STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 06/16/2022

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS C # Covid -19 Census: 81 Sample Size: 8 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. Complaint #: NJ00155311, NJ00155477 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a	F 806		7/30/22

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

Electronically Signed | 06/30/2022

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 806	Continued From page 1 different meal choice; This REQUIREMENT is not met as evidenced by: C #: NJ00155311 Based on interviews, record review and review of other pertinent facility documents on 6/15/22 and 6/16/22, it was determined that the facility failed to honor a resident's meal preferences for 2 of 8 residents (Residents #1, and #2) reviewed for meal preferences. This deficient practice was evidenced by the following: On 6/15/22 at 10:00 am, the lunch menu for residents showed but not limited to the following: roast garlic pork with gravy and egg salad sandwich. 1. Resident #1 was admitted to the facility on EX Order 26.4B1 with diagnosis that included but was not limited to: EX Order 26.4B1 . The Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 showed that the Resident was EX Order 26.4B1 and required assistance in EX Order 26.4B1 The Nutritional Assessment (NA) dated 4/25/22, documented by Registered Dietician (RD) under "..food preferences..." showed "No Pork". The General Information Details (GID) from the Food Service Director (FSD) and the Unit census notes showed that the Resident should not be given "pork" for all meals. 2. Resident #2 was admitted to the facility on	F 806	1.What Corrective action was accomplished for Residents affected by the deficient practice? The affected residents #1 and #2 diets were immediately removed and were provided with the substitute that the residents preferred. All diet orders were immediately reviewed for food preferences and documented. The Food Service Staff immediately in-serviced on the proper procedures for distributing meals once delivered to the site. To ensure that all patients receive a meal based on their food preferences. All nursing staff were also in-serviced on identifying residents□ food preferences to prevent serving the in-correct food tray to the resident. Continuous in-service will be maintained to ensure that the proper procedures are followed. 2.How will the facility identify other Residents having the potential to be affected by the same deficient practice? All Residents have the potential to be affected by this deficient practice 3.What measures will be in place or systemic changes made to ensure that the deficient practice will not re-occur? All food preferences will be entered into	

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F 806	Continued From page 2 EX Order 26.4B1 with diagnosis that included but was not limited to: EX Order 26.4B1 . The MDS for Resident #2 dated EX Order 26.4B1 showed that the Resident was EX Order 26.4B1 and Ex.Order 26.4(b)(1) during meals. The NA dated 12/9/20 documented by the RD showed that the Resident dislikes pork. The GID and the Unit census notes showed that the Resident should not be given pork for all meals. The Registered Nurse (RN #1) and the Certified Nursing Assistant (CNA #1) were interviewed on 6/15/22 from 12:47 pm to 2:00 pm. They stated that the food was served in a disposable aluminum take away container with cardboard cover. Each container did not have a resident's name; however, it was labeled with a type of diet (regular or puree)and preferences such as "no pork". CNA #1 revealed that Residents #1 and #2 had pork for lunch because she served their lunch trays. RN #1 confirmed that Resident #1 had pork for lunch because she fed Resident #1. When asked if they were aware that the Residents should not be given pork; they have no answer. Resident #2 was interviewed on 6/15/22 at 3:30 pm in the presence of the Activity Aide (AA), the Resident stated that he/she was served pork for lunch; however the Resident did not eat the pork and only ate potatoes and corn. Resident #2 stated that he/she dislikes the pork. Resident #3 was interviewed on 6/16/22 at 9:30	F 806	the Electronic Health system used by dietary with reference to patient□s name and room number. These resident□s labels will be printed, prior to meal service and adhered to the food containers before leaving the kitchen for distribution on the unit floors. All food containers will be labeled with residents name and diet preference such as No Pork will be identified. The food labels will contain the food preference for that meal. Alternatives meal selection will be made available when the meal is being distributed in case patient may want to make another selection. All containers will be checked by the Food & Nutrition Supervisor and or designee when preparing food for that particular meal and again before leaving the kitchen for delivery. All food containers will be checked on arrival to the unit for accurate labeling by the Nursing designee to ensure that the resident is receiving their preferred meal. 4.How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur? The Food Service Director/Executive Chef/Designee will conduct daily rounds to check every shift daily x 1 month, then daily x 2 months to ensure that residents are receiving meals of their preference.	

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F 806	Continued From page 3 am. The Resident stated that he/she had not been served pork/beef during meals because the Resident had to remind the staff that he/she does not eat pork/beef. However, during the first few days of admission the Resident was served food that contained pork/beef. The policy titled, "Resident Food Preferences..." revised 1/2021, under policies showed ",,,Residents are served meals...and comply with food preferences..." NJAC 8:39-17.4(a)(1)	F 806	Audit trends will be reported at the Quarterly QAPI meeting. The Food Service Director/Executive Chef/Designee will conduct inspection of residents/ patients food containers every shift x 1month, then daily x 1 months. Audit trends will be reported at the Quarterly QAPI meeting. The Food Service Director/Executive Chef/Designee will check all food container for proper name labeling at the point of delivery to patients/residents daily x 1 month, then Bi-weekly for 2 months. Audit trends will be reported at the Quarterly QAPI meeting.	

