STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET ELIZABETH, NJ 07206**

(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 Complaint #: NJ00166073, NJ00166001, NJ00164909 Survey Date: 9/1/23 Census: 88 Sample: 18 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries,	F 640		9/14/23

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

Electronically Signed | 09/15/2023

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
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET ELIZABETH, NJ 07206**

(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 640	Continued From page 1 and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to transmit a Minimum Data Set (MDS) - Annual and Quarterly Reporting Assessment in accordance with federal guidelines. This deficient practice was identified for 13 of 13 residents reviewed for resident assessment (Resident #43, #44, #23, #5, #51, #53, #49, #20, #1, #26, #16, #65, #64). This deficient practice was evidenced by:	F 640	1. Affected residents: Residents #'s: 43,5,20,1 MDS assessments were completed and transmitted on [redacted]. Residents #'s: 44,23,51,49 MDS assessments were completed and transmitted on [redacted] Residents #'s: 53,26,65.16,64 MDS assessments were completed and transmitted on [redacted]	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET ELIZABETH, NJ 07206**

(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 640	Continued From page 2 On 8/25/23 at 11:30 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. A MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2019) under Non-Comprehensive Assessments and Entry and Discharge Reporting, page 2-32" .... MDS must be transmitted (submitted and accepted into the QIES (Quality Improvement and Evaluation System) ASAP system) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days). " Further review of the RAI (Resident Assessment Instrument) Manual under Comprehensive Assessments, page 2-20 " .... MDS must be transmitted (submitted and accepted into the QIES ASAP system) electronically no later than 14 calendar days after the care plan completion date (V0200C2 + 14 calendar days)." 1.) Resident #43 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted] The Quarterly MDS was not transmitted until [redacted] 2.) Resident #44 was observed to have a Quarterly MDS completion date of [redacted] and	F 640	2. Residents with potential to be affected: All residents have the potential to be affected by the deficient practice. MDS coordinator and the Director of Nursing completed an audit of residents MDS assessments on 8/29/23. All residents MDS assessments have been completed and transmitted within the required timeframe as of 9/1/2023. 3. Measures that will be put in place: MDS coordinator was re-educated by the Director of Nursing on 8/29/2023 on the timely completion and transmission of resident MDS assessments. Workload was redistributed to ensure a balanced distribution of MDS assignments and ultimately timely completion and transmission of residents MDS's. MDS coordinator will submit the MDS submission validation reports to the Director of Nursing who will compare those reports to the weekly MDS schedule to ensure all MDS's were transmitted timely. 4. Monitoring: An audit tool was developed to monitor compliance with timely completion and transmission of resident MDS	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET ELIZABETH, NJ 07206**

(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 640	Continued From page 3 was due to be transmitted no later than [redacted]. The Quarterly MDS was not transmitted until [redacted]. 3.) Resident #23 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted]. The Quarterly MDS was not transmitted until [redacted]. 4.) Resident #5 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted]. The Quarterly MDS was not transmitted until [redacted]. 5.) Resident #51 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted]. The Quarterly MDS was not transmitted until [redacted]. 6.) Resident #53 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted]. The Quarterly MDS was not transmitted until [redacted]. 7.) Resident #49 was observed to have an Annual MDS completion date of [redacted] and was due to be transmitted no later than [redacted]. The Annual MDS was not transmitted until [redacted]. 8.) Resident #20 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted]. The Quarterly MDS was not transmitted until [redacted]. 9.) Resident #1 was observed to have an Annual	F 640	assessments The director of nursing will audit completion and transmission of resident assessments weekly x4 weeks, then every two weeks x 4 weeks and monthly thereafter for 3 months and report findings to QAPI committee. Ongoing monitoring will be determined by the QAPI committee. Audit tools will be reviewed weekly by the administrator/DON and findings reported at the Quarterly QAPI committee.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET ELIZABETH, NJ 07206**

(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 640	Continued From page 4	F 640		

MDS completion date of [redacted] and was due to be transmitted no later than [redacted]. The Annual MDS was not transmitted until [redacted]

10.) Resident #26 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted] The Quarterly MDS was not transmitted until [redacted]

11.) Resident #16 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted] The Quarterly MDS was not transmitted until [redacted]

12.) Resident #65 was observed to have a Quarterly MDS completion date of [redacted] and was due to be transmitted no later than [redacted] The Quarterly MDS was not transmitted until [redacted]

13.) Resident #64 was observed to have an Annual MDS completion date of [redacted] and was due to be transmitted no later than [redacted] The Annual MDS was not transmitted until [redacted]

On 8/25/23 at 1:04 PM, the surveyor interviewed the facility's Registered Nurse (RN) MDS Coordinator who was responsible for completing and transmitting the MDS assessments who acknowledge that the above MDS assessments were transmitted late. No further information was provided.

On 8/30/23 at 12:19 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). No further information was

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET ELIZABETH, NJ 07206**

(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 640	Continued From page 5 provided. NJAC 8:39-11.2	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately code resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for one 1 of 18 residents, (Resident #3) reviewed for accurate coding of MDS. This deficient practice was evidenced by the following: On 8/24/23 at 9:54 AM, Resident #3 was observed sitting on wheelchair in hallway, able to wheel self around unit. The Resident responded to the surveyor appropriately when spoken to stating that they were ok and had no issues with care. The Resident refused to continue the interview. The surveyor reviewed the resident's hybrid medical chart which included review of paper as well as computerized medical chart. A review of Resident #3's Face Sheet (a one-page summary of important information about the resident) documented the resident's diagnosis which included but was not limited to	F 641	1. Affected resident: Resident #3 MDS assessment was modified on [redacted] to accurately reflect coding for falls, was transmitted on [redacted] and accepted. 2. Residents with the potential to be affected: All residents with falls are at risk to be affected by the deficient practice. An audit of all residents who experienced falls will be conducted by the MDS coordinator to ensure that falls were accurately coded on the resident's MDS assessment 3. Measures that will be put in place: The MDS coordinator was re-educated on 8/28/2023 by the Director of Nursing regarding accurate coding of resident's MDS assessments.	9/14/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	655 EAST JERSEY STREET ELIZABETH, NJ 07206

(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 641	Continued From page 6 EX Order 26 § 4b1 [redacted] A review of the Progress Note dated [redacted] documented, " Resident AAO (Awake, Alert, Oriented) x 3 stable. Resident called for help, [redacted] Assessment done no apparent injury, denies pain. Message left for Doctor, informed family member." A review of the Progress Note dated [redacted] documented, " At approximately 8:42 AM this writer heard loud noise in dayroom, writer ran into dayroom, upon assessment resident [redacted] in [redacted] with EX Order 26 § 4b1 [redacted], this writer called 911 immediately. Upon assessment EX Order 26 § 4b1 [redacted] Noted resident trying to move EX Order 26 § 4b1, Re-educated resident to [redacted] and not move [redacted]. Resident complaining of EX Order 26 § 4b1 [redacted] Emergency Medical Service arrived on scene, left with resident at 9:06 AM. " Further review of the Progress Note dated [redacted] documented, "Around 1:00 AM Resident roommate reported that resident was [redacted] Resident was assisted [redacted] with EX Order 26 § 4b1 [redacted], stated EX Order 26 § 4b1 [redacted]. Assessment done [redacted], no	F 641	The Director of Nursing will oversee all MDS assessments to ensure that residents who experienced falls were coded on the MDS accurately prior to submission. 4. Monitoring: An audit tool has been developed to monitor compliance with accurate coding of residents experiencing falls on the MDS assessment. The Director of nursing and the MDS coordinator will audit resident assessments for accurate coding of falls on the MDS weekly x4weeks, then every other week x4weeks and monthly thereafter x3mos. All audits will be reviewed by the Administrator. All audit findings will be reported quarterly at the QAPI committee. The need for ongoing audits will be determined by the QAPI committee based on the results of prior audits. The Director of Nursing will be responsible to implement the acceptable plan of correction as outlined.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	655 EAST JERSEY STREET ELIZABETH, NJ 07206

(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 641	Continued From page 7	F 641		

[redacted] noted, complained of [redacted] on their [redacted] given with effective."

Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], indicated that Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted]. This score established that Resident #3 had a EX Order 26 § 4b1 [redacted]

A review of Resident #3's MDS dated [redacted], Section J1800 - Any Falls Since Admission/Entry or Reentry or Prior Assessment coded as "0", indicating that the resident had [redacted] since their last Annual Assessment of [redacted]

The documentation in the MDS contradicted the resident's history of falls based on the Progress Notes dated on EX Order 26 § 4b1 [redacted]

On [redacted] at 10:41 AM, the surveyor along with MDS Coordinator reviewed the Quarterly assessment dated [redacted] which documented "0" under J1800, indicating [redacted] occurred since last assessment of [redacted].

Further review of the Progress Notes dated EX Order 26 § 4b1 [redacted] with the MDS Coordinator, revealed that Resident #3 had [redacted] on [redacted] with [redacted] on [redacted] with [redacted], and [redacted] l on [redacted].
The MDS Coordinator stated, she missed coding the [redacted]. No further information was provided.

