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 01/16/2025

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 Complaint #:NJ180911 Survey Date:1/12/2025 - 1/16/2025 Census: 93 Sample: 23 +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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		2/10/25

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

Electronically Signed | 01/31/2025

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

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide privacy for a resident during [NJ Exec Order 26.4b] care. Specifically, the bedroom and bathroom doors were not closed, [NJ Exec Order 26.4b1] the resident's [NJ Exec Order] [NJ Exec Order] This deficiency was noted for 1 out of 20 residents (Resident # 38) reviewed. This deficient practice was evidenced by the following: On 01/13/2025 at 10:19 AM, the surveyor observed Resident # 38 in the [NJ Exec Order 26.4b1] [redacted], with the wheelchair positioned in front of the resident while getting dressed. The door was open, [NJ Exec Order 26.4b1] the resident's [NJ Exec Order 26.4b1]. During an interview with the surveyor on 01/13/2025 at 10:39 AM, the Licensed Practical	F 550	1. Immediate action for resident affected by the deficient practice: Resident #38 - Immediate corrective action was taken to ensure resident's privacy. Resident was spoken to regarding importance of maintaining the door closed during care and the care plan for resident #38 was updated. The staff involved (LPN#1) was counseled on the importance of maintaining resident privacy during all care and dressing activities. 2. Identifying other resident's with the potential to be affected: All residents have the potential to be affected by this deficient practice. A full audit of current practices related to privacy during personal will be conducted	

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F 550	Continued From page 2 Nurse #1 (LPN #1) said that she was uncertain whether the bedroom and bathroom doors should remain open during the time the resident was getting dressed. During an interview with the surveyor on 01/15/2025 at 11:40 AM, the U.S. FOIA (b)(6) [redacted] said that the bedroom and bathroom doors should have been closed while the resident was getting dressed. A review of a facility policy dated 03/2024 titled, "Quality of Life -Dignity", revealed, "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." N.J.A.C. 8:39-4.1(a)(16)	F 550	by the RN Managers to ensure privacy during hygienic care is provided. 3. Measure / Systemic Changes to ensure compliance: a) Conducted an in-service training for all staff, emphasizing the importance of maintaining privacy during care, including proper use of doors and privacy curtains. b) Reviewed the facility's Quality of Life/Dignity policy, highlighting the requirement to protect resident privacy during personal care. c) Policies and procedures were reviewed to ensure they are clear and communicates regulatory requirements on privacy. d) Reinforced the expectation that all doors and curtains must be closed during care unless otherwise indicated by the resident's preferences. e) Staff reminded to document any resident preferences for open doors in their care plan. 4. Monitoring the continued effectiveness of the systemic change: The RN unit Manager / Designee will: a) Conduct three audits per week of privacy practices weekly for 2 weeks and then monthly for 3 months using an audit tool to monitor staff adherence to privacy protocols. b) Results of these audits will be reviewed in quarterly Quality Assurance Performance Improvement meetings. Any identified trends or areas of concern	

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F 550	Continued From page 3	F 550	will result in additional corrective actions or education. 5. Responsibility and Oversight: The Director of Nursing / Designee will oversee the implementation and monitoring to ensure sustained compliance	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to keep the call device system within reach for a resident who was [redacted] on staff. This deficiency was identified for 1 out of 1 resident (Resident # 32) reviewed for Accommodation of Needs. This deficient practice was evidenced by the following: On 01/13/2025 at 10:01 AM, the surveyor reviewed the electronic medical records (EMR) for Resident #32. The EMR revealed that he/she had a diagnoses of but not limited to [redacted] A review of the significant change in status	F 558	1. Immediate action for resident affected by the deficient practice: a) Resident #32 is unable to use the call bell due to NJ Exec Order 26.4b1 [redacted]. Therefore the immediate actions involved updating the care plan to reflect the resident's inability to use the call bell. b) Staff were in-serviced immediately to ensure proactive monitoring for resident #32. 2. Identifying other residents with the potential to be affected: a) All residents requiring additional support or accommodations due to	2/10/25