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S 000	Initial Comments C # Covid -19 Census: 81 Sample Size: 8 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. Complaint #: NJ00155311, NJ00155477 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	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: C #: NJ00155311 NJ00155477	S 560	1.What Corrective action was accomplished for residents affected by the	7/30/22

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

Electronically Signed — 06/30/22

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S 560	Continued From page 1 Based on interviews and review of pertinent facility documentation on 6/15/22 and 6/16/22, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for the weeks of 5/22/22 to 5/28/22 and 5/29/22 to 6/4/22. The facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. The CNAs were responsible for providing direct care to the residents. 05/22/22 had 7 CNAs for 83 residents on the day shift, required 10 CNAs. 05/23/22 had 9 CNAs for 83 residents on the day shift, required 10 CNAs. 05/26/22 had 9 CNAs for 82 residents on the day shift, required 10 CNAs. 05/27/22 had 7 CNAs for 82 residents on the day shift, required 10 CNAs. 05/29/22 had 9 CNAs for 82 residents on the day shift, required 10 CNAs.	S 560	deficient practice? The Director of Nursing in-serviced the staffing coordinator on: Including/utilizing, All Certified Nursing Assistants (CNA) working as Activity Aides as direct care givers on the days that there are not enough aides to work, The staffing coordinator was in service on how to enter the total number of direct care staff to match the daily census, The staffing coordinator was in-serviced on how to check and generate the staffing report from the PJPM to ensure adequate CNAs are scheduled and reported. Human Resources will have open CNA positions posted and running. 2.How will the facility identify other Residents having the potential to be affected by the same deficient practice? All Residents have the potential to be affected by this deficient practice. 3.What measures will be in place or systemic changes made to ensure that the deficient practice will not recur The ADON/Designee will check the daily staffing schedule 24 hours prior to the start of the shifts to ensure that adequate CNAs are scheduled according to the daily census The DON/Designee will check to ensure that all Activity Aides that are CNAs will be	

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S 560	Continued From page 2 05/30/22 had 7 CNAs for 82 residents on the day shift, required 10 CNAs. 05/31/22 had 8 CNAs for 82 residents on the day shift, required 10 CNAs. 06/01/22 had 8 CNAs for 81 residents on the day shift, required 10 CNAs. 06/02/22 had 8 CNAs for 81 residents on the day shift, required 10 CNAs. 06/03/22 had 9 CNAs for 81 residents on the day shift, required 10 CNAs. 06/04/22 had 8 CNAs for 81 residents on the day shift, required 10 CNAs. During an interview on 6/15/22 at 10:00 am, the Director of Nursing (DON) stated that the facility was aware of the staffing ratios.	S 560	utilized as supplemental direct caregivers on any day of low CNA staffing. The DON/Designee will check with Human Resources to ensure that all CNA applications are reviewed as soon as possible. 4 How will the facility monitor it's corrective actions to ensure that the deficient practice is being corrected and will not re-occur DON/ADON/Designee will audit the daily staffing sheet daily x 4 weeks, then weekly for 4 weeks, then quarterly. Audit trends will be reported at the Quarterly QAPI meeting for review and recommendations.	
S1790	8:39-27.2(i) Mandatory Quality of Care (i) Each resident shall receive at least one bath (tub or shower) per week unless contraindicated. This REQUIREMENT is not met as evidenced by: C #: NJ 155311 Based on interviews, record review, and review of other pertinent facility documents on 6/15/22 and 6/16/22, it was determined that the facility failed to ensure that a resident who was NJ Exec. Order 26:4.b.1 activities of daily living was provided with a shower at least one bath (tub or shower) per week. This deficient practice was identified for 2 of 3 residents (Residents #1 and #6) reviewed for shower and was evidenced by the following:	S1790	1 What Corrective action was accomplished for residents affected by the deficient practice? Resident affected were given shower and Aide documented that shower given under the ADLs/Bathing section. In-service was given to all the CNAs and the Nurses; that unless contraindicated that all resident will receive at least two showers per week and the CNAs will document in the Matrix/Care assist (electronic medical record) that "shower"	7/30/22

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S1790	Continued From page 3 1. Resident #1 was admitted to the facility on [NJAC 8:43E-2.1 and] with diagnosis that included but was not limited to: [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]. The Minimum Data Set (MDS), an assessment tool dated [NJAC 8:43E-2.1 a], showed that the Resident's cognitive status was [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] and required [NJ Exec. Order 26:4.b.1] from staff for [NJ Exec. Order 26:4.b.]. A review of Point of Care Activities of Daily Living (POC-ADL) report from [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] showed that the Resident had only one (1) shower, on [NJAC 8:43E-2.1 and E]. In addition, the Progress Notes (PN) showed no documented evidence that the Resident received the weekly showers from [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] except on [NJAC 8:43E-2.1 and E]. 2. Resident #6 was admitted to the facility on [NJAC 8:43E-2.1 and] with diagnosis that included but was not limited to: [NJAC 8:43E-2.1 and Exe]. The MDS for Resident #6 dated 5/1/22, showed that the Resident's cognitive status was [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] and required [NJ Exec. Ord] Ex.Order 26.4(b)(1) for [NJAC 8:43E-2.1 an]. A review of POC-ADL report from [NJAC 8:43E-2.1 a] did not reflect that the Resident received a shower. In addition, the PN showed no documented evidence that the Resident received weekly shower from [NJAC 8:43E-2.1 and Exec Order 26, 4. b] [NJAC 8:43E-2.1 a]. A review of the printed shower schedule for the [NJAC 8:43E-2.1 and] dated [NJAC 8:43E-2.1 and E] showed that Resident # 6 was on the shower list every Wednesday and Saturday, however, Resident #6 was not on the schedule for shower.	S1790	was given on scheduled shower days. Reviewed all residents electronic showers schedule in ADLs flow sheets done. 2.How will the facility identify other Residents having the potential to be affected by the same deficient practice? All Residents have the potential to be affected by this deficient practice. 3.What measures will be in place or systemic changes made to ensure that the deficient practice will not recur Director of Nursing reviewed the Shower Policy and made revision: All unit will have daily residents 'shower scheduled on Aides daily assignment sheet Aides will notify the assigned nurse of residents refusal of shower Nurse will check with resident the reason for refusal of shower and document in the electronic medical record Aides will document in the residents electronic medical record that shower is given or resident refusal ADON/Unit Manager will review the electronic ADLs flow sheet weekly for accurate documentation All nurses and Aides were in-serviced by the ADON on the revised shower policy. CNAs were in-serviced not to document partial bath if resident refuses but to inform nurse so that nurse can investigate the reason for the refusal and mitigate as needed	

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S1790	Continued From page 4 The Certified Nursing Assistant (CNA #2) was interviewed on 6/16/22 at 11:40 AM, she stated that residents receive a shower twice a week, and she checks the shower schedule on the printed list or in the system under POC-ADL. She further stated that she reports to the nurse when a resident refuses a shower. CNA #2 revealed that partial bath is not the same as shower. The Registered Nurse (RN #1) was interviewed on 6/16/22 at 2:35 PM, she stated that residents have printed shower schedules twice a week and are updated by her as needed. The surveyor asked why Resident #1 was not on the shower list. She stated that Resident #1 was transferred from the [NJAC 8:43E-2.1 and] a week ago and she should have updated the list. RN #1 explained that CNAs could check the daily shower schedule in POC-ADL. She further explained that shower refusal is reported to the nurse, and documented in the Treatment Administration Record (TAR). A review of TAR for Residents #1 and #6 did not indicate a shower schedule. CNA #3 was interviewed on 6/16/22 at 2:55 PM, she stated that she was the regular CNA during the evening shift when Resident #1 was on the [NJAC 8:43E-2.1 and] [NJAC 8:43E-2.1 and Exec] She stated that the Resident's family requested a shower, however, Resident #1 continued to receive a bed bath due to his/her [NJAC 8:43E-2.1 and Ex] Furthermore, she did not report the refusal of the shower to the nurse or offer it at another time. The Director of Nursing (DON) was interviewed on 6/16/22 at 4:15 PM, she stated that residents should receive shower two times per week and residents on the [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] should	S1790	4.How will the facility monitor it's corrective actions to ensure that the deficient practice is being corrected and will not re-occur The nurses will remind the Aides daily about the completion of residents' showers and documentation DON/ADON/Designee will conduct daily rounds to check on the residents scheduled for shower to ensure shower is given x 1 month and then randomly DON/ADON/Unit Manager will review the electronic ADLs flow sheets for accurate documentation of residents showers weekly x 4 weeks DON/ADON/Designee will conduct audit trends monthly and report at the Quarterly QAPI meeting.	

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S1790	Continued From page 5 receive shower daily or based on preference. She expected the CNAs to provide a shower to residents once or twice a week as stated in their policy and document in the POC-ADL. She could not explain why Residents #1 and #6 did not receive a shower or why the CNAs did not document showers in the POC-ADL for the aforementioned dates. Review of the policy titled "Shower Bath" reviewed on 3/19, under Policy showed "All residents unless contraindicated, will receive a bath or shower at least two per week..."	S1790		

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 B. Wing Y2	8/1/2022 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 F0806	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(d)(4)(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/08/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/16/2022	☐ YES ☐ NO