On 8/30/23 at 12:19 PM, the survey team met with Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the concern above. No further information was

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET ELIZABETH, NJ 07206**

(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 641	Continued From page 8 provided. NJAC 8:39-33.2(d)	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12001L	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	655 EAST JERSEY STREET ELIZABETH, NJ 07206

(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) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	1. Immediate corrective action: All efforts to employ facility staff will continue as ongoing until there is adequate staff to serve all residents until that time. The facility will continue to fill open positions with agency staff until a full complement of facility staff are employed. 2. Residents with the potential to be affected: Due to the nature of the deficient practice, all residents have the potential to be	9/14/23

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

Electronically Signed | 09/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12001L	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
TRINITAS HOSPITAL	655 EAST JERSEY STREET ELIZABETH, NJ 07206

(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) COMPLETE DATE
S 560	Continued From page 1 requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to	S 560	affected. 3. Measures to be put in place: Contracts with additional agencies has been secured to supplement staff Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to strengthen our competitive position in the market. Administrator will continue to reach out to the various nursing schools and C.N.A programs, posting opened positions in an effort to recruit new graduates. 4. Monitoring: The Administrator / Designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results will be quantified and submitted to the QAPI committee throughout the year. Based on the results, it will be determined by the QAPI committee if ongoing monitoring/reporting is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12001L	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
TRINITAS HOSPITAL	655 EAST JERSEY STREET ELIZABETH, NJ 07206

(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) COMPLETE DATE
S 560	Continued From page 2 affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 8/6/23 to 8/12/23 and ending 8/13/23 to 8/19/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 4 of 14 day shifts as follows: For the 2 weeks of staffing 8/6/2023 to 8/12/2023 and 8/13/2023 to 8/19/2023 the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows- -08/06/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs. -08/14/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -08/15/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -08/19/23 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. The facility's Licensed Nursing Home Administrator was informed of their deficient practice on 8/23/23 at 11:18 AM. No further information was provided.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
12001L Y1	A. Building B. Wing Y2	9/18/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	655 EAST JERSEY STREET ELIZABETH, NJ 07206

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	09/14/2023	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	
9/1/2023	☐ 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
	315442	A. BUILDING **01** B. WING _____	C **09/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET** **ELIZABETH, NJ 07206**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/23/2023. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/23/23 and 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. Trinitas Hospital is a seven-story building with a basement that was built in 1974. The survey was for the fourth and fifth floors only. It is composed of Type II protected construction. The facility is divided into 10 - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 88 of 124.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.	K 291		9/14/23

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

Electronically Signed | 09/15/2023

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
	315442	A. BUILDING **01** B. WING _____	C **09/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET** **ELIZABETH, NJ 07206**

(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 291	Continued From page 1 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 88 residents. Findings include: An observation on 08/23/23 at 03:08 PM revealed emergency lighting was not provided at the emergency generator transfer switch, located in the electrical room in the building across the street from the hospital. The Maintenance Director was present at the time of the observation and confirmed the emergency lighting was not present at the emergency generator transfer switch. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110 .	K 291	1. Immediate corrective action taken for those residents identified: No resident was found to be affected by the deficient practice. Engineering researched and ordered the necessary equipment that was installed on 08/28/2023 by the in-house electrician at the emergency generator transfer switch in the electrical room in the building across the street from the hospital in accordance with NFPA 110 Standards for Emergency and Standby Power Systems(2010 Edition) Section7.3. 2. Residents with potential to be affected: Due to the nature of the deficient practice, all residents, staff and visitors have the potential to be affected. In-house engineering staff will conduct monthly generator battery emergency light testing. During this time, any deficiencies that are identified will be immediately corrected. 3. Measures that will be put in place / system changes: The Maintenance Supervisor was re-educated on the preventative maintenance program by the Maintenance Director.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING **01** B. WING _____	C **09/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET** **ELIZABETH, NJ 07206**

(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 291	Continued From page 2	K 291	Maintenance Supervisor / in-house maintenance staff will test generator battery emergency light monthly as part of the facilities preventative maintenance program for proper operation and compliance. 4. Monitoring: The Maintenance Supervisor / Designee will be responsible for completing monthly inspections. The Maintenance Director will review the preventative maintenance worksheets monthly. A maintenance QAPI audit tool will be utilized monthly to monitor compliance. The results of these audits will be reviewed in QAPI monthly meeting for 6 months or until 100% compliance is achieved. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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
315442 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/18/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	655 EAST JERSEY STREET ELIZABETH, NJ 07206

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. #	Completed	Reg. #	Completed
LSC K0291	09/14/2023	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	
9/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO