and the resident refused the cookie. A review of the bingo card (blister pack) for EX Order 26 § 4b1 reflected a cautionary to "Take with food." (Error#1)	F 759	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: LPN who made the medication errors was counseled and in-serviced re: Following Cautionaries when passing medications. Emphasis was made on ensuring that medications with cautionaries to give with food, should be administered with food. No adverse effects were noted on Resident #131 and Resident #78. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents who have prescribed medications with cautionaries to give with food, are at risk for the same deficient practice. A list of these residents was obtained from the Pharmacy and cross-referenced with the MARs (Medication Administration Records). III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL	7/8/22

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F 759	Continued From page 33 The surveyor reviewed the medical records for Resident #131. A review of the resident's current Physician Order Report reflected a physician's order (PO) dated [redacted] for EX Order 26 § 4b1 ; EX Order 26 § 4b1 [redacted] A review of the corresponding Medication Administration Record (MAR) reflected the EX Order 26 § 4b1 administration time was 9:00 AM. On 4/21/22 at 8:23 AM, the surveyor observed the breakfast truck was delivered to the first floor sub-acute unit. On 4/21/22 at 9:10 AM, the surveyor asked the LPN to review the medication label for the EX Order 26 § 4b1 for Resident #131, which revealed a cautionary warning to "Take with food." At this time, the LPN acknowledged that she should have administered the EX Order 26 § 4b1 with food. On 4/29/22 at 9:46 AM, the surveyor interviewed the Consultant Pharmacist (CP), who stated she conducted drug regimen reviews and medication pass observations with facility nurses monthly. The CP stated that cautionaries were included on the bingo card, such as take with food that the nurses were expected to follow. The CP continued that take with food included two crackers with four ounces of milk, a snack provided by the kitchen, or a meal within ten minutes. The CP stated that if the resident refused food, the nurse would be expected to	F 759	NOT RECUR: All nurses were in-serviced on Proper Medication Administration, with emphasis on ensuring that medications with cautionaries to give with food, should be administered with food. IV. MONITORING OF CORRECTIVE ACTIONS: The Pharmacy Consultant or designee will conduct Medication Administration Audits on 2 nurses weekly x 1 month, and monthly thereafter x 3 months. Focus of the Med Pass Observation Audits will be on Nurses Compliance in giving medications with food when the cautionaries specify that the medications should be given with food. Results of Med Pass Observations will be reported to the Director of Nursing and Administrator on a monthly basis and reported in the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and or action plans on a quarterly basis. V. COMPLETION DATE: 07/08/2022	

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F 759	Continued From page 34 educate the resident that the medication required to take with food. On 4/29/22 at 10:25 AM, the surveyor interviewed the Director of Nursing (DON), who stated that nurses were expected to follow medication cautionary warnings and that the LPN should have administered the medications with food. On 5/2/22 at 10:25 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, Assistant Director of Nursing (ADON), Corporate Human Resources/Payroll, and survey team, acknowledged that medications with cautionaries to give with food, should be administered with food. 2. On 4/21/22 at 8:23 AM, the surveyor observed the LPN during the medication pass, administer five (5) medications to Resident #78, including one EX Order 26 § 4b1 [redacted] The surveyor observed that the above medications had cautionary warnings to "Take with food." At the time of administration, the surveyor observed that the resident had no meal tray, and the LPN did not offer food. (Error#2, #3, & #4) The surveyor interviewed the LPN, who confirmed that the resident had not had breakfast yet. The surveyor reviewed the medical record for Resident #78.	F 759		

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F 759	Continued From page 35	F 759		

A review of the current PO Report reflected a PO dated [redacted] for EX Order 26 § 4b1 give one tablet twice daily; a PO dated [redacted] for EX Order 26 § 4b1, give [redacted] and a PO dated 4/12/22 for EX Order 26 § 4b1, give [redacted]

A review of the corresponding MAR reflected the following:

EX Order 26 § 4b1 [redacted] aily at 9:00 AM and 5:00 PM
EX Order 26 § 4b1, one tablet by mouth daily at 8:00 AM
EX Order 26 § 4b1 caplet by mouth every [redacted] at [redacted].

On 4/21/22 at 8:23 AM, the surveyor observed the breakfast truck was delivered to the first floor sub-acute unit.

On 4/21/22 at 9:10 AM, the surveyor asked the LPN to review the medication label for the EX Order 26 § 4b1, which all revealed cautionary warnings to "Take with food." The LPN acknowledged that she should have followed the cautionary warnings and should have administered the medications to Resident #78 with food or with their breakfast trays.

On 4/29/22 at 9:46 AM, the surveyor interviewed the CP, who stated she conducted drug regimen reviews and medication pass observations with facility nurses monthly. The CP stated that cautionaries were included on the bingo card, such as take with food that the nurses were expected to follow. The CP continued that take

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F 759	Continued From page 36 with food included two crackers with four ounces of milk, a snack provided by the kitchen, or a meal within ten minutes. The CP stated that if the resident refused food, the nurse would be expected to educate the resident that the medication required to take with food. On 4/29/22 at 10:25 AM, the surveyor interviewed the DON, who stated that nurses were expected to follow medication cautionary warnings and that the LPN should have administered the medications with food. On 5/2/22 at 10:25 AM, the LNHA, in the presence of the DON, ADON, Corporate Human Resources/Payroll, and survey team, acknowledged that medications with cautionaries to give with food, should be administered with food. A review of the facility's "Infection Control - Medication Administration" policy dated 2/1/22 included to verify medication name and label, compare it to the physician order or medication administration record (MAR), verify the dosage, and verify the route of administration (i.e., orally, intravenously, or subcutaneously)... NJAC 8:39-29.2 (d)	F 759		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the	F 800		7/8/22

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F 800	Continued From page 37 preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide foods that were maintained at the appropriate temperature. This deficient practice was identified during 2 of 2 observed lunch meal services and was evidenced by the following: 1. On 4/26/22 at 11:34 AM, the surveyor informed the Food Service Director (FSD) that they wanted to observe temperatures taken of both the hot and cold lunch meal items as well as observe the thermometer used calibrated. The FSD informed the surveyor that the cook was the person who took the meal temperatures and instructed the cook to calibrate the thermometer. At this time, the cook informed the surveyor and FSD that she was unaware of how to calibrate a thermometer, that she might have been shown previously but forgot how to, and that she did not calibrate the thermometer prior to taking temperatures. On 4/26/22 at 11:39 AM, the surveyor observed the FSD calibrate the facility's kitchen thermometer to 32 degrees Fahrenheit (F), which the FSD confirmed was the appropriate temperature. On 4/26/22 at 11:51 AM, the surveyor interviewed the cook, who stated that cold foods/drinks needed to be 40 F or below. The surveyor, in the presence of the FSD, observed the cook take the following temperatures: Turkey sandwich 49 F Whole milk 50 F	F 800	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Food service Director was immediately counseled by the Administrator regarding the Dietary Department□s failure to ensure that food provided to residents was maintained at the appropriate temperature. The Consultant CDM (Certified Dietary Manager) in-serviced the Dietary Staff on properly calibrating the thermometer and on monitoring food temperature using a food thermometer. No residents were adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents on have the potential to be affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All Dietary Staff were in-serviced by the Consultant CDM (Certified Dietary Manager) on the facility□s Food Temperature and Food Handling Policies to ensure that the facility provides food that is maintained at the appropriate temperature.	

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F 800	Continued From page 38 2% milk 55 F On 4/26/22 at 12:01 PM, the FSD instructed Dietary Aide #1 to remove the milks from the tray line and to put the turkey sandwiches in the freezer to cool. The FSD stated that cold items needed to be served at 40 F or below. 2. On 4/28/22 at 11:03 AM, the surveyor entered the kitchen and observed an opened case of nutritional health shakes unattended on a preparation table. The surveyor observed eleven health shakes were labeled and placed directly on the table. On 4/28/22 at 11:51 AM, the surveyor observed the contracted Consultant Certified Dietary Manager (CDM) calibrate the facility's kitchen thermometer to 32 F. On 4/28/22 at 11:54 AM, the surveyor requested the Consultant CDM take the temperature of one of the health shakes on the table and observed the temperature was 56 F. The Consultant CDM stated that the health shakes were delivered to the facility frozen and then placed in the refrigerator when needed to thaw. The Consultant CDM confirmed that the eleven labeled health shakes were above a safe temperature and needed to be discarded. The Consultant CDM removed a health shake from the box that was still partially frozen and stated that he would put these health shakes in the refrigerator. On 4/28/22 at 11:55 AM, the surveyor interviewed Dietary Aide #2, who stated that he removed the health shakes from the freezer that morning before breakfast around 8:30 AM. Dietary Aide	F 800	Competency Skills Checks were conducted on the cooks and Food Service Director by the Regional Dietary Supervisor in calibrating the food thermometer and in properly using a food thermometer to monitor food temperature. IV. MONITORING OF CORRECTIVE ACTIONS: The Regional Dietary Consultant or designee will conduct food temperature audits for breakfast, lunch and dinner once a week x 4 weeks, then monthly thereafter x 4 months to ensure that food provided to residents is maintained at the appropriate temperature. Results of the audits will be reported to the Administrator monthly and will be presented at the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plan. V. COMPLETION DATE: 07/08/2022	

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F 800	Continued From page 39	F 800		

#2 that he was defrosting and labeling the health shakes for tomorrow's supplements after lunch service was finished.

On 4/28/22 at 12:09 PM, the surveyor interviewed the FSD, who stated that the health shakes were delivered to the facility frozen, and the case was removed to the refrigerator one at a time as needed. The FSD stated that each health shake was labeled to discard after two weeks from being removed from the freezer. The FSD stated that the health shakes should have remained in the freezer or refrigerator until Dietary Aide #2 was able to label them. The FSD confirmed all cold items should be maintained at 40 F or below.

3. On 4/28/22 at 11:42 AM, the surveyor observed the contracted Consultant CDM calibrate the facility's kitchen thermometer to 32 F. In the presence of the cook, the surveyor observed the Consultant CDM take temperatures for the hot and cold lunch meal items. The surveyor observed the following cold items:

Fat free milk 43 F
Whole milk 45 F

On 4/28/22 at 11:59 AM, the surveyor interviewed the FSD, who stated that cold items needed to be maintained at 40 F or below.

On 5/2/22 at 10:25 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADN), Corporate Human Resources/Payroll, and survey team, acknowledged these concerns.

A review of the facility's undated "Food

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F 800	Continued From page 40 Temperatures" policy included... the temperature of potentially hazardous cold foods will be no greater than 40 degrees when served to residents. A review of the facility's "Food Handling" policy dated 2/1/22 included... foods are held at appropriate temperatures while being served. Monitoring of food temperatures using a food thermometer should be performed regularly...	F 800		
F 804 SS=E	NJAC 17.4(a)(2) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure standardized recipes were utilized to ensure food was prepared to conserve nutritive value and flavor. This deficient practice was identified for 3 of 3 observed lunch meals prepared and the evidence was as follows: During a standard survey form 4/19/22 through 5/2/22, the survey team received the following food complaints from sampled residents:	F 804	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: a) Dietary Consultant interviewed the residents (Resident #9, Resident #3, Resident #27, and Resident #19) who complained about the food to discuss and address their individual concerns related to the food/meals. All 4 residents were satisfied with the facility's plan of	7/8/22

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F 804	Continued From page 41 1. On 4/19/22 at 10:44 AM, the surveyor interviewed Resident #9 who stated he/she disliked the food here. The resident stated they talked to the Licensed Nursing Home Administrator (LNHA) who informed them that the facility had a new chef. The resident stated he/she ate eggs and wheat soup; that their family brought sandwiches for them because the food was inedible. On 4/28/22 at 9:50 AM, the surveyor observed Resident #9 sitting in their wheelchair in their room. The resident stated everything was good at the facility except the food. The Resident continued that breakfast was okay but not lunch and dinner. The resident stated that he/she spoke with the Food Service Director (FSD) who said that the food would change in May. The resident stated if he/she disliked a food, that they would eat a peanut butter and jelly sandwich and their family brought them food. The resident also stated that they were given salt and pepper shakers to add to the food which helped because the food was bland. 2. On 4/19/22 at 11:19 AM, the surveyor interviewed Resident #3 who stated that the food was "terrible" that it tasted "bad" and sometimes was off (hot foods cold and cold foods hot). On 4/22/22 at 11:14 AM, the surveyor re-interviewed Resident #3 who stated that the "food had no taste at all." 3. On 4/20/22 at 10:40 AM, the surveyor interviewed Resident #27 who complained that the food was "terrible" and that the food was cold and not palatable.	F 804	correction to rectify the deficient practice by implementing standardized recipes. The 4 residents were encouraged to continue communicating any issues that they have related to food served by the facility to ensure that they are addressed promptly. b)Facility immediately replaced the Dietary Management Company and contracted with a Dietitian Consulting Company to assist in promptly correcting the deficient practice. Standardized recipes were implemented. The Cooks, the Food Service Director and the Dietary Staff were in-serviced on properly following these standardized recipes to ensure that food is prepared to conserve nutritive value and flavor II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE a)All residents have the potential to be affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: a)Facility replaced the Dietary Management Company and contracted with a Dietitian Consulting Company to assist in promptly correcting the deficient practice. Standardized recipes were implemented. b)The Cooks, the Food Service Director and the Dietary Staff were in-serviced on	

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F 804	Continued From page 42 4. On 4/20/22 at 10:19 AM, the surveyor observed Resident #19 lying in bed. The resident complained to the surveyor that the food was not good, it had no taste. The surveyor reviewed the Cycle 3 Fall/Winter Menu provided by the facility. The surveyor observed the main lunch meal for 4/26/22 was spaghetti and meatballs with vegetables; 4/27/22 roasted chicken with yellow rice and vegetables; and 4/28/22 teriyaki salmon with white rice and vegetables. The surveyor made the following observations and interviews with the kitchen staff based on the provided menu: On 4/26/22 at 11:42 AM, the surveyor observed the lunch meal food line which contained spaghetti, meatballs in tomato sauce, and mixed vegetables. At this time, the surveyor interviewed the Cook who confirmed the lunch meal was spaghetti and meatballs with mixed vegetables and the alternate meal was a turkey sandwich. When asked if the meatballs were a delivered prepared food item, or she made the meatballs from scratch, the Cook stated that she made the meatballs. The Cook stated that she did not follow a written recipe, that she made the meatballs from "how she knew how to." On 4/26/22 at 12:29 PM, the surveyor interviewed the FSD who stated that the facility had a contracted [name redacted] Food Service Company that started in January 2022. On 4/26/22 at 12:35 PM, the FSD stated that the contracted [name redacted] Food Service Company usually sent the facility frozen prepared meatballs, and they did not so there was no recipe for the meatballs. The FSD stated that the	F 804	properly following these standardized recipes to ensure that food is prepared to conserve nutritive value and flavor c)Competency Skills Checks were conducted on the cooks and Food Service Director by the Regional Dietary Supervisor of the new Dietary Company to ensure that they are competent in properly following the standardized recipes to ensure that food is prepared to conserve nutritive value and flavor. IV. MONITORING OF CORRECTIVE ACTIONS: a)The Regional Dietary Consultant or designee will conduct observation audits for breakfast, lunch and dinner once a week x 4 weeks, then monthly thereafter x 6 months to ensure that the cooks are compliant in following the standardized recipes to ensure that food is prepared to conserve nutritive value and flavor. b)Results of the above audits will be reported to the Administrator monthly and presented in the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plan.	

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Cook prepared the meatballs using the Cook's own recipe.

On 4/26/22 at 1:22 PM, the surveyor interviewed the facility's Registered Dietitian (RD #1) via telephone who stated that the menus for the meals served were created by an outside food company who their registered dietitian reviewed the menus. RD #1 stated that each meal needed to have a certain amount of nutrients such as protein. RD #1 stated that there should be standardized recipes followed for each menu item to ensure the taste, consistency, and nutrients were the same throughout.

On 4/27/22 at 11:30 AM, the surveyor observed the main meal of chicken drumsticks on the steam table for lunch.

On 4/28/22 at 11:04 AM, the surveyor observed the Cook grinding salmon. At this time, the surveyor interviewed the Cook who stated that she was preparing the mechanical ground salmon for the lunch meal. The Cook stated that she did not follow a recipe but put garlic and butter on the salmon and cooked it. The Cook stated that lunch was teriyaki salmon and that she prepared her own teriyaki sauce that she made herself.

At this time, the surveyor interviewed the Cook regarding how she prepared yesterday's Roast Chicken meal. The Cook stated that the menu indicated "rotisserie" chicken, but she made "baked" chicken because they did not have. The Cook stated she placed the chicken leg (drumstick) and put [name redacted] no salt added seasoning blend on the chicken and placed in a pan to bake. The Cook stated that

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there were no standard recipes, that she "just makes food how she knows how to." The Cook added that the facility was switching food companies and would have standard recipes next month.

On 4/28/22 at 11:12 AM, the surveyor interviewed the FSD who stated that the facility did not have a standardized recipe for teriyaki salmon. The FSD acknowledged that it was important to have a recipe because certain people cannot have certain things in their diet like salt.

On 4/28/22 at 11:13 AM, the surveyor in the presence of the FSD interviewed RD #2 who stated that today was her first day at the facility, but from a nutrition standpoint, it was important to have a standardized recipe to ensure that the same amount of ingredients was in the meal for consistency. RD #2 stated that meal should taste the same every time made regardless of who prepared the meal because they followed a recipe. RD #2 stated that the recipe ensured not only consistency in taste, but that each serving contained the appropriate amount of nutrients needed for each resident for that meal.

At this time, the FSD stated that he had received food complaints from residents, and he spoke to those residents to see if they preferred a different food item like a sandwich. The FSD stated that the contracted [name redacted] Food Service Company provided them with standard recipes that they did not use and could not speak to why they did not use. The FSD provided the surveyor with a "Baked Chicken" recipe and a "Teriyaki Fish" recipe and confirmed again that there was no meatball recipe. The teriyaki fish was prepared with tilapia according to the recipe, but

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the FSD stated that the facility was delivered salmon instead.

A review of the "Baked Chicken" recipe included for 100 servings:

25 pounds of chicken drumsticks
2/3 teaspoon ground black pepper
1/2 cup ground paprika
1/3 cup salt

At this time, the surveyor informed the FSD that this was not how the Cook informed them that the chicken was prepared. The FSD could not speak to it.

A review of the "Teriyaki Baked Fish" recipe included for 100 servings:

100 - 4-ounce tilapia
3-1/10 bunches of sliced green onions
3/8 gallons of cold water
1-1/8 pound granulated sugar
1-1/8 tablespoon salt
1-1/8 tablespoon ground black pepper
12-1/3 ounce chopped garlic
3/8 cup ginger powder
24-5/8 pounds vegetable oil
3/8 pounds corn starch slurry
3/8 gallon soy sauce

On 4/28/22 at 11:26 AM, the surveyor re-interviewed the Cook regarding how she prepared the teriyaki salmon. The Cook stated that she put parsley and butter on the salmon and cooked for twelve minutes. The Cook stated for the teriyaki sauce she added a can of crushed pineapple to the blender, added chicken stock, 1/2 cup corn powder, and teriyaki sauce. The

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Cook stated that she used one cup of teriyaki sauce since it was salty and 4-ounces of the chicken base (powder) as the chicken stock. The Cook stated that maybe she added 3 ounces of melted butter to each pan.

At this time, the surveyor re-interviewed the Cook how she prepared the meatballs from the 4/26/22 lunch meal. The Cook confirmed she did not follow a recipe but said used twenty-five pounds of ground beef, minced garlic, nine eggs, 3 cups breadcrumbs, 1 cup of parsley. The Cooked stated that the facility did not always have the ingredients needed so they used what they had on hand.

On 2/28/22 at 11:30 AM, the surveyor observed the Cook prepare chicken gray. The Cook used a two-ounce ladle and scooped two heaping portions of flour (not leveled off) and placed it in a pan with a four-ounce scoop of melted butter. The Cook then added an unmeasured amount of boiling water to the pan plus one heaping scoop of chicken base powder using a two-ounce ladle that was not leveled off and placed into the pan and mixed to combine.

After the Cook prepared the gravy, the surveyor observed her immediately prepare mashed potatoes by pouring an unmeasured amount of boiling water into a deep half pan and poured melted "margarine" into it. The surveyor asked the Cook if the melted liquid she used to cook was margarine and not butter as originally stated, the Cook confirmed "yes." The Cook then began to add the powdered potatoes to the water/margarine mixture while whisking. The Cook stated that she knew how much potato powder to add by observing the consistency.

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F 804	Continued From page 47 The surveyor reviewed the five pound twelve ounce can of powdered potatoes that the Cook used for the mashed potatoes. The directions for 96 servings were as follows: 2 pounds 14 ounces mashed potato mix 1-1/2 gallons water 2 pints nonfat liquid milk 4 teaspoon salt margarine or butter On 5/2/22 at 10:25 AM, the LNHA in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Human Resources/Payroll, and survey team acknowledged that the kitchen was not using standard recipes. A review of the facility's undated "Food Preparation" policy included that meals will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable and served attractively and at proper temperatures. Recipes: a file of standardized recipes is located in the kitchen. Purpose: standardized recipes give the same result each time they are use; they take the guess work out of food preparation; the exact number of servings to be expected is known; they help make purchasing more accurate... The cook and the Food Service Director are responsible for tasting all prepared food in order to judge the quality of the finished product. A review of the facility's "Dietary Services - Food and Drink" policy dated 2/1/22 included ... food prepared by methods that conserve nutritive value, flavor, and appearance...	F 804		

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F 804	Continued From page 48	F 804		
F 812 SS=D	NJAC 8:39-17.2(a); 17.4(a)(3) 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 and interview, it was determined that the facility failed to a.) maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness and b.) separate the hand washing sinks from the food preparation area to prevent splashing and contamination of the clean food preparation area. This deficient practice was evidenced by the following:	F 812	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Facility had Maintenance Department install partitions between the handwashing sinks and the food preparation area in the kitchen. The metal baffles above the flat top grill were cleaned immediately to remove the brown grease-like substance.	7/8/22

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F 812	Continued From page 49 On 4/19/22 at 9:53 AM, the surveyor in the presence of the Food Service Director (FSD) observed the following: 1. In the food preparation area, the surveyor observed two of two handwashing sinks with no partitions between the hand washing sinks and the food preparation area. Next to one of the hand washing sinks, on the food preparation area, there was a container of clean silverware. The FSD stated that he was not aware of the need for a partition between the sink and the food preparation area. He stated that it could be possible for splashing from hands while washing to contaminate the clean silverware and clean food preparation surface. 2. Above the flat top grill, the surveyor observed half of the metal baffles soiled with a brown grease-like substance. The FSD stated that these baffles should be cleaned. On 5/2/22 at 10:25 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Human Resource/Payroll, and survey team, acknowledged these concerns. A review of the facility's "Food and Nutrition Services" policy dated 2/1/22, included... store, prepare, distribute and serve food under sanitary conditions following proper sanitation and food handling practices to prevent the outbreak of foodborne illness.... the facility will store, prepare, distribute, and serve food in accordance with professional standards for food safety...	F 812	II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All Dietary Staff were in-serviced on the regulations and facility□s policies on the following: Maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for development of a food borne illness; and Separate the handwashing sinks from the food preparation area to prevent splashing and contamination of the clean food preparation area. IV. MONITORING OF CORRECTIVE ACTIONS: Regional Dietary Consultant or designee will conduct Kitchen Observation Audits weekly x 1 month; then thereafter x 6 months. Emphasis will be made on maintaining the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for development of a food borne illness; and separating the handwashing sinks from the food preparation area to prevent splashing and contamination of the clean food preparation area.	

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F 812	Continued From page 50 NJAC 8:39-17.2(g)	F 812	Results of the above audits will be reported to the Administrator monthly and presented in the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plan. V. COMPLETION DATE: 07/08/2022	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations	F 838		7/8/22

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F 838	Continued From page 51 that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents, it was determined that the facility failed to ensure the facility-wide assessment included: a.) competencies for dietary staff and, b.) employee competencies for pureed texture diets. This deficient practice was identified by the following:	F 838	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Facility immediately replaced the Dietary Management Company and contracted with a Dietitian Consulting	

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F 838	Continued From page 52 On 4/19/22 at 10:55 AM, during the entrance conference with the Director of Nursing (DON) and Director of Marketing, the surveyor requested a copy of the Facility Assessment. On 4/27/22 at 9:58 AM, the surveyor reviewed the Facility Assessment dated completed 3/29/22. A review of the facility's report for services and care provided for nutrition individualized dietary requirements, liberal diets, specialized diets, IV [intravenous] nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions. Consult with speech therapist for upgrade or downgrade of diet. For staff training/education and competencies included training/education and competencies/skill checks are generally provided upon hire, during monthly in-servicing/training, annual in-servicing/training and/or whenever an area is identified, or new areas are identified based on resident diagnoses and/or clinical condition. Trainings and educations are embodied in the facility's Compliance Program General Policies and Procedures. Among the topics, it included: COVID-19; fraud, waste and abuse law; anti-kickback statue; False Claims Act; billing; payments; governance; medical necessity and quality of care; credentialing; physician self-referral statues; investigation and resolution of compliance reports; non-intimidation and non-retaliation for reporting compliance concerns; other risks. Required in-service training for nurse aides must be done to ensure competencies but must be no less that 12 hours per year... For areas of weakness as determined in nurse aides' performance reviews, additional specialized training... Training for specialized care, as needed, like catherization	F 838	Company to assist in promptly correcting the deficient practice. Facility Assessment was updated to include (a) Competencies for Dietary Staff; and (b) Employee competencies for pureed texture diets. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Facility immediately replaced the Dietary Management Company and contracted with a Dietitian Consulting Company to promptly correct the deficient practice and to ensure the proper and effective completion of the following: (a) Competencies for Dietary Staff; and (b) Employee competencies for pureed texture diets. IV. MONITORING OF CORRECTIVE ACTIONS: The Administrator or designee will conduct audits of 5 Dietary personnel records per month x 4 months to make sure that the following are completed: (a) Competencies for Dietary Staff; and (b) Employee competencies for pureed texture diets. Results of the audits will be reported to the QAPI Committee monthly to ensure	

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F 838	Continued From page 53 insertion/care, colostomy care. diabetic blood glucose testing, oxygen administration... The assessment did not include employee competencies for dietary staff and employee competencies for pureed texture diets. On 4/28/22 at 12:14 PM, the surveyor re-interviewed the FSD who stated that since he has been at the facility (October 2021), he has not in-serviced his staff or conducted competencies on anything related to the kitchen, food safety, food temperatures, etcetera. The FSD stated that the staff has been in-serviced on infection control. On 5/2/22 at 10:25 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, Assistant Director of Nursing (ADON), Corporate Human Resource/Payroll, and survey team, stated that the facility assessment addressed what the plan was to maintain the services of the facility. The LNHA confirmed that it was specific to the population of the facility. The LNHA acknowledged that the facility did not specifically address pureed texture foods and competencies for dietary staff. The LNHA stated that the contracted [name redacted] Food Service Company was supposed to be conducting competencies with kitchen staff. NJAC 8:39-5.1(a)	F 838	on-going compliance V. COMPLETION DATE: 07/08/2022	
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program.	F 865		7/1/22

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F 865	Continued From page 54 §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that: a.) their Quality Assurance and Performance Improvement (QAPI) Program was being implemented and b.) a QAPI plan for food concerns was implemented. This deficient practice was identified during the standard survey and was evidenced by the following: A review of the facility's "Quality Assurance and Performance Improvement" policy dated 2/1/22, included "These policies are intended to ensure the facility develops a plan that describes the process for conducting QAPI/QAA [Quality Assurance and Performance Improvement/Quality Assessment and Assurance] activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of the nursing home residents, through continuous attention to quality	F 865	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Upon notification of the deficient practice, the facility contracted with a new Dietary Management Company and a new Dietitian Consulting Company to promptly correct the deficient practice. Facility Assessment was updated and a QAPI Plan was implemented to address all food concerns. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE	

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of care, quality of life, and resident safety." The policy included that the facility will develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.

A further review of the policy included that the facility will maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systemic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. The policy also included that the facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility.

Further review of the policy included that the governing body and/or executive leadership was responsible and accountable for ensuring that the QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

On 4/28/22 at 9:50 AM, the surveyor interviewed Resident #9 who stated they disliked the food; the food had no taste. The resident continued that he/she had spoken to the Food Service Director (FSD) who informed the resident that the food would change in May. The resident stated that

THAT THE DEFICIENT PRACTICE WILL NOT RECUR:

Facility immediately replaced the Dietary Management Company and contracted with a Dietitian Consulting Company to promptly correct the deficient practice and to ensure the proper and effective implementation of a QAPI Plan to address all food concerns.

A Program Improvement Plan (PIP) was developed to ensure that the all food concerns are addressed promptly and the Food Service Director is actively involved in the implementation of the QAPI Program.

IV. MONITORING OF CORRECTIVE ACTIONS:

The Administrator or designee will conduct audits of all complaints and/or grievances related to food/dietary concerns on a monthly basis x 6 months. This is to ensure that all food concerns are addressed promptly and properly. Results of the audits will be reported to the QAPI Committee monthly to ensure on-going compliance.

V. COMPLETION DATE: 07/01/2022

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he/she received sandwiches if they did not want the meal offered.

On 4/28/22 at 11:13 AM, the surveyor interviewed the FSD who stated that he was aware of residents complaining about the food. The FSD stated that some residents liked certain foods, while others did not. When the resident complained about the food, the FSD stated that he spoke with the resident and offered them other food options like a sandwich.

On 4/28/22 at 12:14 PM, the surveyor re-interviewed the FSD who stated that since he has been at the facility (October 2021), he has not in-serviced his staff or conducted competencies on anything related to the kitchen, food safety, food temperatures, etcetera. The FSD stated that the staff has been in-serviced on infection control.

A review of the last three quarterly Quality Assurance Performance Improvement meeting held on 10/21/21, 1/4/22, and 4/13/22 all included the FSD had signed in attendance.

On 5/2/22 at 10:18 AM, the surveyor interviewed the FSD regarding their participation in the quarterly QAPI meeting, which the FSD replied that he did not attend the QAPI meeting. At this time, the surveyor observed a document on the FSD's desk which reflected QAPI meeting 5/1/22 and informed the FSD that they were questioning their participation in these meeting. The FSD responded that he only participated in a daily morning meeting. When asked if he addressed any kitchen concerns at these meetings, the FSD responded that he addressed staffing, kitchen equipment breaking, and food order shortages.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 57	F 865		

When asked how he addressed the residents' concerns with food, the FSD responded that he walked around and talked to the residents. If it was a concern that he could not "fix" would let the aide or the Director of Nursing (DON) know.

On 5/2/22 at 10:25 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, Assistant Director of Nursing (ADON), Corporate Human Resource/Payroll, and survey team stated that he was unaware of the residents complaining about the food. The LNHA stated that the facility had a food committee and Resident Council was focused on food as well. The LNHA stated that if there were any issues related to food, the FSD addressed issues immediately.

On 5/2/22 at 10:53 AM, the survey team interviewed the LNHA and DON regarding the facility's QAPI program. The LNHA stated that the FSD was part of the QA committee, but only joined this quarter (April 2022). When asked about the FSD signature of attendance for the October 2021 and January 2022 meetings, the LNHA could not speak. The LNHA stated that in April, the FSD brought the issue of cold food to their attention. The LNHA stated that the number one complaint in all facilities is food. The LNHA stated that the facility contributed food issues to the contracted [name redacted] Food Service Company and their lack of oversight and ordering. The LNHA stated that was why the facility was changing contracted food service companies.

On 5/2/22 at 11:48 AM, the LNHA provided the surveyor with a contract for a new contracted [name redacted] Food Service Company. A

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 58 review of this document revealed a proposal date of 4/7/22 with a contract signed date of 4/26/22 the day the Immediate Jeopardy was called. NJAC 8:39-33.2(a)	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061423	A. BUILDING: _____ B. WING _____	05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Part A: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 1 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	I.CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: a)Facility actively seeks to hire CNAs by continuously running ads in various employment application websites/social media platforms. Staffing Coordinator/Director of Nursing will ensure that all shifts are scheduled with coverage to comply with staffing ratios. Any callouts or no-shows will result in calls made by	7/5/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061423	A. BUILDING: _____ B. WING _____	05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
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S 560	Continued From page 1 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 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. During entrance conference on 4/19/22 at 10:55 AM, the Director of Nursing (DON) in the presence of the Director of Marketing, informed the surveyor that the facility staffing was good. The DON stated that the facility used Temporary Nursing Aides (TNA) as well as offered overtime to staff the facility. The DON stated that the facility used Agency staff as needed. As per the "Nurse Staffing Report" completed by the facility for the weeks of 4/3/22 to 4/9/22 and 4/10/22 to 4/16/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below:	S 560	the Staffing Coordinator and/or shift supervisor to fill the shift□s staffing needs and ensure that all residents are cared for. No residents have been adversely affected by the deficient practice. b)Since facility has not been successful in hiring a Full-Time Infection Preventionist despite its recruitment efforts, facility hired a new Assistant Director of Nursing (with start date of July 5, 2022) so the current IP/ADON will work as the facility□s Full-Time Infection Preventionist. The IP (Infection Preventionist) completed and passed the 25 modules of CDC□s Infection Preventionist Training. She will also register for the IPCO (Infection Prevention and Control Officer) Certification Training that is offered by the American Health Care Association. II.IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE a)All residents have the potential to be affected by the same deficient practice. III.SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR a)Facility□s Recruitment and Retention Strategies and Efforts to comply with the State□s Staffing Ratios have been in progress, which include but are not limited to the following: o Offer Sign on bonuses to attract staff	

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S 560	Continued From page 2 4/8/22 had 14 CNAs for 115 residents on the day shift, required 15 CNAs. Part B: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that the Infection Preventionist who was assigned to oversee their infection control program had no other responsibilities as mandated by the State of New Jersey. This deficient practice was identified, and the findings were as followed: Reference: New Jersey Executive Directive 20-026 "Directive for the Resumption of Services in all Long-Term Care Facilities" dated 1/6/21, directs the following: "iv: Facilities with no Ventilator Beds a. Facilities with 100 beds or more beds or on-site hemodialysis services must: 1.) Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to hiring no later than August 10, 2021." (*extended to February 1, 2022) During entrance conference on 4/19/22 at 10:55 AM, the surveyor asked the Director of Nursing (DON) in the presence of the Director of Marketing, who was responsible for the facility's infection control and prevention program? The DON responded that the Registered Nurse was promoted to the Infection Preventionist (IP) position a few weeks ago, and that she was also as of last week the facility's Assistant Director of Nursing (ADON). The DON also stated that a Regional IP visits the facility monthly.	S 560	o Recruitment bonus to encourage referrals from current staff o Offering daily and weekend bonuses to attract overtime or PRN staff shifts o Aggressively running ads in various employment application websites social media o Flexible shifts and schedules o Working with C.N.A. schools to send Temporary Nurse□s Aides for certification o Currently have contracts with staffing agencies IV.MONITORING OF CORRECTIVE ACTIONS a)HR Director/Staffing Coordinator will provide monthly reports to the Director of Nursing and Administrator regarding status of recruitment and other efforts made to try to comply with the State□s Staffing Ratios. Reports will be submitted to the QAPI Committee monthly X 3 months then quarterly thereafter. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further action plans.	

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S 560	Continued From page 3 On 4/26/22 at 9:55 AM, the surveyor requested from the DON to speak with the IP/ADON. The DON replied that the IP/ADON was the medication cart nurse for the Fifth Floor nursing unit today, and that she would send her to the conference room. On 4/26/22 at 10:01 AM, the surveyor interviewed the IP/ADON who confirmed that she was the Fifth Floor medication cart nurse today because of a callout as well as last Friday (4/22/22) because of a callout. The IP/ADON stated that she had worked at the facility for the past three years, and on 3/27/22, she started her training in infection control. The IP/ADON continued that the previous IP/ADON left the facility on 4/5/22 so she transitioned to the IP/ADON positions. The IP/ADON stated that her job responsibilities as ADON included to assist Staff Coordinator with staffing, monitor all the nurses and their charting, oversee the Second and Fifth Floor nursing units, and wound care. The ADON/IP stated that her job responsibilities for IP included antibiotic stewardship program, quality assurance meetings, infection tracking, and staff infection control education. The ADON/IP stated that the DON oversaw the facility's COVID-19 testing and vaccination efforts. On 4/29/22 at 2:25 PM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), IP/ADON, Regional Clinical Consultant and survey team, stated that the previous ADON who left was only tracking infections and the antibiotic stewardship program because she did not have the required education for the IP role. The DON stated that prior to this IP/ADON, there was no IP, that the facility had utilized consultants during COVID-19.	S 560		

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S 560	Continued From page 4 On 5/2/22 at 10:25 AM, the LNHA in the presence of the DON, IP/ADON, and survey team, acknowledged that the facility needed to hire a full-time infection preventionist. A review of the undated facility provided "Job Title Assistant Director, Nursing" included for the job description: Under the supervision of the Director of Nursing, the Assistant Director of Nursing assumes delegated responsibility and accountability for provisions of resident care according to professional standards of nursing practices... implements nursing policies and procedures... conducts education, infection control, quality assurance and admission screening as assigned... oversees nutrition, wound, restraints, and restorative programs... responsible for making daily rounds on unit to supervise, observe, examine, interview residents, evaluate staffing needs, monitor regulatory compliance, to achieve the care environment and to evaluate staff interactions and and clinical skill competencies. Develops and maintains nursing policies and procedures... establishes and implements infection control program... conducts infection control surveillance and activities to investigate, control and prevent infections in the facility... audits clinical records for accuracy and completeness of comprehensive resident assessments... A review of the facility provided infection preventionist job responsibilities from the American Association of Directors of Nursing Services titled "Infection Preventionist Job Description" dated released April 2019, included under duties and responsibilities: collaborate with the facility leadership and the medical director to develop, implement, and evaluate the annual	S 560		

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S 560	Continued From page 5 infection prevention goals and action plan... establish a facility-wide system for prevention,identification, investigation, and control of infections of resident, staff, visitors, including surveillance designed to identify possible communicable diseases of infections before they spread; conduct outbreak investigations; maintain a system for reporting possible incidents of communicable diseases to local, state, or national agencies as required; oversee antibiotic stewardship program... assess the need for, develop, and present [IPCP]infection prevention and control program in-service education... assess the need for, develop, and implement written policies and procedures for infection control... be accountable for healthcare-acquired and community-acquired infections for residents, staff, volunteers, and visitors.... Part C: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that the Infection Preventionist who was assigned to oversee their infection prevention and control program met the minimum qualifications as mandated by the State of New Jersey. This was deficient practice was identified and the findings are as followed: Reference: New Jersey Executive Directive 20-026 "Directive for the Resumption of Services in all Long-Term Care Facilities" dated 1/6/21, directs the following: "In addition to the requirements in N.J.A.C. 8:39-20, the following practices shall remain in place even as LTCF's (Long-Term Care Facilities) resume normal activities, regardless of the facility's current reopening phase; ...	S 560		

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S 560	Continued From page 6 ii. All facilities except for facilities with ventilator-dependent residents, are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; b. A physician who has completed and infectious disease fellowship; c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of infection control experience." Reference: N.J.A.C 8:39 - Standards for Licensure of Long-Term Care Facilities Subchapter 20. Advisory Infection Control and Sanitation 8:39-20.2 Advisory staff qualifications dated 11/17: "a. The infection control coordinator is certified in Infection Control (CIC) by the National Board of Infection Control.... b. The infection control coordinator is an active member of the National Association for Professionals in Infection Control and Epidemiology, Inc. (APIC).... c. The infection coordinator has completed an APIC Basic Training Course or has received at least 25 hours of training in infection control, and receives additional six hours of training annually."	S 560		

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S 560	Continued From page 7 During entrance conference on 4/19/22 at 10:55 AM, the surveyor asked the Director of Nursing (DON) in the presence of the Director of Marketing, who was responsible for the facility's infection control and prevention program? The DON responded that the Registered Nurse was promoted to the Infection Preventionist (IP) position a few weeks ago, and that she was also as of last week the facility's Assistant Director of Nursing (ADON). The DON also stated that a Regional IP visits the facility monthly. A review of the facility provided IP/ADON's infection control training was as followed: Centers for Disease Control and Prevention (CDC) Nursing Home Infection Preventionist Training Course completed 19.75 contact hours on 3/27/22 CDC Nursing Home Infection Preventionist Training completed two continuing education units on 3/27/22. There was no evidence that the IP/ADON completed 25 hours of infection control education or was a CIC. On 4/26/22 at 10:01 AM, the surveyor interviewed the IP/ADON who stated that she had worked at the facility for three years and was previously the subacute nursing unit manager. The IP/ADON stated that on 3/27/22, she started her CDC Nursing Home Infection Preventionist Training Course for the infection preventionist role. The IP/ADON stated that she had no additional infection control training besides the CDC training. The IP/ADON stated that the facility had a CIC who came to the facility three times a	S 560		

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S 560	Continued From page 8 month to educate her and assist as needed. The IP/ADON stated that there were no additional nurses who assisted in infection control. On 4/29/22 at 2:25 PM, the DON in the presence of the LNHA, IP/ADON, Clinical Consultant, and survey team confirmed that the IP/ADON did not have the minimum required infection control education. The DON stated that he facility used contracted CIC's as consultants. NJAC 8:39-5.1(a)	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315355 Y1	A. Building B. Wing Y2	7/11/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

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 F0578	Correction	ID Prefix F0658	Correction	ID Prefix F0677	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	06/13/2022	LSC	07/01/2022	LSC	07/08/2022
ID Prefix F0689	Correction	ID Prefix F0712	Correction	ID Prefix F0759	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	07/08/2022	LSC	07/08/2022	LSC	07/08/2022
ID Prefix F0800	Correction	ID Prefix F0804	Correction	ID Prefix F0812	Correction
Reg. # 483.60	Completed	Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	07/08/2022	LSC	07/08/2022	LSC	07/08/2022
ID Prefix F0838	Correction	ID Prefix F0865	Correction	ID Prefix	Correction
Reg. # 483.70(e)(1)-(3)	Completed	Reg. # 483.75(a)(2)(h)(i)	Completed	Reg. #	Completed
LSC	07/08/2022	LSC	07/01/2022	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?
5/2/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061423 Y1	A. Building B. Wing Y2	7/11/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

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	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/05/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/2/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	R 07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 07801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 An on-site revisit survey was conducted on 7/11/22. Census: 128 Sample: 3 The facility was found to be in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities.	{F 000}		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/02/2022**

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET** **DOVER, NJ 07801**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/21/22 and 4/22/22, 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 The Nursing Home is a 6-story building that was built in 90's, It is composed of Type II unprotected construction. The facility is divided into 10- smoke zones. The generator does 100% of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 155 certified beds. At the time of the survey the census was 124.	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/26/2022

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

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K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of	K 161		7/13/22

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K 161	Continued From page 2 approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide an acceptable construction type and construction standards in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6. This deficient practice was identified for 4 of 6 accessible building observations and evidenced by the following: 1. On 4/21/22 during the building tour at 12:20 PM, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim), observed on floor #6, that when the ceiling tiles were removed on both sides of the 2-hour barrier from the old section of the building to the new section of the building, it was observed that the beam, metal box truss and supporting corrugated steel decking were all unprotected with no fire resistant rating provided. 2. On 4/21/22 during the building tour at 12:50 PM, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim) observed on floor #5, that when the ceiling tiles were removed on both sides of the 2-hour barrier from the old section of the building to the new section of the building, it was observed that the beam, metal box truss and supporting corrugated steel decking were all unprotected with no fire resistant rating provided. 3. On 4/21/22 during the building tour at 1:30 PM, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim)	K 161	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a) The facility requested for a Time Limited Waiver since the time frame to complete the repairs in addressing all areas to achieve the required 2-hour fire protection is estimated to exceed the required 60 days to comply. The facility hired a contractor to provide scope of work for repair/replacement of the missing fire protection on the unprotected structural steel beams visible above the ceiling. Completion date for construction of work related to this waiver would be 12/31/2025. b)To mitigate the current situation and to ensure the safety of the residents/staff /visitors, the Director of Maintenance or designee will conduct monthly in-services to all staff on life saving strategies that focus on fire prevention and resident transfer techniques. The Director of Maintenance will also ensure that monthly fire drills are conducted. c) No residents, staff or visitors were directly affected by this deficient practice. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what	

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K 161	Continued From page 3 observed on floor #4, that when the ceiling tiles were removed on both sides of the 2-hour barrier from the old section of the building to the new section of the building, it was observed that the beam, metal box truss and supporting corrugated steel decking were all unprotected with no fire resistant rating provided. 4. On 4/21/22 during the building tour at 2:10 PM, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim) observed on floor #3, that when the ceiling tiles were removed on both sides of the 2-hour barrier from the old section of the building to the new section of the building, it was observed that the beam, metal box truss and supporting corrugated steel decking were all unprotected with no fire resistant rating provided. On 4/21/22 at approximately 1:10 PM, the surveyor conducted an interview with the Maintenance Director (interim) and Administrator (interim). The surveyor asked for a set of building plans identifying the metal deck was restrained or unrestrained, UL assembly and fire resistance rating for the steel beams and composite metal corrugated deck. At that time, no documents and/or drawings were provided. The Administrator (interim) was informed of the findings at the Life Safety Code exit conference on 4/22/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Life Safety Code. Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6.	K 161	corrective action will be taken? a)All residents, staff and visitors have the potential to be affected by the deficient practice. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a)The facility requested for a Time Limited Waiver and hired a contractor to provide scope of work for repair/replacement of the missing fire protection on the unprotected structural steel beams visible above the ceiling. Completion date for construction of work related to this waiver would be 12/31/2025. b) The facility has implemented a monthly fire safety inspection form to be completed by the Director of Maintenance or designee to ensure that all fire safety systems such as ceiling systems, door closers and penetrations are in full operational condition. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4a)The Director of Environmental Services or Designee will conduct monthly audits until completion of all work related to the tag to assess continued fire safety	

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K 161	Continued From page 4	K 161	requirements. Audit findings will be presented monthly to the QAPI Committee on a monthly basis for evaluation and follow up while the waiver is active. 4b)Until the completion of the construction of work related to this waiver, the Administrator or Designee will conduct the following monthly audits to ensure that the residents/staff/visitors are kept safe: (a) Review Sign-in sheets to ensure that monthly in-services to all staff are completed on life saving strategies that focus on fire prevention and resident transfer techniques (b)Review evidence of completion of monthly fire drills; and (c) Review of completed monthly fire safety inspection form to ensure that Director of Maintenance or Designee checked all fire safety systems (such as ceiling systems, door closers and penetrations) to ensure that they are in full operational condition. Findings of the above audits will be reported to the QAPI Committee on a monthly basis and will be incorporated in the Facility□s QAPI Program.	
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	K 222		6/27/22

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K 222	Continued From page 5 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 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.	K 222		

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K 222	Continued From page 6 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 observation and interview from 4/21/22 to 4/22/22, it was determined that the facility failed to ensure that exit doors locked with a delayed egress device were provided with instructional signage as per the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was identified in 4 of 6 egress doors and evidenced by the following: 1. On 4/21/22 at 12:20 PM, the surveyor, Maintenance Director (interim) and Administrator (interim), observed the floor #5 dining/day room had a delayed egress device installed on the door for non-emergency egress. The door was not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button keypad and opened with the activation of the fire alarm. 2. On 4/21/22 at 12:30 PM, the surveyor,	K 222	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a)The Maintenance staff placed instructional signage on the egress doors, which have a delayed egress device installed on the door for non-emergency egress. Specifically, signs with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds" were placed in the following egress doors: (1) By the door for non-emergency egress in Floor #5 Dining/Day room (2) By the door for non-emergency egress in Floor #4 Dining/Day room (3) By the exit/egress door by elevator #3 in Floor #3 (4) By the #1 exit/egress door by	

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K 222	Continued From page 7 Maintenance Director (interim) and Administrator (interim), observed the floor #4 (currently closed) dining/day room, that when the delayed egress was activated, it was delayed by approximately three (3) seconds before the 15-second function would activate. 3. On 4/21/22 at 1:20 PM, the surveyor, Maintenance Director (interim) and Administrator (interim), observed the floor #3 exit/egress door by elevator #3 had a delayed egress device installed on the door for non-emergency egress. The door was not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button keypad and opened with the activation of the fire alarm. 4. On 4/22/22 at 1:28 PM, the surveyor, Maintenance Director (interim) and Administrator (interim), observed the floor #1 exit/egress door by Resident Room [redacted] had a EX Order 26 § 4b1 [redacted] EX Order 26 § 4 installed on the door for non-emergency. The door was not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button keypad and opened with the activation of the fire alarm. The Maintenance Director (interim) and Administrator (interim), confirmed the findings at the time of the observations. The Administrator (interim) was informed of these findings during the Life Safety Code survey exit conference on 4/21/22.	K 222	Resident Room [redacted] in Floor #1 (5) Floor # 4 door was repaired so there no delay before 15 agrees b) No residents were directly affected by this deficient practice. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a)All residents who have access to exit doors locked with a delayed egress device have the potential to be affected by the deficient practice. There were no residents affected by this situation. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a)The Maintenance staff placed instructional signage, i.e. Signs with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds" by all egress doors with delayed egress device installed on the door for non-emergency egress. b)The maintenance director and/or designee will test exit doors weekly to ensure there is no delayed prior to 15 seconds function is activated 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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K 222	Continued From page 8 NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222	program will be put into place: a)The Maintenance Director or designee will perform observation audits monthly x 6 months, to ensure that exit doors locked with a delayed egress device are provided with instructional signage as required by regulation (Signs with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds) in addition to ensure that there is no delay prior to 15 seconds egress is activated Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program to ensure on-going compliance	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/22/22, the facility failed to provide stair thread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3.	K 225	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a)The Maintenance staff painted marking stripes on the nosing of each step, each floor landing, and handrails of the exit/egress stairwells (A, B and back	6/27/22

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K 225	Continued From page 9 The deficient practice was observed in 3 of 3 stairwells identified by the Maintenance Director as A, B and back stairwell in the facility and evidenced by the following: While touring the facility on 4/21/22, from approximately 9:40 AM to 3:00 PM, the surveyor, Maintenance Director (interim) and Administrator (interim) observed that the exit/egress stairwells, revealed that marking stripes were not present on each step, floor landing, and handrails for the 3 stairwells observed. The findings were verified by the Maintenance Director (interim) and Administrator (interim) at the times of the observations. The Administrator (interim) was informed of this finding during the Life Safety Code survey exit conference on 4/22/22. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	stairwells) in the facility. b)No residents were affected by this deficient practice. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a)All residents, staff and visitors who may have access to the exit/egress stairwells have the potential to be affected by the deficient practice. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a)The Maintenance staff painted marking stripes on the nosing of each step, each floor landing, and handrails of all exit/egress stairwells in the facility. This is to promote optimal safety of all individuals who have access to the stairwells. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: a)The Maintenance Director or designee will perform observation audits monthly x 6 months, to ensure that all stairwells have stair thread marking stripes (applied as a material that is integral with the nosing of each step, each floor's landing and handrails) with solid and continuous	

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K 225	Continued From page 10	K 225	marking stripes. Results of audits will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program to ensure on-going compliance.	
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on interview and observation, in the presence of the facility's Maintenance Director (interim) and Administrator (Interim) from 4/21/22 to 4/22/22, it was determined that the facility failed to ensure that exits did not pass through an intervening room. This deficient practice was identified in 1 of 2 exits and evidenced by the following: During a tour of the building on 4/21/22 to 4/22/22, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim), observed 1 of 2 of exits located on floors 3 through 6 that passed through the Dayroom/Dining room, instead of directly to the exit stairway. This condition was acknowledge by the Administrator (interim) during the tour and	K 252	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1a)No residents were directly affected by this deficient practice. 1. The Facility has contracted with an Architectural firm to review the affected area for compliance 2012 NFPA 101 19.2 Means of Egress. The facility respectfully requests a Time Limited Waiver so that the Architect can complete the assessment and the facility can complete any and all work required to ensure regulatory compliance	7/27/22

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET** **DOVER, NJ 07801**

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K 252	Continued From page 11 verbally conveyed to him during the Life Safety Code survey exit conference on 4/22/22. This will now be cited for not following their accepted Plan of Correction (POC) from previous survey. A new waiver request from the facility will now be required. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.5.4 NFPA 101-2012 edition Life Safety Code sections 7.4 and 7.5	K 252	2. All staff who work on the affected units will be in-serviced to ensure that the egress areas are always clear of any obstacles. 3. The facility will mark the flooring on floors 3-6 thereby creating “visual” barriers to help staff identify the area that needs to remains clear at all times. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 2a)All residents, staff and visitors who are in Floors 3 through 6 have the potential to be affected by the deficient practice. 2b)The facility conducted a review of all other exiting areas to ensure compliance with 23012 NFPA 101 19.2. No other areas were found to be out of compliance or other residents found to be affected. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 1.All staff shall be inserviced on the changes and to keep egress area clear at all times. 2.The facility shall add to the safety audit tool the review of exits monthly. 3.Based on the recommendation of the design professionals, facility will implement said recommendations to	

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K 252	Continued From page 12	K 252	ensure compliance. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: a)The Maintenance supervisor/Designee will continue to monitor life safety in the facility in accordance with regulations via monthly rounds on the audit tool, with focus on ensuring that the exit areas in the horizontal exit paths on Floors 3 through 6 are clear of any obstacles at all times. Audits will be done monthly until completion of work related to the Time limited waiver. b)Monitoring of Life Safety in the facility (including any changes to the structure or the building) via monthly rounds and completion of quarterly in-services will be reported to the QAPI Committee on a quarterly basis to ensure on-going compliance. Findings will be discussed in quarterly QAPI Meeting and will be incorporated in the Facility QAPI Program. Monitoring will be done monthly and reported quarterly until completion of work related to the Time limited waiver.	
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of	K 271		6/27/22

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K 271	Continued From page 13 obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/22/22, the facility failed to provide and maintain a level walking surface, free of all obstructions and impediments and handrails, to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient condition was identified for 3 of 4 exit discharges observed and was evidenced by the following: 1. At 10:20 AM, during an exterior tour of the building from 9:30 AM to 2:30 PM, the surveyor and Maintenance Director (interim) observed that the egress/exit by the exterior garage (left of the main entrance), was not set level. Approximately a three-inch (3") step leading to the blacktop was observed. 2. At 10:40 AM, during an exterior tour of the building from 9:30 AM to 2:30 PM, the surveyor and Maintenance Director (interim) observed that in the floor 1 dining/day/conference room leading to the outside patio, that two tables and five chairs were blocking the exit/egress path to the public way. The path was not free of all obstructions or impediments to full instant use in the case of fire or other emergency. 3. At 10:55 AM, during an exterior tour of the building from 9:30 AM to 2:30 PM, the surveyor and Maintenance Director (interim) observed that	K 271	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a)To ensure a level walking surface, the facility had a contractor set level the step leading to the blacktop egress/exit by the exterior garage (left of the main entrance). b)The Maintenance Staff immediately moved the two tables and five chairs that were blocking the exit/egress path to the public way in the Floor 1 dining/day/conference room leading to the outside patio, c)The Maintenance Staff installed a handrail on the steps going towards the public way in the Subacute exterior entrance. d)No residents were directly affected by this deficient practice. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a)All residents, staff and visitors have the potential to be affected by the deficient practice.	

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K 271	Continued From page 14 the Subacute exterior entrance had three concrete steps to the public way, but was not provided with a handrail. The Maintenance Director (interim) confirmed the findings at the time of the observations. The Administrator (interim) was informed of the finding at the Life Safety Code exit conference on 4/22/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7, 19.2.7	K 271	b)Interim Maintenance Director conducted rounds to ensure that facility is in compliance with regulations governing Discharge from Exits. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a)Administrator/Designee in-serviced Maintenance staff to ensure that facility is in compliance with regulations governing Discharge from Exits. Emphasis was made on the following: (a) Maintain level walking surfaces, (b) Ensure that paths are free of all obstructions and impediments, and (c) Handrails are installed on steps to promote safety when exiting. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: a)Maintenance Director /Designee will conduct monthly rounds x 6 months to ensure that (a) Level Walking Surfaces are maintained, (b) Paths are free of all obstructions and impediments, and (c) Handrails are present on steps to promote safety when exiting. Any issues will be reported to the Administrator immediately for corrective actions. Findings will be submitted to the QAPI Committee on a monthly basis x 6 months. QAPI Committee will determine the need for further action plans if	

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K 271	Continued From page 15	K 271	necessary.	
K 293 SS=D	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 observation and interview from 4/21/22 to 4/22/22, in the presence of the Maintenance Director (interim) and Administrator (interim), the facility failed to provide signs with a directional indicator showing the direction of travel, in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 2 of 20 exit signs observed and was evidenced by the following: 1. On 4/22/22 at 12:28 PM, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim), observed in the basement that when exiting the kitchen area, a wall mounted exit sign would not provide a proper directional indicator, as both arrows were removed from the sign and the left removed arrow would now lead you into a wall. 2. On 4/22/22 at 12:30 PM, the surveyor in the	K 293	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1a)The Maintenance Assistant replaced the mounted Exit Sign in the basement (when exiting the kitchen) with a new Exit Sign that provides the proper directional indicator for all individuals who may have access to the basement. 1b)The Maintenance Assistant installed an Exit Sign on the wall when exiting from north side of basement to south side to provide a proper directional indicator for for all individuals who may have access to the basement. 1c)No residents, staff or visitors were affected by this deficient practice. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what	6/27/22

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K 293	Continued From page 16 presence of the Maintenance Director (interim) and Administrator (interim), observed in the basement when exiting from the north to the south section, that there was no exit sign displayed. The findings was verified by the Maintenance Director (interim) and Administrator (interim) at the time of the observation. The Administrator (interim) was informed of these findings at the Life Safety Code exit conference on 4/22/22. NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293	corrective action will be taken? 2a)All individuals (staff, residents or visitors) have the potential to be affected by the deficient practice. Interim Maintenance Director conducted rounds to ensure that the facility has signs with a directional indicator showing the direction of travel in every location where the direction of travel to reach the nearest exit is not apparent. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 3a)Administrator/Designee in-serviced Maintenance staff to ensure that the facility has directional signs (with a directional indicator showing the direction of travel) are placed in every location where the direction of travel to reach the nearest exit is not apparent. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4a)Maintenance Director or Designee will conduct monthly rounds x 6 months to ensure that the facility has signs with a directional indicator showing the direction of travel, in every location where the direction of travel to reach the nearest exit is not apparent. Any issues will be immediately corrected. Findings will be submitted to the QAPI Committee on a monthly basis x 6 months. QAPI	

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K 293	Continued From page 17	K 293	Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview from 4/21/22	K 321	1)What corrective action(s) will be	6/27/22

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K 321	Continued From page 18 to 4/22/22, in the presence of the Maintenance Director (interim) and Administrator (interim), it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous area in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in 1 of 25 hazardous storage areas in the facility and was evidenced by the following: On 4/21/22 at 12:35 PM, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim) observed that Resident Room [redacted] was turned into a hazardous storage room. The room contained ten plastic containers filled with holiday decorations, six filled combustible cardboard boxes and four mattresses. The room was over 50 square feet in size and the door did not have a self-closing device installed. An interview was conducted with the former Maintenance Director (interim) at the time of the observation, who confirmed that hazardous storage areas must have a door with a self-closing device. The Administrator (Interim) was informed of the finding at the Life Safety Code exit conference on 4/22/22. NJAC 8:39-31.2(e)	K 321	accomplished for those residents found to have been affected by the deficient practice? 1a)Maintenance Assistant installed a self-closing device in Room Number [redacted] which was turned into a hazardous storage room. No residents, staff or visitors were affected by the deficient practice. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 2a)All residents, staff and visitors who may have access to hazardous storage areas have the potential to be affected by the deficient practice. The Interim Maintenance Director and Interim Administrator conducted rounds to ensure that self-closing devices and hardware are installed on all doors to hazardous storage areas in the facility. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 3a)Administrator/Designee in-serviced Maintenance staff to ensure that self-closing devices and hardware are installed on all doors to hazardous storage areas in the facility. 4)How the corrective action(s) will be monitored to ensure the deficient practice	

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K 321	Continued From page 19	K 321	will not recur, i.e., what quality assurance program will be put into place: 4a)Maintenance Director/Designee will conduct monthly rounds x 6 months of all hazardous storage areas in the facility to ensure that self-closing devices and hardware are installed on their doors. Findings will be submitted to the QAPI Committee monthly basis x 6 months. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent facility documentation, in the presence of the facility's Maintenance Director (interim) and Administrator (interim) on 4/21/22, it was determined that the facility failed to ensure that the fixed interior wall surfaces have a flame spread rating of Class A or B.	K 331	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a)Facility contacted the vendor that completed installation of the 36-inch carpet on the lower section of the walls in	7/1/22

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K 331	Continued From page 20 This deficient practice was evidenced for 6 of 6 corridors and was evidenced by the following: During a tour of the facility on 4/21/22, the surveyor observed in exit corridors, carpet on the lower section of the walls. The carpet measured approximately 36 inches up from the floor. The Maintenance Director (interim) was asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface. A document was provided from the facility vendor indicating the carpet was treated with shield plus fire retardant prior to installation from 3/8/17 to 3/15/17, but did not provide any documentation on how long the shield plus fire retardant lasts. The document also indicated the carpet was Class 1-Nylon but the interior wall finish must have a flame spread rating of Class A or Class B where an approved automatic sprinkler system was installed in accordance with section 9.7, Class C interior wall finish materials shall be permitted. The Administrator (interim) was notified of the findings at the Life Safety Code exit conference on 4/22/22. There were no further documents provided. N.J.A.C. 8:39-31.2(e) N.J.A.C. 8:39-31.1(c) NJAC 101 2012 edition Life Safety Code 10.2.3* and 10.2.8.1	K 331	the exit corridors in each floor. The vendor provided confirmation in writing of the type of carpet that exist. It is a FH27P/ Duration II 36 has Class A/Class 1 fire rating. Documentation from vendor verified the wall carpet specifications, treatment of the carpets with shield plus fire retardant and confirmed that the flame spread rating of fixed interior wall surfaces meet the regulatory requirements. No residents were affected by the situation. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a)All residents, staff and visitors have the potential to be affected by the deficient practice. Facility's Maintenance Director will maintain pertinent documentation related to ensuring that the facility is in compliance with regulations related to the Flame Spread rating of fixed interior wall surfaces. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a)Administrator or designee will have the facility vendor conduct a monthly evaluation of the carpets on the lower sections of the walls in the exit corridors in each floor to ensure that the facility is in	

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K 331	Continued From page 21	K 331	compliance with regulations related to the Flame Spread rating of fixed interior wall surfaces. Any recommendations and/or measures taken to ensure compliance will be properly documented by the vendor and adhered to by the facility. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: a)Administrator will review documentation/reports by the facility vendor and will continue to monitor life safety in the facility on a monthly basis. Findings will be submitted to the QAPI Committee monthly basis x 6 months. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K 351		6/27/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 22 of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 4/22/22 in the presence of facility Maintenance Director (interim) and Administrator (interim), it was determined that the facility failed to provide automatic fire sprinkler system protection to all areas in accordance with NFPA 13. This deficient practice was identified for 1 of 2 areas observed and was evidenced by the following: At 12:38 PM, the surveyor observed that there was no fire sprinkler protection provided to the outside (green) overhang canopy. The (green) outside overhang canopy indicated "Regency Grande Nursing Center" measured approximately twelve-feet by twelve-feet (12' x 12'). The outside of the metal frame was attached to the building. An interview was conducted with the Maintenance Director (interim) and Administrator (interim) at the time of the observation, where they confirmed that the outside overhang did not have any fire sprinkler coverage. The Administrator (interim) was informed of the observation at the life Safety Code exit conference on 4/22/22. NJAC 8:39-31.2(e) NFPA 13, 25	K 351	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1a)The outside (green) overhang canopy was completely removed and taken down by the Interim Maintenance Director and Maintenance Assistant. Therefore, the installation of fire sprinkler protection or coverage for the canopy is no longer necessary. No residents, staff or visitors were adversely affected by the deficient practice. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 2a)All residents, staff and visitors have the potential to be affected by the same deficient practice. The Interim Maintenance Director conducted rounds to ensure that sprinklers are installed throughout the facility premises in areas that require sprinkler protection coverage.	

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	315355	A. BUILDING **01** B. WING _____	**05/02/2022**

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K 351	Continued From page 23	K 351	3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 3a)Administrator in-serviced the Maintenance Department to ensure that automatic fire sprinkler system protection is installed throughout the facility premises in areas that require sprinkler protection coverage, including under exterior roofs or overhang canopies that are attached to the building. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4a)Maintenance Director/Designee will conduct monthly rounds x 6 months to ensure that automatic fire sprinkler system protection is installed in all areas that are attached to the building. Findings will be submitted to the QAPI Committee monthly basis x 6 months. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		6/27/22

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K 363	Continued From page 24 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/22/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch	K 363	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1)The facility completed the following corrective measures to make sure that the	

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K 363	Continued From page 25 restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in 4 of 50 resident room doors observed and was evidenced by the following: 1. On 4/22/22, during the building tour from 9:00 AM to 3:30 PM, the surveyor and Maintenance Director (interim) observed that the door to Resident Room [redacted] did not latch into the door frame properly,due to the door being warped at the top, leaving approximately a half-inch (1/2") opening. 2. On 4/22/22, during the building tour from 9:00 AM to 3:30 PM, the surveyor and Maintenance Director (interim) observed that the door to Resident Room [redacted] did not latch into the door frame due to a hardware issue. 3. On 4/22/22, during the building tour from 9:00 AM to 3:30 PM, the surveyor and Maintenance Director (interim) observed that the door to Resident Room [redacted] latched into the doorframe, but left a gap at the top of the door approximately 1/4 to 1/2 inch. 4. On 4/22/22, during the building tour from 9:00 AM to 3:30 PM, the surveyor and Maintenance Director (interim) observed that the door to Resident Room [redacted] did not latch into the doorframe, due to the bed #1's privacy curtain blocking the door from latching into its doorframe. An interview was conducted with the Maintenance Director (interim) at the time of the observations who confirmed the above findings.	K 363	deficient room doors will close and latch. This will ensure that corridor doors are able to resist the passage of smoke, to properly confine fire and smoke products, to properly defend occupants in place, and protect all individuals in the facility: a)The Maintenance Staff installed a gap sealing strip to repair the ¿ opening top of the door in Room Number [redacted] and Room Number [redacted] b)The Maintenance Staff replaced the doorknobs on Room Number [redacted] and 516. c)Maintenance staff moved the nightstand in Room Number [redacted] to prevent the privacy curtain from blocking the door and from latching into the doorframe. No residents, staff and/or visitors were adversely affected by the deficient practice. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 2a)All residents, staff and/or visitors have the potential to be affected by the deficient practice. Interim Director of Maintenance made rounds to ensure that all room doors close and latch properly. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 3a)Administrator in-serviced the	

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K 363	Continued From page 26 The Administrator (interim) was informed of the finding at the Life Safety Code exit conference on 4/22/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	Maintenance Department to ensure that the facility is compliant in properly confining fire and smoke products and in properly defending occupants in place by making sure that all room doors will close and latch. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4a)Maintenance Director/Designee will conduct monthly rounds x 6 months to ensure that all room doors will close and latch so they are able to resist the passage of smoke, properly confine fire and smoke products and to properly defend occupants in place. Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program to ensure on-going compliance	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 521		7/26/22

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K 521	Continued From page 27 Based on observation and interview from 4/21/22 to 4/22/22, in the presence of the Maintenance Director (interim) and Administrator (interim), it was determined that the facility failed to a.) ensure resident bathroom ventilation systems for 35 of 45 (shared bathroom) units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B and b.) provide smoke dampers for 4 of 4 corridor vents shafts observed. These deficient practices were evidenced by the following: A. During a tour of the building on 4/21/22 and 4/22/22, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim), observed that the ventilation in the following resident room bathrooms did not function: Floor #6 resident rooms [redacted] (7-bathrooms) Floor #5 resident rooms [redacted] (7-bathrooms) Floor #4 resident rooms [redacted] (7-bathrooms) Floor #3 resident rooms [redacted] 7-bathrooms) Floor #2 resident rooms [redacted] (7-bathrooms) The surveyor requested that the Maintenance Director (interim) confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation.	K 521	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1a)The exhaust fans on the roof have been replaced to ensure that the ventilations in the following resident room bathrooms are properly functioning: (a) Floor #6 - Resident rooms [redacted]; (b) Floor #5 - Resident rooms [redacted]; (c) Floor #4 - Resident rooms [redacted] (d) Floor #3 - Resident rooms [redacted] and (d) Floor #2 - Resident rooms [redacted] 1b)The facility is requesting for a Time Limited Waiver for the installation of the smoke actuated dampers on floors 6,5,4,3,2 and 1. The facility hired an HVAC professional to install the appropriate dampers to ensure smoke resistance between areas of refuge. Completion date for completion of work related to this waiver would be 9/15/2022. 1c)No residents, staff or visitors were adversely affected by the deficient practice. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 2a)All residents, staff and visitors have the potential to be affected by the deficient practice.	

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K 521	Continued From page 28 At that time, the surveyor interviewed the Maintenance Director (interim) and Administrator (interim), who confirmed that the exhaust vents in the above resident room bathrooms were not functioning when tested. B. During a building tour on 4/21/22 and 4/22/22, the surveyor in the presence of the Maintenance Director (interim) and Administrator (interim), observed 4 of 4 wall transfer grills on floors 6, 5, 4, 3, 2 and 1 that were all in the same shaft of the facility on each floor in the following locations of the facility: 1. back elevator approximately one-foot by one-foot (1' x 1') grill open to all floors approximately eight-inch (8") bump out from the wall. 2. back elevator approximately twenty-inch by eighteen-inch (20" x 18") unprotected metal panel open at the top and bottom approximately 8" bump out from the wall. 3. approximately 1' x 1' grill, water heater supply return. 4. approximately 1' x 1' grill on the elevator #1 side. The Maintenance Director (interim) confirmed that each transfer grill observed went from floors 1 through 6 and were not provided with any smoke -actuated dampers or other approved means to resist the transfer of smoke into areas of refuge. The Administrator (interim) was informed of the finding at the Life Safety Code exit conference on 4/22/22.	K 521	3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 3a)Facility had a contractor replace the exhaust fans in the roof to ensure that the ventilation systems of the affected bathrooms are properly functioning. 3b)The facility is requesting for a Time Limited Waiver for the installation of the smoke actuated dampers on floors 6,5,4,3,2 and 1. The facility hired an HVAC professional to install the appropriate dampers to ensure smoke resistance between areas of refuge. Completion date for completion of work related to this waiver would be 9/15/2022. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4a)The Director of Environmental Services/Designee will conduct monthly inspections and testing of the ventilation systems to ensure proper air ventilation in resident bathrooms. Findings will be submitted to the QAPI Committee monthly basis x 6 months. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance. 4b)The Director of Environmental Services or Designee will conduct monthly audits until completion of all work related	

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K 521	Continued From page 29 NFPA 90 A NFPA 101-2012 edition Life Safety Code NFPA 101-19.5.2.1 section 9.2.2 NFPA 101 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NFPA 101 19.3.6.4.1 Transfer grills, regardless of whether they are protected by fusible link dampers, shall not be used in corridor walls or doors. NJAC 8:39-31.2(e)	K 521	to the tag to assess continued fire safety requirements. Audit findings will be presented monthly to the QAPI Committee on a monthly basis for evaluation and follow up while the waiver is active. 4c)Until the installation of the smoke actuated dampers on floors 6,5,4,3,2 and 1, the Administrator or Designee will conduct the following monthly audits to ensure that the residents/staff/visitors are kept safe: (a) Review Sign-in sheets to ensure that monthly in-services to all staff are completed on life saving strategies that focus on fire prevention and resident transfer techniques (b)Review evidence of completion of monthly fire drills; and Findings of the above audits will be reported to the QAPI Committee on a monthly basis and will be incorporated in the Facility□s QAPI Program.	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the	K 531		6/27/22

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K 531	Continued From page 30 level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 4/22/22, it was determined that the facility failed to a.) ensure elevators were inspected on the Phase I and Phase II required monthly testing for 2 of 2 elevators, in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. and b.) maintain an elevator emergency audible alarm for 1 of 2 elevators, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: A). At 12:50 PM, the surveyor, Maintenance Director (interim), and Administrator (interim) observed no evidence that the Fire Fighters Emergency Operations Inspection and Test was performed and a written record of Phase I recall by use of the key switch, and a minimum of one floor operation, including findings documented monthly. Maintenance Director (interim) only recorded elevator #1 and elevator #2 on a monthly checklist. B). At 11:15 AM, the surveyor, Maintenance Director (interim), and Administrator (interim) both confirmed that the elevator #1 alarm bell did not activate when the Maintenance Director (interim)	K 531	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility completed the following corrective measures to ensure that all residents, staff and visitors who use the elevators are not adversely affected by the deficient practice: a)Elevator Repair Company was immediately contacted and technician repaired the elevator alarm bell for Elevator # on 4/21/2022. b)The required Fire Fighters Emergency Operations Inspection and Test was conducted and the completed Elevator Phase I and Phase II . No residents, staff or visitors were negatively affected by the deficient practice. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

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K 531	Continued From page 31 pushed the button to test in the event of an emergency. These findings were verified by the Maintenance Director (interim) at the time of the observations. The Administrator (interim) was informed of the finding at the Life Safety Code exit conference on 4/22/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531	2a)All residents, staff and visitors have the potential to be affected by the deficient practice. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator educated the Maintenance Staff regarding the following: (a) Ensure that elevators are inspected on the Phase I and Phase II required monthly testing for elevators, and (b) Ensure that an emergency audible alarm is maintained and properly functioning for each elevator. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director/Designee will conduct monthly audits to ensure that (a) Elevators are inspected on the Phase I and Phase II required monthly testing for elevators, and (b) Elevator emergency audible alarm is properly functioning for each elevator. Completed Audits Logs will be submitted to the Administrator on a monthly basis x 6 months. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance	
K 918 SS=F	Electrical Systems - Essential Electric Syste	K 918		6/27/22

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K 918	Continued From page 32 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 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 interview and review of facility	K 918	1)What corrective action(s) will be	

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K 918	Continued From page 33 documents on 4/21/22, in the presence of the Maintenance Director (interim), it was determined that the facility failed to a.)certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and b.) exercise the emergency electrical generator on load for 12 times each year in accordance with NFPA 99. This deficient practice was identified for 1 of 1 generator logs provided by the Maintenance Director (interim) and was evidenced by the following: A.) A review of the generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds, when the load test was conducted for 6 of 12 required load tests. No weekly or monthly log was provided for March and April 2022, also no transfer time was documented on the monthly load test for 11/16/21, 12/2/21, 1/13/22, and 2/29/22. B.) A review of the facility's emergency generator log for the previous 12 months revealed that the facility exercised the emergency generator weekly 24 times and for 6 of the required 12 (load) tests last year. No documents for the months of 5/21, 6/21, 7/21, 8/21, 9/21, and 10/21 weekly or monthly were provided. The Maintenance Director (interim) and Administrator (interim) both confirmed the documents provided on the generator above were correct and confirmed the dates provided.	K 918	accomplished for those residents found to have been affected by the deficient practice? a)The Maintenance staff were reeducated on the importance to do weekly and monthly test. The Maintenance Director/Designee conducted the Generator Testing to ensure that the time needed by their generator to transfer power to the building was within the required 10-second time frame b)No residents have been affected by the deficient practice. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a)All residents, staff and visitors have the potential to be affected by the deficient practice. Director of Maintenance will ensure that Generator Testing is performed and logged as scheduled: o Exercise the Emergency Generator Weekly o Monthly Full-Load Generator testing 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 3a)Administrator educated the Maintenance Staff to ensure that Generator Testing is performed and the Weekly and Monthly Logs are completed	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET** **DOVER, NJ 07801**

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K 918	Continued From page 34 The Administrator (interim) was informed of the findings at the Life Safety Code exit conference on 4/22/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	promptly and properly, including but not limited to the following: (a) Certify the time needed by the generator to transfer power to the building is within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and (b) Exercise the emergency electrical generator on load for 12 times each year 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: a)Administrator or designee will conduct monthly audits of the Generator Logs x 6 months to ensure that Maintenance Director is in compliance with the Generator Testing requirements. Results of the audits will be reported in the quarterly QAPI Committee Meetings. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity	K 920		6/27/22

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K 920	Continued From page 35 may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/21/22, the facility did not prohibit the use of power strips, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was identified for 5 of 30 areas observed and was evidenced by the following: 1. At 12:00 PM, the surveyor, Maintenance Director (interim), and Administrator (interim) observed in Resident Room [redacted] that there were electronics plugged into three white multi-outlet power strips attached to each other. The third	K 920	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility completed the following corrective measures to ensure the prevention of an electrical fire or electric shock hazard and ensure that all residents, staff and visitors are not adversely affected by the deficient practice: a)The Interim Maintenance Director removed the three (3) power strips plugged into the wall outlet in Room Number [redacted] b)The Maintenance Staff removed the yellow extension cord in the dry storage room in the basement and the commercial ice machine was properly plugged. c)The refrigerator in the Assistant Director	

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K 920	Continued From page 36 multi-outlet power strip was then plugged into a duplex wall outlet. 2. At 12:21 PM, the surveyor and Maintenance Director (interim) observed in the basement that a yellow extension cord was plugged into a duplex wall outlet. The extension cord was then going through the drop ceiling tiles to the next room and plugged into a commercial ice machine. 3. At 12:25 PM, the surveyor and Maintenance Director (interim) observed in the floor 5 ADON (Assistant Director of Nursing) office that a refridgerator was plugged into a white multi-outlet power strip. The power strip was then plugged into the duplex wall outlet. 4. At 12:32 PM, the surveyor and Maintenance Director (interim) observed in Resident Room [redacted] that a white multi-outlet power strip was attached to the top of a resident's night stand. The power strip was plugged into a duplex wall outlet. A policy and procedure was asked for multi outlet power strips, but was not provided at the time of exit. 5. At 1:28 PM, the surveyor and Maintenance Director (interim) observed in floor 3 ADON office that a refridgerator was plugged into a white multi-outlet power strip. The power strip was then plugged into the duplex wall outlet. The findings were verified by the Maintenance Director (interim) at the time of the observations. The Administrator (interim) was notified of the findings at the Life Safety Code exit conference on 4/22/22.	K 920	of Nursing□s Office in Floor 5 has been disconnected from the power strip by the Maintenance Staff and plugged into the duplex wall outlet. d)The Interim Maintenance Director removed the power strip that was attached to the top of the nightstand in Room [redacted]. Room [redacted] and all resident rooms on the 4th Floor have not occupied by any resident for several months. e)The refrigerator in the Assistant Director of Nursing□s Office in Floor 3 has been disconnected from the power strip by the Maintenance Staff and plugged into the duplex wall outlet. No residents, staff or visitors have been affected by the deficient practice. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a)All residents, staff and visitors have the potential to be affected by the deficient practice. Interim Director of Maintenance conducted rounds to ensure that power strips are NOT utilized in the facility as a substitute for adequate wiring, exceeding 75% of the capacity. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 3a)Facility staff was in-serviced regarding the following: Use of Power strips in the facility are PROHIBITED (as a substitute	

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K 920	Continued From page 37 NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2.	K 920	for adequate wiring, exceeding 75% of the capacity). This is to enhance the prevention of an electrical fire or electric shock hazard. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4a)Maintenance Director/Designee will conduct monthly rounds X 6 months to ensure that power strips are not utilized in the facility. Results of the audits will be reported to the QAPI Committee on a monthly basis. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual	K 923		6/27/22

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K 923	Continued From page 38 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 4/22/22, in the presence of the Maintenance Director (interim) and Administrator (interim), it was determined that the facility failed to prohibit combustible storage within 5-feet of quantities of oxygen exceeding 300 cubic feet in accordance with NFPA 99. This deficient practice was identified for 23 of 23 portable oxygen cylinders and was evidenced by the following: On 4/22/22 at 10:38 AM, the surveyor, Maintenance Director (interim), and Administrator (interim) observed on floor #1 in the Oxygen Storage room that 23 portable oxygen cylinders (more then 300 cubic feet), were stored next to combustible storage (approximately 10 filled cardboard boxes).	K 923	1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1a)To ensure the safety of all individuals (residents, staff and visitors) in the facility, the Maintenance Staff removed the 23 portable oxygen cylinders from the rehabilitation gym. All oxygen cylinders have been separated with at least 5 feet of space from combustible storage. No residents, staff and/or visitors were adversely affected by the deficient practice. 2)How will you identify other residents having the potential to be affected by the	

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K 923	Continued From page 39 An interview was conducted with the Maintenance Director (interim) who stated that the cylinders must be separated by five-feet (5') from combustibles when an automatic fire sprinkler system is provided. The building has a fully functional sprinkler system. The Administrator (interim) was informed of the finding at the Life Safety Code exit conference on 4/22/22. NJAC 8:39-31.2(e) NFPA 99	K 923	same deficient practice and what corrective action will be taken? 2a)All residents, staff and visitors have the potential to be affected by the deficient practice. Director of Maintenance conducted rounds to ensure that all oxygen cylinders are stored in areas with at least 5 feet of space from combustible storage. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 3a)Facility staff was in-serviced regarding ensuring that all oxygen cylinders are stored in areas with at least 5 feet of space from combustible storage. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4a)Maintenance Director/Designee will conduct monthly rounds x 6 months to ensure that all oxygen cylinders are stored in areas at least 5 feet of space from combustible storage. Findings will be submitted to the Administrator monthly and reported in the QAPI Meeting quarterly. QAPI Committee will determine the need for further action plan(s) to ensure on-going 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
315355 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/16/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

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 K0161	07/13/2022	LSC K0222	06/27/2022	LSC K0225	06/27/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0252	07/27/2022	LSC K0271	06/27/2022	LSC K0293	06/27/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	06/27/2022	LSC K0331	07/01/2022	LSC K0351	06/27/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	06/27/2022	LSC K0521	07/26/2022	LSC K0531	06/27/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0918	06/27/2022	LSC K0920	06/27/2022	LSC K0923	06/27/2022

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?
5/2/2022	☐ YES ☐ NO