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F 558	Continued From page 4 Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b1 indicated that Resident #32 had NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 in both NJ Exec Order 26.4b1 and NJ Exec Order 26.4b. On 01/13/2025 at 9:59 AM, the surveyor observed the resident in the bedroom, seated in a NJ Exec Order 26.4b NJ Exec Order 26. chair NJ Exec Order 26.4b1 next to the right side of the bed. The call device was out of reach, hanging from the NJ Exec Order 26. system connected to the wall on the left side of the bed. On 01/14/2025 at 10:58 AM, the surveyor observed the resident in the bedroom, seated in a NJ Exec Order 26.4b chair next to the right side of the bed. The call device was out of reach, hanging from the NJ Exec Order 26.4b system connected to the wall on the left side of the bed. During an interview with the surveyor on 01/15/2025 at 11:40 AM, the U.S. FOIA (b)(6) said that the resident needs access to a call device and acknowledged that it is not appropriate for him/her to be without one. The U.S. FOIA (b) indicated that she would reassess the situation and seek an appropriate solution. A review of a facility policy dated 03/2024 titled, "Call System", revealed, "The facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities. If a resident is physically incapable of actuating a call system, the resident shall be physically housed in a resident room close enough to the nursing station to allow for line-of-sight supervision at a frequency identified	F 558	mobility or cognitive limitations have the potential to be affected. A facility wide audit was conducted to ensure all residents with physical and cognitive limitations care plans were reviewed and updated to reflect their inability to use the call bell. b) Staff re-educated on rounding every 2 hours and visually confirming resident comfort, repositioning as needed, toileting and assessing for pain. 3. Measures / Systemic Changes to ensure compliance: a) In-service training conducted for all staff to reinforce 2 hourly rounding to assess the needs for those residents w/ cognitive or physical impairments since they are unable to use the call bell. b) Reviewed the facility call device system policy with staff, emphasizing compliance with the policy to maintain resident safety and dignity c) Call system policy was reviewed and updated to clarify expectations for staff to round every 2 hours on residents with physical and cognitive impairments and report any issues immediately. d) Care planning processes were updated to include specific documentation of resident needs related to their inability to use the call bell system. 4. Monitoring the continued effectiveness of the systemic change: a) The Director of Nursing / Designee will conduct daily audits for two weeks	

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F 558	Continued From page 5 by a through individualized nursing assessment." N.J.A.C. 8:39-27.1 (a)	F 558	then weekly for three months with focus on residents identified as requiring their needs being anticipated by staff due to their inability to used the call bell. b) Audit results will be reviewed at the quarterly Quality Assurance Performance Improvement meetings for three months to assess compliance and identify trends. Additional corrective actions will be implemented as needed d) The Director of Nursing will also ensure staff accountability through performance evaluations and corrective actions when necessary. 5. Responsibility of Oversight: Director of Nursing / Administrator	
F 577 SS=F	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 577		2/10/25

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F 577	Continued From page 6 years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to maintain the most recent State of New Jersey inspection results in a place readily accessible to the residents, families, and the public. The deficient practice was identified on 3 of 3 units. This deficient practice was evidenced by the following: During the Resident Council Meeting on 01/15/2025 at 10:00 AM, five of five [NJ Exec Or] and [NJ Exec Order 26.4] residents said they were not aware of the location of the State Survey results and that the facility had not spoken to them about the results. During a tour of each unit, the surveyor had to ask at the nurse's station where the State survey results binder was kept. The surveyor was told by the unit secretary or nurse that was at the desk at each unit that it was located behind the nurse's station. The surveyor was also told at each unit that if the residents asked for it, they could see it. On the [NJ Exec Order 26.4] unit the U.S. FOIA (b)(6) could not locate the binder when asked. The [U.S. FO] said, "I know it's here somewhere". There were no posted signs to direct resident's, families, and the public to the location of the survey results. These binders were not accessible to residents or	F 577	1. Immediate action for resident affected by the deficient practice: There was no adverse effect on the residents identified during the survey. However, immediate action was taken to ensure that the State survey results were properly posted and accessible to all residents, families and visitors. 2. Identifying other residents with the potential to be affected: a) All residents, families and visitors have the potential to be affected by the deficiency b) An audit was conducted across all units to ensure compliance w / the requirement to maintain the accessibility of survey results. 3. Measure / Systemic Changes to ensure compliance: a) Immediately, the State of NJ survey results binder was relocated across from the nurses station on the wall mounted in file magazine holders and in the resident day rooms with clear signage directing	

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F 577	Continued From page 7 visitors without asking staff. During an interview with the surveyor on 01/15/2025 at 10:34 AM, the U.S. FOIA (b)(6) said that the survey results are located on the unit behind the desk. The U.S. FOIA (b) then said the residents were allowed to go behind the nurse's station and ask or get look at the results if there was someone behind the desk to help them. When asked if they considered if the results binder was readily accessible to the residents or public, the U.S. FOIA (b)(6) stated, "No". The facility was unable to produce a policy in reference to the State of New Jersey inspection results. NJAC 8:39-9.4(b)	F 577	residents, families and the public to its' location. b) A policy was created outlining the requirement to prominently display survey results, with clear instruction on maintaining accessibility. c) All staff were educated on the importance of making the survey results readily accessible, including where the results are located and how to assist residents or visitors in accessing them. d) A Resident council meeting was held on 1/16/25 by the U.S. FOIA (b)(6) informing residents about their right to access the survey results located in the binder that can be found in the day rooms and on the wall in front of the nurses station. e) A notice will be distributed to all residents and their families, outlining the location of survey results. 4. Monitoring the continued effectiveness of the systemic change: a) The Activities Director / Designee will conduct daily audits for 2 weeks and then weekly for three months to ensure survey results are in the appropriate location and accessible. b) Audit results will be reviewed at the quarterly Quality Assurance Performance Improvement committee and additional corrective measures will be implemented as needed. 5. Responsibility of oversight: The Administrator will be responsible for	

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F 577	Continued From page 8	F 577	ensuring compliance and will oversee adherence to the implemented policy and audit process.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		2/10/25

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F 584	Continued From page 9 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain a clean, safe, and sanitary environment for 2 of 3 units (South and North Units). This deficient practice was evidenced by the following: On 01/12/2025 at 10:28 AM, Surveyor #1 observed the baseboard trim in room [NJ Exec O] detached from the wall on the [NJ Exec Order] Unit. On 01/13/2025 at 10:35 AM, Surveyor #1 observed water stains on the ceiling tiles in the shower room on the [NJ Exec Order 26.4b1] Unit. On 01/13/2025 at 10:43 AM, Surveyor #1 observed the shower room on the [NJ Exec Order 26.4b1] Unit, which including a portable commode, three commode buckets, a commode lid, and a non-stick food placement mat placed on a chair in the corner. During an interview with Surveyor #1 on 01/15/2025 at 9:58 AM, the [U.S. FOIA (b)(6)] said that water stains could indicate condensation or a leak and if wet ceiling tiles are observed, an investigation is conducted, followed by the replacement of ceiling tiles as needed.	F 584	1. Immediate action for the deficient practice: a) All affected areas, including rooms were deep cleaned and sanitized b) A work order was entered for the water stained ceiling tiles and for repairs to base board trim and other damaged fixtures. 2. Other residents with the potential to be affected: a) All residents have the potential to be affected by the deficient practice. b) A thorough inspection of the entire facility will be conducted to identify additional areas needing attention. 3. Measure / Systemic changes to ensure compliance: a) Policy and procedure titled "Homelike Environment to clarify specific staff responsibilities for maintaining a clean and safe environment was reviewed. b) Nursing and housekeeping staff will collaborate to ensure medical equipment and personal spaces remain clean and orderly	

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F 584	Continued From page 10 During an interview with Surveyor #1 on 01/15/2025 at 10:14 AM, the [U.S. FOIA (b)(6)] [redacted]), said that shower rooms are cleaned regularly and as needed. Housekeeping does not handle residents' personal items, emphasizing that they do not touch any private belongings. During an interview with Surveyor #1 on 01/15/2025 at 11:40 AM, the [U.S. FOIA (b)(6)] [redacted] said that nursing staff shares the responsibility of cleaning the shower rooms, and while they remove residents ' personal items, housekeeping conducts a thorough cleaning afterward. A review of the dated facility policy 03/2024, titled, "Homelike Environment", revealed, "The facility staff and management shall maximize to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. Those characteristics include cleanliness and order." 2.) On 01/12/2025 at 10:04 AM during the initial tour of the fourth floor, Surveyor # 2 observed Resident # 84's room. At that time, the surveyor observed [NJ Exec Order 2] stains on the wall near the bed and on a [NJ Exec Order 26.4b1] located on a [NJ Exec O] in the room. The garbage receptacle had no bag in it. The bedside table adjacent to the bed was observed to have dried stains on it. On 01/14/2025 at 10:37 AM, Surveyor # 2 observed Resident # 84's room. At that time, the surveyor observed that the garbage receptacle had no bag in it. The room also emanated a [NJ Exec Order 26.4b1] .	F 584	c) Environmental staff will be re-trained on maintaining cleanliness in shared responsibilities, such as ensuring resident's medical equipment is sanitized. d) A weekly audit checklist will be introduced to monitor compliance with cleanliness standards e) Residents will be invited to provide feedback during monthly resident council meetings on the cleanliness and comfort of their environment. 4. Monitoring: a) A random selection of 10 resident rooms will be inspected weekly for the next three months to ensure cleanliness and maintenance standards are maintained. b) Results of inspections will be reviewed in quarterly Quality Assurance Performance Improvement meetings to track progress and make adjustments as needed. 5. Responsible parties: Environmental services Director, Director of Nursing and Administrator are responsible for ensuring compliance.	

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F 584	Continued From page 11	F 584		

On 01/15/2025 at 11:35 AM during an interview with the surveyor, the U.S. FOIA (b)(6)) replied, "Daily. Housekeeping is twenty-four seven but lesser on evenings and overnights." when the surveyor asked how often resident rooms are cleaned. The U.S. FOIA (b) explained that cleaning entails the garbage, floors, dusting, bedside tables, and the garbage.

3.) On 1/14/25 at 9:58 AM while touring the NJ Exec O floor, surveyor #3 observed large area of NJ Exec Order 2 splatter residue on the wall to the right of Resident #52's bed behind their NJ Exec Order 26.4b1 and dresser. Surveyor #3 also observed NJ Exec Order 2 residue on the NJ Exec Order 26.4b1.

On 1/14/25 at 10:08 AM, surveyor #3 interviewed Certified Nursing Assistant (CNA #1) who reported that all of nursing is responsible to ensure the resident's rooms are clean. When asked who would make sure that the resident's medical equipment remained clean CNA #1 responded, the nurse.

On the same date at 10:48 AM, surveyor #3 interviewed Licensed Practical Nurse (LPN #1) acknowledged the large area of NJ Exec Order 2 residue behind the NJ Exec Order 26.4b1 and dresser. LPN #1 stated that the room is their home and it should not have NJ Exec Order splatter on the wall.

On the same date at 11:06 AM, surveyor #3 interviewed Unit Manager Registered Nurse (UMRN# 1) who stated that the NJ Exec Order 2 residue appeared to be NJ Exec Order 26.4b1. UMRN #1 confirmed that the wall should not be that condition and it should have been identified by

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F 584	Continued From page 12 nursing or housekeeping. When asked why the wall should not look like that UMRN# 1 responded, because this is their home and we should keep it clean. On 1/16/25 at 9:59 AM, surveyor #3, interviewed the U.S. FOIA (b)(6) who acknowledged the NJ Exec Order 8 residue on Resident #52's wall and that it should have been identified by housekeeping. On 1/16/25 at 10:04 AM, surveyor #3, interviewed the U.S. FOIA (b)(6), in the presence of the U.S. FOIA (b)(6), who confirmed that the NJ Exec Order 8 residue on Resident #52's wall should have identified and should not present in that condition. On 1/16/25 at 11:35 AM, surveyor #3, interviewed the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6)) acknowledged NJ Exec Order 8 residue on Resident #52's wall should have been cleaned to ensure homelike environment. N.J.A.C. 8:39-31.3(a) N.J.A.C. 8:39-31.4 (a)	F 584		
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.	F 640		2/10/25

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F 640	Continued From page 13 (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, 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	F 640		

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F 640	Continued From page 14 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 complete and transmit a Minimum Data Set death in facility tracking record in accordance with federal guidelines. This deficient practice was identified for 1 of 2 residents reviewed for resident assessment (Resident #58). This deficient practice was evidenced by: On 01/13/2025 at 12:07 PM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. On 01/13/25 at 12:07 PM, the surveyor reviewed Resident #58's electronic medical record. The record revealed that the resident [NJ Exec Order 26.] on [NJ Exec Order 26.4b1]. The electronic health record reflected that there was no [NJ Exec Orde] in facility tracking record completed for the resident's [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1] On 01/13/25 at 12:13 PM, the surveyor interviewed the U.S. FOIA (b)(6) . The [U.S. FOIA (b)] [redacted] confirmed that the [NJ Exec Orde] in facility tracking record was not completed or transmitted for Resident #58. She stated it should have been completed by [NJ Exec Order 26.4b1]. 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. The surveyor reviewed the facility's policy entitled	F 640	1. Immediate action for resident affected by the deficient practice: a) The MDS for resident #58 was immediately completed and transmitted to the CMS system upon identification of the deficiency on [NJ Exec Order 26.4b1]. b) The MDS tracking record for resident #58 was updated and verified to reflect accurate submission dates. 2. Identifying other residents with the potential to be affected: a) All residents have the potential to be affected by the deficient practice. b) A full audit of all resident with death in facility assessments and their corresponding submission dates (past 3 months) will be conducted by the MDS Coordinator. c) Any delayed or incomplete MDS submissions identified during the audit will immediately be addressed, completed and transmitted to the CMS system. 3. Measures / System changes to ensure compliance: a) The policy titled MDS Completion and Submission Timeframes was reviewed, no changes were required. b) Weekly for two weeks, meetings will be instituted with the MDS coordinator, Director of Nursing and Administrator to	

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F 640	Continued From page 15 "MDS Completion and Submission Timeframes" with a revised date of August 30, 2024. The policy revealed that the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. NJAC 8:39-11.2	F 640	review the status of pending assessments c) Any identified issues with assessments will be addressed immediately, and steps will be documented. d) All nursing and administrative staff involved in MDS process will be re-educated on the importance of timely submissions 4. Monitoring / Systemic Changes to ensure compliance: a) Weekly audits of MDS submissions will be conducted monthly by the MDS coordinator for the next three months of all residents with death in facility to verify timely encoding and transmission. b) After the initial three months, audits will be conducted quarterly thereafter c) Audit findings will be reviewed during the quarterly Quality Assurance and Performance committee meetings to identify trends or recurring issues and procedures adjusted or additional training will be provided to maintain compliance if any further issues are identified. 5. Responsibility of Oversight: MDS coordinator, Director of Nursing and Administrator	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		2/10/25

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F 656	Continued From page 16 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged	F 656		

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F 656	Continued From page 17 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive care plan to address an NJ Exec Order 26.4b1 for 1 of 23 residents (Resident #59) reviewed. The deficient practice was evidenced by the following: On 01/12/25 at 10:00 AM, the surveyor observed Resident #59 in the room with an NJ Exec Order 26.4b1 [redacted] The surveyor reviewed Resident #59's medical record which reflected that the resident had diagnoses which included NJ Exec Order 26.4b1 [redacted] A review of the physician orders for Resident # 59 reflected an order dated NJ Exec Order 26.4b1 for the resident to have a NJ Exec Order 26.4b1. The minimum data set, an assessment tool, dated [redacted] MDS reflected that Resident #59 used an NJ Exec Order 26.4b1 [redacted] used daily. The surveyor reviewed the resident's care plans which revealed there was no care plan developed to address the NJ Exec Order 26.4b1 which was initiated on NJ Exec Order 26.4b1. On 01/15/25 at 10:53 AM, the surveyor interviewed the U.S. FOIA (b)(6) who said the NJ Exec Order 26.4b1 should be included in the care plan. The U.S. FOIA (b)(6) and surveyor reviewed	F 656	1. Immediate action for the affected resident: a) The interdisciplinary Care team met to discuss the need for a NJ Exec Order 26.4b1 and same was discontinued by the primary care doctor since resident #59 no longer presents an NJ Exec Order 26.4b1 2. Other residents who could be affected: a) An audit was conducted of all current residents with orders for wander guards to ensure their care plans include accurate and comprehensive details regarding the devices and that the doctors orders for the need of a wander guard was being followed. b) Any Identified gaps in care plans were corrected immediately, and staff notified of updates to ensure compliance. 3. Measures / Systems to prevent re-occurrence: a) The facility policy on comprehensive care plans was reviewed and revised to ensure all care plans are person centered and address all physician orders, including the use of wander guards. b) All nursing staff responsible for care - planning were re-educated on care plan development and updates, emphasizing the inclusion of all ordered devices and	

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F 656	Continued From page 18 the care plans of Resident #59 together. She confirmed that there was no care plan addressing the NJ Exec Order 26.4b1 A review of the policy titled, "Care Plans-Comprehensive", with a revised date of January 1, 2025 reflected "2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS." It further reflected "8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change." NJAC 8:39-27.1(a)	F 656	resident -specific safety interventions. 4. Monitoring of continued effectiveness of the systemic change: a) The DON / Designee will conduct weekly audits of care plans for the next three months to verify that wander guards are properly documented and implemented. b) After the initial 3 months, audits will be conducted monthly for an additional three months, then quarterly. c) Findings from the audits will be discussed in the monthly Quality Assurance Committee meeting to ensure ongoing compliance and address any identified issues. 5. Responsibility of Oversight: Director of Nursing, Administrator	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		2/10/25

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F 880	Continued From page 19 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 20 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to use appropriate infection control practices, such as hand hygiene and Personal Protective Equipment (PPE) when providing care and other NJ Exec Order 26.4b1 care activities to 3 of 3 residents (Resident #23, #52, #84) reviewed under the Infection Control Task. The deficient practices were evidenced by the following: 1. On 1/14/2025 at 10:24 AM, surveyor #1 observed Licensed Practical Nurse (LPN#1) perform NJ Exec Order 26.4b1) care, which was identified as requiring techniques (NJ Exec Order 26.4b1 on Resident #52 and observed the following: At 10:31 AM, following Resident #52's assessment by LPN #1 it was determined that that U.S. FOIA (b)(6) was required to clear their	F 880	1. Immediate action for resident affected by the deficient practice: a) Cannot retroactively correct the deficient practice for R52, R82 and R23. However, LPN#1 was immediately educated about expectations related to hand hygiene, sterile technique, aseptic technique, and NJ Exec Orde care. b) RN1, CNA1, CNA2, and RN2 were immediately educated about PPE requirements for residents on NJ Exec Orde c) RN1 was immediately educated on the requirement to perform hand hygiene between glove changes. 2. Identifying other residents with potential to be affected: All residents have the potential to be affected by the deficient practice. 3. Measures / Systemic changes to ensure compliance:	

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F 880	Continued From page 21 NJ Exec Order 26.4b1 LPN #1 removed her disposable gloves and applied sterile gloves without performing hand sanitation. Upon completion of NJ Exec Order 26.4b1, LPN #1 removed the sterile gloves and washed their hands with soap and water lathering under the flow of running water for fifteen seconds. At 10:39 AM, LPN #1 proceeded to apply sterile gloves in order to change Resident #52's NJ Exec Order 26.4b1). While applying the right glove, LPN#1 grabbed the thumb of the glove with the ungloved left hand which broke the sterility of the right glove. During the NJ Exec Order 26.4b1 change at 10:41 AM, LPN #1 recognized that she did not have the correct NJ Exec Order 26.4. With sterile gloves applied, LPN #1 retrieved the proper supplies, opened the package, and continued with the change which resulted in a break of aseptic techniques. At 10:46 AM, following the NJ Exec Order 26.4b1 change, LPN #1 removed the sterile gloves and changed to disposable gloves without hand sanitization. At 10:51 AM, surveyor #1 interviewed LPN #1 who confirmed that handwashing was not completed for the required 15-20 seconds that there should have been hand sanitizing between glove changes. LPN #1 also acknowledged that she broke aseptic techniques and the sterility of the gloves when she touched the thumb of the right glove and when she gathered supplies in the room with the gloves on. During an interview with another surveyor on	F 880	a) All nursing staff re-educated on importance of following enhanced barrier precaution protocols, including all required PPE. b) All nursing staff re-educated on appropriate hand hygiene technique with return demonstration. c) All licensed staff were re-educated on sterile technique when performing trach care, and aseptic technique when performing wound care. 4. Monitoring the continued effectiveness of the systemic change : a) DON or designee will perform 3 observational audits per week x 4 weeks, then monthly x 2 months, to ensure appropriate hand hygiene is completed. b) DON or designee will perform 3 observational audits per week x 4 weeks, then monthly x 2 months, to ensure EBP protocol is followed. c) DON or designee will do one trach care observation and one wound care observation per week x 4 weeks, then monthly x 2 months, to ensure infection control protocols are followed. d) Audit findings will be brought to quarterly QAPI meeting to determine whether additional follow up is needed. Responsibility of Oversight: Infection Preventionist, Director of Nursing, Administrator	

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F 880		F 880		

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1/15/2025 at 10:00 AM , the [US FOIA (b)(6)] confirmed that hand hygiene is "essential" between glove changes to prevent cross contamination.

During an interview with surveyor #1 on 1/16/2025 at 11:35 AM, the [U.S. FOIA (b)(6)] in the presence of the [U.S. FOIA (b)(6)] acknowledged that hand sanitation should be completed between glove changes, the hand washing length, and break in sterile technique.

A review of facility policy titled, "Tracheostomy Care", Revised 12/24, under section "General Guidelines" included: 1. Aseptic technique must be used: c. during tracheostomy tube changes, either reusable or disposable [...] 2. [...] Sterile Gloves must be used during aseptic procedures ...

A review of facility policy titled, "Handwashing/Hand Hygiene", Revised 3/24, under section "Policy Interpretation and Implementation" included: 5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-microbial soap and water (...) 6. In most situations, the preferred method of hand hygiene is with and alcohol-based hand rub. If hands are not visibly soiled use and alcohol based rub containing 60-95% ethanol or isopropanol for the following situations (...)b. before donning sterile gloves; (...) j. after removing gloves.

2.) On 01/13/2025 at 11:28 AM while outside of Resident # 84's room, Surveyor # 2 observed Registered Nurse (RN) # 1 in the room. RN # 1 was disconnecting the [NJ Exec Order 26.4b1] ([NJ Exec Order 26.4b]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

NJ Exec Order 26.4b1 to provide NJ Exec Order 26.4b1) that was connected to Resident # 84 from the NJ Exec Order 26.4b1 on a RN # 1 was wearing gloves but not a disposable gown.

At that time, Surveyor # 1 also observed a sign outside the doorway that was titled, 'NJ Exec Order 26.4b1 The sign revealed that providers and staff must wear gloves and a gown for the following NJ Exec Order 26.4b1 Resident Care Activities. The sign revealed a list including "Device care or use: NJ Exec Order 26.4b1 "

A review of Resident # 84's Active Orders revealed an order for, 'NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 : [Brand name redacted] at /hour X hours. Up and Down at or when NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 at every hours X hours to run with Twice a day start at NJ Exec Order 26.4b1 Remove 10:00 AM."

A review of Resident # 84's Electronic Medical Record (EMR) revealed an order to clean a to NJ Exec Order 26.4b1 with daily.

A review of Resident # 84's Care Plan revealed a focus for, NJ Exec Order 26.4b1, presence of: : NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1".

On 1/13/2025 at 11:30 AM, Surveyor # 2 observed the sign outside the doorway of Resident # 84's room that was titled, 'NJ Exec Order 26.4b1

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 01/16/2025

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F 880	Continued From page 24	F 880		

NJ Exec Order 26.4b1 Everyone Must:" The sign revealed that providers and staff must wear gloves and a gown for the following NJ Exec Order 26.4b1 Resident Care Activities. The sign revealed a list including 'NJ Exec Order 26.4b1 ."

On the same date at 11:33 AM, Surveyor # 2 observed Registered Nurse (RN) # 1 with assistance from Certified Nurses Aide (CNA) # 1 perform NJ Exec Order 26 care on Resident # 84. At that time, CNA # 1 did not don a gown while in the room.

During the NJ Exec Order 2 care at approximately 11:43 AM, RN # 1 removed the soiled dressing from Resident # 84's NJ Exec Order 26. At that time, RN # 1 removed the disposable gloves and applied a new pair of gloves. RN # 1 did not perform any hand hygiene between changing gloves.

At approximately 11:46 AM, after NJ Exec Order 26.4b1 , RN # 1 removed the disposable gloves and applied a new pair of gloves. RN # 1 did not perform any hand hygiene between changing gloves.

Lastly, RN # 1 applied a NJ Exec Order 26.4b1 to Resident # 84's NJ Exec Order 26.4. At that time, RN # 1 removed the disposable gloves. RN # 1 did not perform and hand hygiene after removing the gloves. RN # 1 and CNA # 1 then proceeded to NJ Ex and NJ Exec Order 26.4 Resident # 84 in their bed. CNA # 1 did not wear a gown throughout the entire observation of NJ Exec Order 2 care.

At approximately 11:50 AM during an interview with Surveyor # 2, RN # 1 said CNA # 1 should have worn a gown in the room. RN # 1 said that

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F 880	Continued From page 25	F 880		

he washed his hands before NJ Exec Order 26 care and didn't use alcohol-based hand rub between glove changes.

On 1/15/2025 at 10:20 AM during an interview with Surveyor # 2, the U.S. FOIA (b)(6) confirmed that staff should be performing hand hygiene between glove changes clarifying it is important to prevent transmission.

On 1/15/2025 at 11:35 AM during an interview with the U.S. FOIA (b)(6)), Surveyor # 1 asked when a nurse is disconnecting a completed NJ Exec Order 26.4b1 for a resident with a NJ Exec Order 26.4b1 , should the nurse be wearing a gown if they are on NJ Exec Order 26.4b1 ? The U.S. FOIA (b) replied, "yes." The surveyor then asked why would that be important. The U.S. FOIA (b) replied, "Because there is an opening an it could possibly transfer possible infection." During the same interview with Surveyor # 2, the U.S. FOIA (b)(6) replied, "Yes" when the surveyor asked should a nurse perform hand hygiene between glove changes during wound care. The U.S. FOIA (b) said it is important for infection control.

A review of the facility policy titled, "Handwashing/hang hygiene" with a revised date of 3/24 revealed, "Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: k. Before and after changing a dressing...e. Before handling clean or soiled dressing, gauze pad, etc., j. After removing gloves."

3.) Surveyor #3 observed a sign for NJ Exec Order 26.4b1 to the right of the door outside Resident #23's room. The sign reflected

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F 880	Continued From page 26	F 880		

that everyone must clean hands, including before and when leaving room. Providers and staff must also wear gloves and gown for the following [redacted] resident care activities: [redacted] providing [redacted] changing linens, changing [redacted] and [redacted].

On 01/12/2025 at 10:21 AM, Surveyor #3 observed Resident #23 receiving care. Certified Nurses Aide (CNA) #2 was observed performing direct care on this resident wearing a mask and gloves. CNA #2 was not wearing a gown. When asked if she should be wearing a gown the CNA responded, "oh yeah".

On 01/14/2025 at 11:18 AM, Surveyor #3 observed Registered Nurse #2 at Resident #23's bedside adjusting the [redacted]. RN #2 was observed wearing gloves and no gown. When asked at that time if she should be wearing a gown, RN #2 responded yes.

A review of the medical record reflected that Resident #23 had diagnosis which included [redacted]).

A review of the quarterly minimum data set, an assessment tool, dated [redacted] reflected that Resident # 23 had [redacted] and [redacted] It reflected that Resident # 23 utilized a [redacted].

During an interview on 01/15/2025 at 10:22 AM, the [redacted] said that when a resident is on [redacted] a gown should be utilized when providing care and adjusting [redacted]

A review of the policy titled "Enhanced Barrier

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F 880	Continued From page 27 Precautions" with an effective date of 04/05/2024 reflected that all residents with medical devices including feeding tubes require gloves and gowns to be worn during high contact resident care. NJAC 8:39 19.4(a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12001L	A. BUILDING: _____ B. WING _____	C 01/16/2025

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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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for 12 of 14 day shifts as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. Immediate Action: a) The Facility adjusted staff schedules to fill any future anticipated gaps using available staff and by securing additional per-diem C.N.A's to cover deficiencies. b) During identified shifts with deficient staffing, all residents were reviewed to ensure care needs were met without negative outcomes. 2. Other resident with potential to be affected by the deficient practice: a) A full audit of staffing levels for all shifts	2/10/25

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

Electronically Signed | 01/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing prior to survey from 12/29/2024 to 01/11/2025, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -12/29/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -01/02/25 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -01/04/25 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -01/05/25 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -01/06/25 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. During an interview on 01/14/2025 at 11:57 AM, the Staffing Coordinator (SC) stated that she is	S 560	over the previous one month was conducted to identify any additional non compliance with staffing ratios. b) Any additional instances of insufficient staffing identified during the audit were addressed by implementing temporary agency support 3. Measures / System changes: a) The staffing policy was revised to include a tracking system for shift coverage to ensure compliance with minimum staffing ratios. b) A scheduling system was implemented to identify potential gaps at least 14 days in advance, allowing time to secure additional staff. c) The staffing coordinator will review schedules weekly to ensure compliance d) Agreement was established with staffing agency to provide a consistent pool of back up C.N.A's in the event of unexpected absences. e) All staff were retrained on NJ staffing requirement and the importance of compliance to ensure quality resident care. 4. Monitoring: a) Staffing coordinator will conduct daily reviews of staffing ratios to ensure compliance b) The Administrator / Designee will conduct weekly audits of staffing schedules for the next 90 days followed by monthly audits for six months. c) Findings from audits will be presented at the QAPI committee meeting for review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12001L	A. BUILDING: _____ B. WING _____	C 01/16/2025

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S 560	Continued From page 2 aware of the minimum staffing ratio requirement of direct care staff. She stated the facility is meeting the requirement. The surveyor reviewed the facility provided policy titled, "Staffing", with a revised date of 3/2024. The policy reflected that our facility provides adequate staffing to meet needed care and services for our resident population. The policy reflected 1. Our facility shall maintain: a. One Certified Nurse Aide (CNA) to every eight residents for the day shift.	S 560	and action as needed d) Resident council meetings will include a discussion on care quality, and any concerns related to staffing . Responsible parties: Staffing Coordinator, Director of Nursing , Administrator	

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	3/13/2025 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 F0550	Correction	ID Prefix F0558	Correction	ID Prefix F0577	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(g)(10)(11)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025
ID Prefix F0584	Correction	ID Prefix F0640	Correction	ID Prefix F0656	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/10/2025	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	
1/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
12001L Y1	A. Building B. Wing Y2	3/13/2025 Y3

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

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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	02/10/2025	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?
1/16/2025	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/14/25. 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 (NJDOH), Health Facility Survey and Field Operations on 01/14/25. The facility 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 conducted for the fourth and fifth Long-Term Care floors only. The building is composed of Type II protected construction. The facility is divided into 10 - smoke zones. The generator powers 100% of the building per the U.S. FOIA (b)(6) . The current occupied beds are 93 of 124.	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar	K 712		3/11/25

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

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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 712	Continued From page 1 with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least one fire drill per quarter per shift in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.1.6. This deficient practice had the potential to affect all 30 residents who resided on that wing at the facility. Findings include: A review of the facility's untitled fire drill records provided by the facility revealed no documented evidence a fire drill was conducted for the 4th Floor South's second shift staff for the first quarter of 2024. During an interview on 01/14/25 at 4:45 PM, the facility's U.S. FOIA (b)(6) who conducted the fire drills confirmed the fire drill was not completed on the second shift in the first quarter for the 4th Floor South. NJAC 8:39-31.2(e)	K 712	1. Immediate action for resident affected by the deficient practice: No residents were found to have been affected by the deficient practice. 2. Other residents with the potential to be affected: All residents, staff and visitors have the potential to be affected by this deficiency. 3. Measures to be put in place/Systemic changes: The Assistant Director of Maintenance and the Director of Maintenance: a) Conducted an in-service training for the staff members responsible for conducting fire drills regarding fire safety and documentation protocols. (Please see Attached as requested) b) Developed a fire drill schedule for the year to ensure that at least one fire drill is conducted on each shift, as required (Please see attached as requested) 4. Monitoring: The Director of Maintenance / Designee will:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 712	Continued From page 2	K 712	a) Monitor the documentation of the fire drills monthly for three months to ensure fire drills are conducted as required. b) An audit tool will be used to monitor compliance. c) Results of the audit will be reviewed at the quarterly quarterly Quality Assurance Performance Improvement meetings for three months or until 100% compliance is achieved d) The Quality Assurance Performance Improvement team will identify trends or patterns and make recommendations to revise the plan as indicated 5. Responsibility of Oversight: Director of Maintenance, Administrator	

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	3/13/2025 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 K0712	03/11/2025	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	
1/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO