STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. BUILDING _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015		5/20/24

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

Electronically Signed | 05/01/2024

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

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E 015	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: see investions for kitchen, LaVerne Champion Based upon observations, staff interviews and review of pertinent facility documents, it was determined that the facility failed to a.) have a sufficient supply of emergency food readily available and b.) have all the emergency menu food items in stock, in accordance with facility policy and the emergency preparedness plan. The deficient practice was evidenced by the following: On 03/25/24 at 09:00 AM, the survey team entered the facility and was made aware by	E 015	1. The emergency supply was inventoried on 3/25/24 by the Food Service Director and Orders were placed by the for the following items reconstituted milk, peanut butter, beef stew, canned chicken, ravioli, carrots, green beans, sloppy joe, peaches, chocolate pudding, peas and crackers, juice, corned beef hash, beets and chili to replenish the emergency supply. 2. The facility acknowledges that all residents can be affected by this identified concern.	

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E 015	Continued From page 2 US FOIA (b)(6) that the facility was licensed for 180 beds and the facility census was 123 (the number of residents who currently resided at the facility). On 03/25/24 at 10:10 AM, the surveyor toured the kitchen with the US FOIA (b)(6) and the US FOIA (b)(6). During the initial tour, the surveyor was escorted to a storage room which contained the facility's emergency water and food supply. In the presence of the surveyor and the US FOIA (b) the regional US FOIA (informed the surveyor of the food items and quantities available in the facility's emergency food supply. The regional US FOIA (b) stated that the facility had a contracted vendor who was operating the kitchen up until February 2024 and since then the facility had been working on replenishing the emergency food supply. The surveyor requested the letter from the contracted vendor that they were no longer providing service to the facility effective February 2024. On 03/26/24 at 09:11AM, the US FOIA (b)(6) provided the surveyor with a 3-day emergency menu which was titled [name redacted]" EMERGENCY MENU GUIDE FOR NO ELECTRICITY, NO GAS". The surveyor reviewed and compared the emergency menu to the food that was observed in the emergency food storage during the initial tour. Review of the emergency menu revealed that there was no evidence of the listed reconstituted milk, peanut butter, beef stew, canned chicken, ravioli with sauce, carrots, green beans, sloppy joe, peaches, chocolate pudding, peas, and crackers in the facility's emergency food storage supply observed during the initial kitchen tour. The surveyor then reviewed the quantity of food	E 015	3. The Food Service Director (FSD) or designee will inspect the emergency supply for any discrepancies in the inventory or expirations, weekly, for 3 months. If there are any discrepancies or expired food, orders will be immediately placed by the FSD with the appropriate vendors to replenish the inventory. The Administrator will inspect the emergency supply monthly for any discrepancies in the inventory based on the emergency supply list for 3 months. If any descripencies are found, they will be immediately reported to the FSD 4. The Food Service Director or designee will report audit results at QAPI meetings monthly for 3 months or until compliance is obtained.	

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E 015	Continued From page 3	E 015		

that was available in the facility's emergency food supply which revealed that the facility did not have a 3 day supply of juice, cereal, corn beef hash, beets, and chili based on the census of 123.

On 03/26/24 at 09:36 AM, in presence of the survey team and the facility's US FOIA (b)(6), the regional US FOIA provided the surveyor with an invoice order dated 03/25/24 from [name redacted] and an invoice from [name redacted] dated 03/27/24. Both invoices contained food items which were on the 3- day emergency food menu but not in the facility's emergency food storage area at the time of the initial kitchen tour. The invoice from [name redacted] dated 3/27/24 revealed that additional juices were ordered.

On 03/26/24 at 10:11 AM, in the presence of the survey team, the surveyor interviewed the US FOIA (b)(6) The surveyor inquired about the invoice dated 3/27/24 from [name redacted]. The US FOIA (b)(6) clarified that the invoice date of 3/27/24 was the delivery date. She confirmed that an order was placed on 3/25/24 at 12:25pm and was scheduled to be delivered on 3/27/24. She also acknowledged that she approved the purchase order for additional emergency supplies. She also provided the surveyor with a letter from the facility informing [name redacted] that "effective NJ Exec Order 26.4b1 all the following [name redacted] will be separating from [name redacted] and bringing our Dietary department management and procurement in house". She further explained that although the separation letter indicated that [name redacted] no longer provided services to the facility effective NJ Exec Order 26.4b1. The contracted vendor remained at the facility until NJ Exec Order 26.4b1.

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E 015	Continued From page 4	E 015		

On 03/27/24 at 02:07 PM, in the presence of the survey team, the surveyor interviewed the [US FOIA (b)(6)] The [US FOIA (b)(6)] stated that he had knowledge of the emergency preparedness, and the purpose of the emergency water and food supply was that if there was a "situation" that the facility was unable to obtain food and water the facility had a supply of emergency food and water. The surveyor inquired if he was aware that there was an insufficient supply of emergency food and he stated he was. The surveyor inquired what was the delay in replenishing the emergency food supply. He explained that the facility had a contract with a vendor who was operating the kitchen and after the contract was terminated, he was working on replenishing the facility's stock. The facility's [US FOIA (b)(6)] also stated that he had difficulty finding some of the food items with one of the contracted vendors he ordered from. He further stated that he communicated with the facility's contracted vendor account manager through electronic mail(e-mail) and that he had to wait for the account manager to assist him with finding the items. The surveyor inquired if he was able to provide the email communications regarding replenishing the emergency food supply and he stated "no, I am not."

On 3/27/24 at 02:30 PM, the surveyor presented the above concerns to the [US FOIA (b)(6)] in the presence of the survey team. The [US FOIA (b)(6)] stated that it was the responsibility of the facility's [US FOIA (b)(6)] to ensure that the emergency food supply was sufficient. She further stated that she and the regional [US FOIA (b)(6)] were responsible for approving food orders and that there was no delay in approval or

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E 015	Continued From page 5 delivery. She stated, "I get emails regarding food ordering and orders come to my phone, if I am not here." There was no additional information provided to the surveyor. Review of an undated facility policy "EMERGENCY AND DISASTER PLANNING POLICY", included under PROCEDURE it stated the following: 2. "The Food Service Director will be responsible for ensuring 3-day emergency supply (as per emergency supplies list attached) is located in the facility with Inventory List, noting expiration date of items." 4. "The Food Service Director will maintain Inventory Check List monthly to check that all documentation is completed correctly, and all stock is accounted for". A review of the undated facility policy titled "Dietary Considerations for Residents" under policy it stated the following: "This facility has planned for the dietary needs of its residents in the case of an emergency situation. The facility shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency." Procedure: 1."Emergency dietary planning for residents and staff includes the consideration of such situations as evacuation and long-term sheltering in place without the support of outside resources (food, water, and food service supplies." NJAC 8:39-31.6(n)	E 015		
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 6 Complaint #: #159502, #159723, #159787, #161847, #167205, #167513, #168877, #169692, #170570 Survey Date: 03/25/2024 to 04/10/2024 Census: 123 Sample: 30 + 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined that the facility failed to provide [NJ Ex Order 26.4b1] to a resident who required [NJ Ex Order 26.4b1] assistance from staff for Activities of Daily Living (ADL). This deficient practice was identified for 1 of 7 residents (Resident #13) reviewed for ADL care. The deficient practice was evidenced by the following: On 03/25/24 at 10:28 AM, during the initial tour of the facility, the surveyor observed Resident #13 in bed, with his/her [NJ Ex Order 26.4b1] from [NJ Ex Order 26.4b1] and the	F 677	1. Resident #13 had [NJ Ex Order 26.4b1] from this identified concern and was provided [NJ Ex Order 26.4b1] by the [US FOIA (b)(6)] immediately after it was brought to his attention. 2. The facility acknowledges that residents who need extensive assistance from staff for nail care can be affected by this identified concern. 3. Nursing managers will assess all residents for the need for nail care. Any resident requiring nail care will receive nail care at the time of the assessment. Any resident who refuses nail care will have a	5/20/24

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F 677	Continued From page 7 NJ Ex Order 26.4b1 with an NJ Ex Order 26.4b1 . The surveyor was not able to observe the resident's NJ Ex Order 26.4b1 from the NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1. Resident #13's NJ Ex had NJ Ex Order 26.4b1 on the NJ Ex Order 2, NJ Ex Order 26.4b1 and the NJ Ex Order 26.4b1. The NJ Ex Or and NJ Ex Order had NJ Ex Order 26.4b1. The surveyor reviewed the medical records for Resident #13. A review of the Admission Record face sheet reflected Resident #13 was admitted to the facility with diagnoses which included, but were not limited to, NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), and NJ Ex Order 26.4b1 (NJ Ex Order 26.). A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool to facilitate resident care dated NJ Ex Order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, indicating the resident was NJ Ex Order 26.4b1. Section NJ Exec NJ Exec Order 26.4b1 and Goals reflected that the resident had an NJ Ex Order 26.4b1 in the NJ Ex Order 26.4b1. The MDS revealed that the resident required NJ Ex Order 26.4b1 assistance and was dependent on staff for most ADLs and NJ Ex Order 26.4b1 . Section NJ NJ Exec Order 26.4b indicated that the resident did not NJ Exec Order 26.4b1. A review of the resident's Care Plan (CP) did not reflect the Resident had a ADL NJ Ex Order 26.4b1 and required assistance with ADLs.	F 677	care plan for refusals and will be reapproached on the next shower day. The ADON or designee will in-service CNAs and nurses on providing nail care on shower days and as needed. Unit managers will conduct a audit of 5 residents a month on their units to ensure that nail care is provided as needed. Any identified issues will be addressed. 4. The Director of Nursing (DON) or designee will present the findings of the audit during monthly QAPI meetings for three months and follow up with feedback as needed.	

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F 677	Continued From page 8	F 677		

On 03/26/24 at 01:26 PM, the surveyor interviewed Certified Nursing Aide (CNA) #1, who stated that if she sees a resident with NJ Ex Order 26.4b1 and the residents were NJ Ex Ord then she would ask the resident if she could NJ Ex Order 26.4b1.

On 04/01/24 at 12:07 PM, the surveyor asked the resident how he/she NJ Ex Ord about his/her NJ Ex Ord or if the staff NJ Ex Order 26.4b1. The resident stated "NJ Ex Order 26.4b1 "

On 04/02/24 at 11:47 AM, the surveyor interviewed CNA #2 who stated she was familiar with Resident #13. She stated that the resident was NJ Ex Ord dependence with NJ Ex Ord CNA #2 stated that she NJ Ex Order 26.4b1 when she provides care. "I NJ Ex Order 26.4 residents NJ Ex Ord if they NJ Ex Order 26.4b1." The surveyor asked the US FOIA (6 if they keep a log for NJ Ex Order 26.4b1 and the US FOIA (6 stated, "No log."

On 04/02/24 at 12:17 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the CNA's are supposed to do NJ Ex Order 26.4b1 such as NJ Ex Order 26 and NJ Ex Order 26.4b1 only. The US FOIA (b)(6) stated, "it was important to NJ Ex Order 26.4b1 because of an NJ Ex Order 26.4b1, easy to NJ Ex Order 26.4 or the NJ Ex Orde and for NJ Ex Order 26.4b1." The US FOIA (b)(6) entered Resident #13's room with the surveyor. When asked about the resident's NJ Ex Order 26.4b1, the US FOIA (b)(6) stated, "The resident has NJ Ex Order 26.4b1 and would benefit from having their NJ Ex Order 26.4b1 today."

On 4/4/24 at 03:17 PM, the survey team met with US FOIA (b)(6) to present the

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F 677	Continued From page 9 above concerns. A review of the facility provided undated "Position Title: Certified Nurse Aide" document under responsibilities/ Accountabilities included: Bathes the resident in bed, tub or shower, combs hair, cleans and cuts fingernails and given shampoos. A review of the facility provided "ADL Care" policy revised on 09/2023 included: The level of assistance needed for any ADL activity will be included on the resident's plan of care. The care plan will describe potential distress triggers or behaviors as related to the completion of ADLs. A review of the facility provided "Comprehensive Care Plan" policy revised on 09/2023 included: The care planning process will include an assessment of the resident's strengths and needs and will incorporate the president's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlines by the comprehensive care plan, shall be culturally competent and trauma-informed. NJAC 8:39-27.2 (g)	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		5/20/24

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F 686	Continued From page 10 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and other facility documentation, it was determined that the facility failed to complete weekly NJ Ex Order 26.4b1 for 3 of 3 residents (Resident #5, #49 and #86) reviewed for NJ Ex Order 26.4b1 . This deficient practice was evidenced by the following: 1.On 03/25/24 at 11:10 AM, during initial tour of the NJ Exec floor, the surveyor observed Resident #5 in bed. The surveyor attempted to interview the resident but he/she was NJ Ex Order 26 to NJ Exec Order 2 the surveyor's questions. A review of Resident #5's Electronic Medical Record (EMR) revealed the following: According to the Admission Record, Resident #5 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4b1 NJ Ex Order 26.4b1) and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 . The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4 , indicated	F 686	1. Resident #5, #49, and #86 had NJ Ex Ord from the concern identified. On 4/3/24, the unit managers completed NJ Exec O assessments on all residents with NJ Ex On the same day, unit managers immediately in-serviced nurses on the policy and procedure for weekly NJ Ex Or and documentation as per policy. 2. The facility acknowledges that all residents can be affected by this identified concern. 3. The ADON/ Designee will continue to educate the nurses on the policies and procedures for weekly skin assessments quarterly and as needed. Unit managers will conduct a random monthly audit of weekly skin assessments of 5 residents' medical records to ensure skin assessments are completed and documented for 3 months. Any identified issues will be addressed. 4. The DON or designee will report the results of the audits during the monthly QAPI meeting for the next three months and follow up with feedback as needed or until compliance is obtained.	

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that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that the resident was [redacted]. Further review of the MDS, revealed the resident had [redacted]).

A review of the physician "Order Summary Report" (OSR) revealed an active physician's order (PO) for: [redacted] weekly every evening shift every Tue for [redacted]. Complete [redacted] (under Evaluation Tab). [redacted] as per protocol.

A review of the Treatment Administration Record (TAR) for [redacted] revealed that the above PO for [redacted] weekly was signed as completed for "Eveni" (evening) on [redacted], [redacted] and [redacted]. The "Eveni" was left blank for [redacted] and [redacted].

A review of the TAR for [redacted] revealed that the above PO for [redacted] weekly was signed as completed for "Eveni" on [redacted], [redacted] and [redacted]. The "Eveni" was left blank for [redacted].

A review of the TAR for [redacted] revealed that the above PO for [redacted] weekly was signed as completed for "Eveni" on [redacted], [redacted], [redacted], and [redacted].

A review of the [redacted] (under the "Evaluations" tab) revealed a "[redacted]" dated [redacted]. There were no other

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NJ Ex Order 26.4b1 documented under the "Evaluations" tab for NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 or NJ Ex Order 2 NJ Ex Orde.

A review of the resident's Care Plan revealed a Focus: potential for NJ Ex Order 26.4b1 development r/t (related to) NJ Ex Order 26.4b1 NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26. seen by NJ Ex Order 26 NJ Ex Order Intervention: Follow facility policies/protocols for the prevention/treatment of NJ Ex Order 26.4b1 in [name redacted].

On 04/01/24 at 12:20 PM, the surveyor interviewed the US FOIA (b)(6)), who confirmed she was Resident #5's assigned nurse. She stated that NJ Ex Order 26.4b1 were usually done at least weekly on shower days. She then stated that the NJ Ex Order 26.4b1 should be documented under "Evaluations" in the EMR.

On 04/02/24 at 09:42 AM, the surveyor interviewed the NJ Ex floor US FOIA (b)(6) who stated that resident's NJ Ex Or gets checked weekly and a NJ Ex Order 26.4b1 should be done in the EMR. He stated that NJ Ex Order 26.4b1 were required "if there was not a NJ Ex Order 26 or if a NJ Ex Order 26 was still there or if the NJ Ex Order 26 was NJ Ex Order 26.4b1 The US FOIA (b)(6) stated that the assessment was charted on the TAR and under the "Evaluation" tab.

On 04/02/24 at 09:48 AM, the US FOIA (b)(6) reviewed the EMR in the presence of the surveyor for Resident #5. He verified the above PO for weekly NJ Ex Order 26.4b1. He confirmed that the NJ Ex Order 26.4b1 under the "Evaluations" tab was the only evaluation documented since NJ Ex Order 26.4b1. The US FOIA (b)(6) confirmed no additional

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NJ Ex Order 26.4b1 were completed since NJ Ex Order 26.4b1. He stated the purpose of the evaluations was to check if NJ Ex Or was NJ Ex Order 2 to make sure the proper treatment was being done. He stated that the evaluations should be done even if a NJ Ex Order 26 was already present because they still need to monitor the NJ Ex Or in addition to the NJ Ex Order 26 to identify any NJ Ex Order 26.4b1. He then stated that the US FOIA (b)(6) would also identify NJ Ex Or.

2. On 03/27/24 at 11:33 AM, the surveyor observed Resident #49 sitting in a NJ Ex Order 26.4b1 in the common area on the NJ Exec floor. The resident had NJ Ex Order 26.4b1.

A review of Resident 49's EMR revealed the following:

According to the Admission Record, Resident #49 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 and a NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).

The Quarterly MDS dated NJ Ex Order 26.4b1, indicated that the facility assessed the resident's NJ Exec Order 26.4b status using a BIMS. The resident scored a NJ Ex out of 15 which NJ Ex Order 26.4b1 that the resident was NJ Ex Order 26.4b1. Further review of the MDS, revealed the resident had one NJ Ex Order 26.4b1.

A review of the physician "OSR" revealed an active PO for: NJ Ex Order 26.4b1 weekly every

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(Monday) on (11-7) evening shift every Mon for NJ Ex Order 26.4b1. Complete NJ Ex Order 26.4b1 (under Evaluation Tab). NJ Exec Order findings as per protocol.

A review of the TARs for NJ Ex Order 26.4b1 revealed that the above PO for NJ Ex Order 26.4b1 weekly was signed as completed for "Night" on NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The "Night" was left blank for NJ Ex Order 26.4b1.

A review of the TARs for NJ Ex Order 26.4b1 revealed that the above PO for NJ Ex Order 26.4b1 weekly was signed as completed for "Night" on NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

A review of the TARs for NJ Ex Order 26.4b1 revealed that the above PO for NJ Ex Order 26.4b1 weekly was signed as completed for "Night" on NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. The "Night" was left blank for NJ Ex Order 26.4b1.

A review of the NJ Ex Order 26.4b1 (under the "Evaluations" tab) revealed a "NJ Ex Order 26.4b1" dated NJ Ex Order 26.4b1. There were no other NJ Ex Order 26.4b1 documented under the "Evaluations" tab for NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1.

A review of the resident's Care Plan revealed a Focus: has a NJ Exec Order 26.4b1 for NJ Ex Order 26.4b1 - NJ Ex Order 26.4b1 - NJ Ex Order 26.4b1, Date Initiated: NJ Ex Order 26.4b1, Revision on: NJ Ex Order 26.4b1.

On 04/02/24 at 09:48 AM, the surveyor interviewed the NJ Exec floor US FOIA (b)(6), who confirmed he was Resident #49's assigned nurse. He reviewed the EMR in the presence of the

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surveyor. He verified the above PO for weekly NJ Ex Order 26.4b1. He then acknowledged that the only documented NJ Ex Order 26.4b1 under "Evaluations" from NJ Ex Order 26.4b1 to present was the" NJ Ex Order 26.4b1 " dated NJ Ex Order 26.4b1.

3. On 03/25/24 at 11:17 AM, during the initial tour of the NJ Exec floor, Resident #86 was observed in a NJ Ex Order 26.4b1 in the NJ Ex Order 26.4b1.

A review of Resident 86's EMR revealed the following:

According to the Admission Record, Resident #86 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4b1 NJ Ex Order 26.4b1, NJ Ex Order 26.4b1) and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).

The Quarterly MDS dated NJ Ex Order 26.4b1, indicated that the facility assessed the resident's cognitive status using a BIMS. The resident scored a NJ Ex out of 15 which indicated that the resident was NJ Ex Order 26.4b1. Further review of the MDS, revealed the resident's NJ Ex Or was NJ Ex Order 2

A review of the physician "OSR" revealed an active PO for: NJ Ex Order 26.4b1 weekly every Monday on evening shift. Every evening shift every Mon for NJ Ex Order 26.4b1. Complete NJ Ex Order 26.4b1 (under Evaluation Tab). Report NJ Exec Order 26.4b1 as per protocol.

A review of the TARs for NJ Ex Order 26.4b1 revealed that the above PO for NJ Ex Order 26.4b1 weekly was signed as completed for "Eveni" on NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The "Eveni"

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was left blank for NJ Ex Order 26.4b1.

A review of the TARs for NJ Ex Order 26.4b1 revealed that the above PO for NJ Ex Order 26.4b1 weekly was signed as completed for "Eveni" on NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

A review of the TARs for NJ Ex Order 26.4b1 revealed that the above PO for NJ Ex Order 26.4b1 weekly was signed as completed for "Eveni" on NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. The "Eveni" was left blank for NJ Ex Order 26.4b1.

A review of the NJ Ex Order 26.4b1 (under the "Evaluations" tab) revealed a "NJ Ex Order 26.4b1 " dated NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. There were no other NJ Ex Order 26.4b1 documented under the "Evaluations" tab for NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1.

A review of the residents Care Plan revealed a Focus: has NJ Ex Order 26.4b1 -r NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 Date Initiated: NJ Ex Order 26.4b1 Revision on: NJ Ex Order 26.4b1. Intervention: Follow facility policies/protocols for the prevention/treatment of NJ Ex Order 26.4b1.

On 04/02/24 at 10:07 AM, the surveyor interviewed the US FOIA (b) who stated that "if NJ Ex Order 26.4b1 was identified, she would call the nurse in to see it."

On 04/02/24 at 10:25 AM, the surveyor interviewed the NJ Exec floor US FOIA (b)(6) who stated that NJ Ex Order 26.4b1 were done weekly in the evening and that it should be documented under the NJ Ex Or

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NJ Ex Order 26.4b1 under "Evaluations" tab. She stated the assessments should be signed off on the TAR as being completed and then document NJ Ex Or [redacted]. The US FOIA (b)(6) stated "it (documentation) should be done regardless of NJ Ex Order 26.4b1 or not." The US FOIA (b)(6) stated the purpose was "to know if a NJ Ex Order 26 was improving, if there was development of a NJ Ex Order 26. and to make sure there was nothing present that wasn't there before."

On 04/02/24 at 10:30 AM, the surveyor interviewed the US FOIA (b)(6) [redacted], who stated that NJ Ex Order 26.4b1 were done weekly by the nurses. She then stated that the CNA's would notify the nurse "if anything new comes up." The US FOIA (b)(6) stated that the assessment was documented on the Medication Administration Record (MAR) or TAR. She further stated that the NJ Ex Order 26.4b1 would be done weekly usually with the resident's shower and if anything, NJ Exec Order 26.4b was found "a NJ Ex Order 26.4b1 would be done."

On 04/03/24 at 12:17 PM, the surveyor interviewed the US FOIA (b)(6) [redacted] who state that NJ Ex Or should be assessed on admission, readmission, weekly and as needed. She stated that it (the NJ Ex Order 26.4b1 should be documented in the EMR under the "Evaluations" tab. The US FOIA (b)(6) stated that every resident should have a weekly NJ Ex Order 26.4b1 regardless of NJ Ex Order 26.4b1 or not. She stated the purpose was to monitor NJ Ex Order 26.4b1 and to make sure interventions were put in place.

At that time, the US FOIA (b)(6) reviewed the facility provided "OSR" for Resident #5 and #49. She

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F 686	Continued From page 18 confirmed that the Complete NJ Ex Order 26.4b1 [redacted] (under Evaluation Tab) should be completed weekly as ordered. She reviewed the TARS and stated that "if nurses are signing the TAR, they were acknowledging that the NJ Ex Or[redacted] was completed on NJ Ex Order 26.4b1 "COMS" tab. She further stated "if they (nurses) don't sign it, it was not completed. If it is not documented, it is not done." She then reviewed the "Evaluations" tab in the EMR in the presence of the surveyor and verified that there was only a NJ Ex Order 26.4b1 documented on NJ Ex Order 26.4b1. On 04/03/24 at 12:45 PM, the surveyor made the US FOIA (b)(6) [redacted] were made aware of the above findings for Residents #5, #49, and #86. No additional information was provided. A review of the facility's policy "Pressure Ulcer Prevention & Management Policy" revised 9/2023, revealed Policy: It is the policy of this facility to assess all resident upon admission; readmission and quarterly thereafter for risk factors associated with Pressure Ulcer development and the necessary precautions to prevent formation. Appropriate interventions will be utilized to prevent pressure ulcer development and to promote healing when pressure ulcer are present. Procedure: 1. All residents will be assessed on admission, re-admission, if noted with significant change in condition, and quarterly thereafter for the risk of PRESSURE ULCER formation using the BRADEN SCALE. 3. THE SKIN ONLY EVAL will be completed by the licensed nurse weekly to determine effectiveness of treatment.	F 686		

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F 686	Continued From page 19 NJAC 8:39-25.2 (c), 27.1(e)	F 686		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to identify and prevent worsening of a NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) for one of four residents (Resident #13) reviewed for NJ Ex Order 26.4 and NJ Ex Order 26.4. This deficient practice was evidenced by: On 03/25/24 at 10:28 AM, during the initial tour of the NJ Ex floor, the surveyor observed Resident #13	F 688	1. Resident #13 was evaluated by NJ Ex Order 26.4b1 on NJ Ex Order 2 and was placed on an NJ Ex Order 26.4b1 program for NJ Ex Orde immediately after the concern was identified. 2. The facility acknowledged that residents at risk of developing/or worsening contractures can be affected by this identified concern. 3. Therapy screened all residents who had a potential for decrease in ROM and identified residents were placed on	5/20/24

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F 688	Continued From page 20 in bed. The resident's NJ Ex Order 26.4b1 was NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 and the NJ Ex Order was NJ Ex Order 26.4b1. When asked by the surveyor, Resident #13 stated that they were not NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1. The surveyor observed that there was NJ Ex Order 26.4b1 or that there was nothing placed NJ Ex Order 26.4b1. On 03/26/24 at 1:26 PM, the surveyor interviewed Certified Nursing Aide (CNA #1) who stated that if she saw a resident with a NJ Ex Order 26.4b1 then she would perform NJ Ex Order 26.4b1 and inform the nurse to schedule the resident for NJ Ex Order 26.4b She also stated that she would place a NJ Ex Order 2 or a NJ Ex Order 26.4b1 in resident's NJ Ex Order On 03/27/24 at 12:00 PM, the surveyor observed Resident #13 in bed. The surveyor observed that there was NJ Ex Order 26.4b1 and there was nothing NJ Ex Order 26.4b1. Resident #13 stated that he/she was NJ Ex Order 26.4b1 but was able to NJ Ex Order 26.4b1 their NJ Ex Order 26.4b1. Resident #13 further stated, "NJ Ex Order 26.4b1 ." On 04/01/24 at 12:07 PM, the surveyor observed Resident #13 in bed and that there was NJ Ex Order 26.4b1 and there was nothing NJ Ex Order 26.4b1. The surveyor interviewed the resident about his/her NJ Ex Order Resident #13 stated NJ Ex Order 26.4b " Resident #13 stated; " NJ Ex O ." On 04/02/24 at 10:41 AM, the surveyor observed Resident #13 in a NJ Ex Order 26.4b1 in his/her room. The surveyor observed that there was NJ Ex Order 26.4b1 or that there was nothing NJ Ex Order 26.4b1	F 688	Occupational Therapy as needed. The Director of Rehab (DOR) will in-service nurses and CNAs on identifying and reporting decreases in ROM. The DOR will in-service US FOIA (b)(6) on the rehab screening policy. Therapists will continue with quarterly screens and any resident who is at risk for contractures will be evaluated for Occupational Therapy and placed on therapy, if appropriate. The Director of Rehab will screen 5 residents a month who are at risk for contractures monthly for 3 months. 4. The Director of Rehab will report all findings at the monthly QAPI meeting for 3 months or until compliance is obtained and findings will be addressed and follow up with feedback and recommendations.	

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F 688	Continued From page 21 the [redacted].	F 688		

The surveyor reviewed the electronic medical records (EMR) for Resident #13.

A review of the Admission Record face sheet revealed Resident #13 was admitted to the facility with diagnoses which included but were not limited to; [redacted], [redacted], and [redacted].

A review of the resident's diagnoses did not include a diagnosis for an [redacted].

A review of the Quarterly Minimum Data Set (MDS), used to facilitate the management of care, dated [redacted], revealed that Resident #13 had a Brief Interview of Mental Status (BIMS), score of [redacted] out of 15, indicating the resident was [redacted]. The MDS also identified that the resident had an [redacted], the [redacted].

A review of the most recent Quarterly MDS dated [redacted], revealed that Resident #13 had a BIMS score of [redacted] out of 15, indicating the resident was [redacted]. The MDS also identified that the resident had an [redacted], the [redacted]

A review of Resident #13's ongoing Care Plan (CP) did not reveal a Focus or intervention for the resident's [redacted] or the [redacted].

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F 688	Continued From page 22 A review of the readmission NJ Exec Order 26.4b1 dated NJ Ex Order 26.4b1 at 20:12 (08:12 PM) did not reveal documentation of the resident's NJ Ex Order or a NJ Ex Order 26.4b1 Additional review of the Physician's Progress notes dated NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 did not reveal documentation of the resident's NJ Ex Order or a NJ Ex Order 26.4b1. A review of nursing Progress notes from NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 did not reveal any documentation of the resident's NJ Ex Order 26.4b1 or a NJ Ex Order 26.4b1 A review of the Order Summary Report (OSR) from NJ Ex Order 26.4b1, did not reveal physician's orders (PO) for a NJ Ex Order 26.4b1. Further review of OSR did not reveal an order for NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 A review of NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 Treatment Administration Record (TAR) did not reveal documentation of treatment to address any interventions for the resident's upper NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 On 04/02/24 at 11:47 AM, the surveyor interviewed CNA #2, who stated that she was familiar with Resident #13. When asked how long the resident had a NJ Ex Order 26.4b1 and what was being done, she stated, NJ Exec Order 26.4b1 ", "I just NJ Ex Order 26.4b1 and make sure it's NJ Ex Order 26.4b1." CNA #2 further stated that Resident #13 does not get NJ Ex Order 26.4b1 and "I don't know if there is a NJ Ex Order 26.4b1 plan of	F 688		

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	315518	A. BUILDING _____ B. WING _____	C 04/10/2024

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care for NJ Ex Order 26.4b1

On 04/02/24 at 12:47 PM, the surveyor interviewed the US FOIA (b)(6) who stated that Resident #13 had a history of a NJ Ex Ord, and he thinks that the resident has had the NJ Ex Order 26.4b1 for long time but "doesn't know when the NJ Ex Order 26.4b1 occurred." The US FOIA (b)(6) further stated that if the US FOIA (b) was providing care to the resident and noticed a new/acute (sudden onset) NJ Ex Order 26.4b1 then "the US FOIA (b) should come and notify the nurses." He then stated that "his/her NJ Ex Orde seems to be NJ Ex Order 26.4b1 NJ Ex Order 26.4b1)." The US FOIA (b)(6) stated that the resident was not on a NJ Ex Order 26.4b1 program (NJ Ex Order 26.4b1 . He further stated that if there was a NJ Ex Order 26 in NJ Ex Order 26.4b1, we discuss it during weekly meetings and if NJ Ex Order 26.4b1 can pick up the resident versus NJ Ex Order 26.4b1 care. The US FOIA (b)(6) was not sure if the resident was supposed to be NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 to why he did not NJ Ex Ord .

On 04/03/24 at 12:54 PM, the surveyor interviewed the NJ Ex Order 26.4b1 who stated that they have a NJ Ex Order 26.4b1 program for residents on Long Term Care (LTC) after the residents have completed their course of NJ Ex Order 26.4b or NJ Ex Order 26.4b1. The NJ Ex educates the nursing staff and aides about NJ Ex Order 26 to prevent NJ Ex Order 26.4b1 The NJ Ex stated the residents are screened quarterly, annually, on re-admission, after NJ Ex Ord or if the staff notices any NJ Ex Order changes. The NJ Ex stated the screening process

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included observation of the resident and interview of the resident if possible. She stated that she would also interview the CNAs and the licensed nursing staff. She stated that Resident #13 was screened within the NJ Exec Order 26.4b1 after he/she came back from the hospital and further stated, "No NJ Ex Order 26.4b1 were reported to me when he/she was screened." The surveyor asked the [redacted] if she knew about Resident #13's NJ Ex Order 26.4b1 she stated she was "Not aware of the resident having any NJ Ex Order 26.4b1 The [redacted] also stated "I wasn't made aware that the resident had [redacted] or a [redacted] in [redacted]

04/03/24 02:10 PM, the surveyor requested a timeline of the NJ Ex Order 26.4b1 for Resident #13 from the US FOIA (b)(6) [redacted]

On 04/04/24 at 09:00 AM, the [redacted] provided the survey team with a handwritten timeline and other documentation of Resident #13's NJ Ex Order 26.4b1 [redacted]. A review of the timeline revealed Resident #13 had an NJ Ex Order 26.4b1 on the Annual MDS dated [redacted]. At this time, the surveyor interviewed the [redacted] in the presence of the survey team. She acknowledged that there was no documentation or care planning for the resident's NJ Ex Order 26.4b1 [redacted]. She further acknowledged that the MDS identification of the NJ Ex Order 26.4b1 did not include the location of the [redacted]

On 04/04/24 at 10:35 AM, the [redacted] stated the resident was admitted to the hospital on [redacted], and was readmitted to the facility on [redacted]. The [redacted] provided a copy of the hospital "Progress Notes" printed on [redacted] 17:11

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(5:00PM). A review of the progress note revealed "Physical Exam ...NJ Ex Order 26.4b1."

A review of the Clinical Admission note dated NJ Ex Order 26.4b1 at 22:50 (10:50 PM), revealed the resident was readmitted from the hospital. Further review revealed under "NJ Exec Order 26.4b1 ... NJ Ex Ord . NJ Ex Order 26.4b1: No NJ Ex Order 26.4b1

A review of the "NJ Exec Order (rehabilition) Screen" dated NJ Ex Order 26.4b1, revealed: "D. Primary Reason for Screen: check mark for b. Re-Admit; 3. NJ Exec Ord)/Specific Observations/Concerns: "PT (patient) is a readmission to facility for hospitalization NJ Ex . PT was referred for concerns about NJ Ex Order 26.4b Discussed with nurses as PT was listed in chart as needing NJ Ex Order 26.4b1 . Staff reports PT can NJ Ex Order 26.4b1 if NJ Ex Order 26.4b1 ...4. NJ Ex Order 26.4b Evaluation Indicated: a. NJ Ex Order 26.4b1, b. NJ Ex Order 26.4b1 , c. NJ Ex Order 26.4b1- All these were marked NJ Ex Order 26.4b1 PT with NJ Ex Order 26.4b1 in NJ Ex Order 26.4 status." Further review did not reveal documentation or evidence of an NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 .

On 04/04/24 at 11:37 AM, the surveyors interviewed the US FOIA (b)(6) who stated, "I personally never worked with (the resident) and I don't think the resident received services." The US FOIA (b) stated if the staff identified any decline in function or limitations with Activities of Daily Living (ADLs) then the staff makes referral to NJ Ex Order 26.4b

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After surveyor inquiry, A review of [redacted] Evaluation dated [redacted] reflected diagnosis: [redacted] ." "Prior [redacted] ... Pt refused last [redacted] attempts." [redacted]

On 04/04/24 at 3:17 PM the survey team met with [redacted] to present the above concerns.

On 04/08/24 at 11:31 AM, the [redacted] stated "she did not have anything additional from [redacted] or [redacted] other than what she already provided due to the computer system change."

A review of the undated facility provided "Position Title: Certified Nurse Aide" document revealed under responsibilities/Accountabilities included: Report any/all changes in resident's condition, any family concerns and resident's complaints to charge nurse and/or supervisor.

A review of the undated facility provided "Position Title: Licensed Practical Nurse" document

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revealed under Responsibilities/ Accountabilities: Takes an active role in direct resident assessment and care; Formulates individualized nursing care plans utilizing the nursing process; Assesses each resident daily and implements a change in the course of action as needed.

A review of the undated facility provided "Position Title: Registered Nurse" document revealed under Responsibilities/ Accountabilities: Takes an active role in direct resident assessment and care; Formulates individualized nursing care plans utilizing the nursing process; Assesses each resident daily and implements a change in the course of action as needed.

A review of the facility policy "Restorative Nursing- Active Range of Motion" policy, revised on 09/2023, revealed: "Unit Manager/Designee will: 7. Follow up with rehab when there are changes in resident condition including either an improvement or decline or unwilling to participate in the restorative program."

A review of the facility provided "Comprehensive Care Plans" policy, revised on 09/2023 included: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive

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F 688	Continued From page 28 and quarterly MDS assessment. 7. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative. A review of the facility provided "ADL Care" policy, revised on 09/2023, revealed "Each resident's physical functioning will be assessed in accordance with the facility's assessment procedures." NJAC 8:39-27.1(a); 27.2(m)	F 688		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of other relevant facility documentation, it was determined that the facility failed to obtain and carry out an order to discontinue a NJ Ex Order 26.4b1 ([redacted]) and to maintain [redacted] according to professional standards of practice. The deficient practice was identified for one of one residents (Resident #326) reviewed for [redacted].	F 694	1. Resident #326 had [redacted] from the identified concern and the [redacted] was removed immediately after it was brought to our attention. The care plan could not be formulated as the [redacted] had already been removed. 2. The facility acknowledged that all residents with IV lines can be affected by the identified concern.	5/20/24

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F 694	Continued From page 29 The deficient practice was evidenced by the following: On 3/26/24 at 11:43 AM, the surveyor observed the resident's NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) with an NJ Ex in place. The NJ Ex Order 26.4b1 was covered by a NJ Ex Order 26.4b1. The NJ Ex Order 26.4b1 was NJ Ex Order 26.4b1. The surveyor noted the NJ Ex Order 26.4b1 was not dated or initialed. There were no NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 the NJ Ex Order 26.4b1 during this observation. A review of the admission record (an admission summary) revealed that the Resident #326 was admitted to the facility with the follow diagnoses, which included but not limited to; NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. Further review of Resident #326's admission record reflected that the resident was admitted to the facility with an NJ E . A review of the resident's admission Minimum Data Set (MDS), a tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, revealed that the resident's Brief Interview for Mental Status (BIMS) score was NJ E out of 15, which indicated the resident was NJ Ex Order 26.4b1 . MDS section NJ E and NJ E reflected that the resident was on NJ Ex Order 26.4b1 within the past NJ Exec Order 26.4b1 while at the facility. A review of the NJ Ex Order 26.4b1 Physician Orders (PO) revealed a PO dated NJ Ex Order 26.4b1 for the following: NJ Ex Order 26.4b1	F 694	3. The ADON or designee will in-service nurses on obtaining orders on continuing/removing IV lines when IV therapy is no longer required and initiating a care plan for residents when IV line is inserted. Unit managers will communicate with the physicians to determine if IV lines can be removed after completion of IV therapy and follow up with the physician's order. In addition, the Unit managers will conduct a weekly review of the medical records of 2 residents who have an IV to ensure that care plan was developed and 2 resident who have completed IV therapy to ensure that IV line was removed, as per physician's orders. 4. DON or designee will report the results of the audits during QAPI monthly meeting for 3 months or until compliance is obtained.	

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NJ Ex Order 26.4b1 for NJ Ex O for NJ Exec Orde days. Further review of the PO did not reveal a PO to maintain or discontinue an NJ Ex Order 2 after the completion of NJ Ex Order 26.4b1. Further review of the PO's did not reveal an order to assess or to discontinue the NJ Ex Order 26.4b1.

A review of the NJ Ex Order 26.4b1 Medication Administration Record (MAR) revealed that Resident #326 had received NJ Ex Order 26.4b1 once a day for NJ Ex Order 26.4b1 from NJ Ex Order 26.4b1 for a NJ Ex O. The order was signed as given as ordered at 0630 (06:30 AM). Further review of the MAR and Treatment Administration Record (TAR) NJ Ex Order 26.4b1 did not reveal that the NJ Ex Order 26.4b1 had been assessed or discontinued.

A review of the Care Plan ([CP] a document that summarizes a person's health condition, specific care needs and health condition) did not reveal a focus for NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1.

A review of the Physician Progress Note dated NJ Ex Order 26.4 entered and signed by an US FOIA (b)(6) revealed: "Recommendation: 4. Can d/c (discontinue) NJ Ex Order 26.4b1 from NJ E standpoint...case and care plan reviewed and discussed with Dr. [name redacted] and nurse."

On 3/28/24 at 11:28 AM the surveyor interviewed the resident's US FOIA (b)(6) The US FOI stated, "the resident is NJ Ex Order 26.4b1" and stated, "I don't know when his/her NJ E was NJ Ex Order 26.4b1."

On 3/28/24 at 11:40 AM the surveyor interviewed

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the US FOIA (b)(6)). The US FOIA (b)(6) stated that the resident came in with the NJ Ex Order 2 from the hospital and further stated, "I don't know when it was NJ Ex Order 26.4b in the hospital, but I have to check his/her hospital records and get back to you." The US FOIA (b)(6) then reviewed Resident #326's progress notes dated from NJ Ex Order 26.4b1, in the presence of the surveyor and stated, "It (the note) says NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1)." The US FOIA (b)(6) reviewed the resident's paper chart/medical records from the hospital. The surveyor requested a copy of the Universal Transfer Sheet ([UTS] ensure that accurate communication of pertinent clinical patient care information is conveyed at the time of a transfer between healthcare facilities or programs). At 12:15 PM, the surveyor received and reviewed the copy of the UTS with the US FOIA (b)(6) which revealed: NJ Ex Order 2 which revealed the option for "NJ Ex Order 26.4b1 " was checked off." At 12:48 PM, the US FOIA (b)(6) and the surveyor went to the resident's room to confirm the access site. The US FOIA (b)(6) acknowledged, "It's an NJ Ex Order 2 and it was NJ Ex Order 26.4b1 that it was NJ Ex Order 26.4b1 ." During a follow up interview with the US FOIA (b)(6) in regard to the purpose of removing an NJ Ex Order 26 the US FOIA (b)(6) stated "NJ Ex Order 26.4b1 is definitely a major one. NJ Ex Order 26.4b1 can lead to causing other things like NJ Ex Order 2 ." The US FOIA (b)(6) further stated that any nurse can get PO to discontinue an NJ Ex Order 2 after the completion of NJ Ex Order 26.4b1 The surveyor reviewed the CP with the US FOIA (b)(6) and asked if NJ Ex Order 26 care or NJ Ex Order 26.4b1 should have been care planned for and US FOIA (b)(6) stated, "it might be that they (the US FOIA (b)(6)) removed it since he/she (the resident) completed his/her NJ Ex Order 26.4b1 ."

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On 3/28/24 at 01:01 PM, the surveyor interviewd the US FOIA (b)(6), who acknowledged that the focus CP for NJ Ex Order 26 care or NJ Ex Order 26.4b1 use was not there.

On 3/28/24 at 02:17 PM, the surveyor interviewed the US FOIA (b)(6)) in regard to her expectation of staff if a resident was admitted with an NJ Ex Order 26. The US FOIA (b) stated, "the NJ Ex Order 2 should be NJ Exec Order 26.4b1 days" but "As a nurse, I will follow the policy." The US FOIA (b) also acknowledged that the NJ Ex Order 2 should have been care planned.

On 4/02/24 at 09:48 AM, the US FOIA (b) provided the surveyor a timeline for Resident #326's NJ Ex Order 26 A review of the time line revealed: "Hospital records state NJ Ex Order 26.4b1, upon admission assessment, resident had NJ Ex Order 26.4b1 to NJ Ex . Resident was receiving NJ Ex Order 26.4b1 from admission to NJ Ex Order 26.4 . On NJ Ex Order 26.4, US FOIA (b)(6) assess resident and recommened NJ Ex O to be removed. No order was written for removal. Staff continued to maintian NJ Ex O and on NJ Ex Ord, the US FO recommended removing NJ Ex Order 26.4 -no order was written. Order received on NJ Ex Order 26.4 (after surveyor inquiry) to remove NJ Ex Order 26.4 and nurse removed with no issues."

On 4/03/24 at 11:43 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that upon admission, the staff should document the kind of access the resident had and when it was NJ Ex Order 26.4b1 She further stated it should all be documented in the admission assessments and also in progress notes. The US FOIA (b)(6) stated, "the NJ Ex Order 2 is NJ Exec Order 26.4 every NJ days" to prevent NJ Ex Order 26.4b1 and for Resident # 326, the NJ Ex Order 2 should have been removed after the completion of NJ Ex Order 26.4b1. The US FOIA (b)(6)

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acknowledged that the CP should have been initiated for [NJ Ex Order 2] and stated, "No, it is not acceptable that the [NJ Ex Order 26] CP wasn't initiated."

On 4/04/24 at 3:17 PM, the survey team met with the [US FOIA (b)(6)] to present the above concerns.

No additional infomration was provided.

A review of the facility's policy "Catheter insertion and care" with an effective date 8/1/2018, revealed: "Policy: Peripheral IV dressings will be changed when needed to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines: 2. Change the dressing if it becomes dampl, loosened or visibly soiled and at least every 5 to 7 days. Change dressing and perform site care if signs and symptoms of site infection are present.

A review of the facility plociy "Comprehensive Care Plans" policy, revised on 09/2023 revealed: "2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."

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VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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F 694	Continued From page 34 NJAC 8:39-25.2(c)5	F 694		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 755		5/20/24

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F 755	Continued From page 35 Based on observations, interviews, record review, and review of facility documentation, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure that a.) staff followed a Physician Orders (PO) for the administration of an NJ Ex Order 2 medication for 1 of 1 resident (Resident #96) reviewed for the management of NJ Ex Order 26 b.) medications were observed as accurately and timely administered to one (1) of five (5) residents, (Resident #54) reviewed for medication administration, and c.) to ensure an accurate inventory of NJ Ex Order 26.4b1 medications (NJ Ex Order 26.4b1) dispensed from the facility's automated medication dispensing system (AMDS) located on the NJ Exec floor nursing unit. The deficient practices were evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical	F 755	1. Residents #96 and #54 had NJ Ex Ord the identified concerns. (a) Resident #96 was discharged from the facility on NJ Ex Order 26.4 and the facility cannot retroactively respond to the NJ Ex Order 2 being administered without NJ Ex Order 26.4b1. (b)Resident #54 had the medications immediately removed from the bedside table upon the identification of the concern. (c)The AMDS count log was created on 3/28/24 for the narcotic counts. The counts are being completed as per the policy. 2. The facility acknowledges that all residents could be affected by the identified concern. 3. (a) The ADON or designee in-serviced nurses on 4/25/24 on following physicians' orders for blood sugar checks before administering insulin. The unit managers will review 5 residents medical records weekly for residents on insulin, with parameters, to ensure insulin is being administered per physician's order. Audits will be conducted for 3 months. (b) The ADON or designee will in-service nurses on ensuring that all residents medications are administered by the nurse and that medications are not left at the bedside. The unit managers will do	

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nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

A.) On 03/26/24 11:49 AM, Resident #96 was observed in the room. The resident was in bed and watching television. The resident was NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 to the surveyor.

A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to the following: NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 .

A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's Brief Interview for Mental Status (BIMS) was NJ Ex out of 15, which indicated that the resident's NJ Ex Order 26.4b1.

A review of the Order Summary Report (OSR) revealed a PO dated NJ Ex Order 26.4 , for NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 in the evening for NJ Ex Order 26.4b1 . NJ Ex O .

rounds in 5 resident's rooms weekly during medication pass to ensure medications are not left at the bedside. These audits will be conducted for 4 weeks and monthly thereafter.

(c) ADON will in-service the Nursing supervisors on completing the AMDS narcotic count as per the facility policy. The DON or designee will review the AMDS narcotic count report once per week for 3 months to ensure the counts are completed.

4.The DON or designee will report the results of the audits during QAPI monthly meeting for 3 months and follow up with feedback as needed.

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A review of the NJ Ex Order 26.4b1 electronic Medication Administration Record (eMAR) revealed the above PO for the NJ Ex Order 26.4b1 had been signed as administered as ordered from NJ Ex Order 26.4 to NJ Ex Order 26.4 at 2000 (08:00 PM). Further review of the eMAR, did not reveal documentation that a NJ Ex Order 26.4b1 was obtained prior to the administration of medication.

A review of the NJ Ex Order 26.4b1 eMAR revealed the above PO for the NJ Ex Order 26.4b1 had been signed as administered as ordered from NJ Ex Order 2 to NJ Ex Order 26.4 at 2000. Further review of the eMAR did not reveal documentation that a NJ Ex Order 26.4b1 was obtained prior to the administration of medication.

On 3/26/24 at 12:40PM, the surveyor interviewed the US FOIA (b)(6)). The US FOIA (b)(6) informed the surveyor that she was the nurse taking care of the resident. The US FOIA (b)(6) stated that the NJ Ex Order 26.4b1 should have been obtained first and then given if the NJ Ex Order 26.4b1 was above the parameters or held according to the parameters. She further stated that if the NJ Ex Order 2 was held it should be documented in the supplemental section of the eMAR.

At that time, the US FOIA (b)(6) reviewed Resident #96's NJ Ex Order 26.4b1 eMAR in the presence of the surveyor for the order dated NJ Ex Order 26.4, for NJ Ex Order 2 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 in the evening for NJ Ex Order 26.4b1 Hold if NJ Ex . The US FOIA (b)(6) confirmed she was unable to verify that the NJ Ex Order 26.4b1 had been obtained prior to the administration of the evening NJ Ex Order 26

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On 3/26/24 at 12:56 PM, the surveyor interviewed the US FOIA (b)(6) in the presence of the US FOIA (b)(6) in reference to the NJ Ex Order 2 parameters. The US FOIA (b)(6) reviewed the NJ Ex Order 26.4b1 eMAR, for the order dated NJ Ex Order 26.4, for NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 NJ Ex Order 26.4b1) in the evening for NJ Ex O Hold if NJ Ex . She acknowledged that the NJ Ex Order 26.4b1 were not documented on the eMAR. She then reviewed the NJ Exec Order 2 and vital sign section of the eMAR which revealed one NJ Ex Order obtained on NJ Ex Order 26.4 at 20:15 (08:15 PM) which was NJ Ex O. She further acknowledged that the NJ Ex Order 26.4b1 should have been obtained and documented on the eMAR. The US FOIA (b)(6) stated the purpose of the parameters on NJ Ex Order 2 was to monitor for NJ Ex Order 26.4b1 NJ Ex Order 26.4b1).

On 3/27/24 at 2:30 PM, the surveyor presented the above concerns to the US FOIA (b)(6) .

There was no additional information provided.

On 03/28/24 at 11:10AM, during a follow up interview with the US FOIA (b)(6) and in the presence of the surveyor, the US FOIA (b)(6) reviewed the NJ Ex Order 26.4b1 eMAR and acknowledged that the NJ Ex was not documented for the order for the NJ Ex Order 2 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 in the evening for NJ Ex O Hold if NJ Ex Order 26.4b1. B). On 4/03/24 at 10:48 AM, the surveyor was touring the NJ Exe floor nursing unit and noted Resident #54 in bed with his/her NJ Ex Order 26.4b1 . The surveyor knocked on the door and greeted the resident. The resident NJ Ex Order 26.4b1

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NJ Ex Orde and NJ Ex Order 26.4b1. At that time, the surveyor noted a medication cup that was turned over on their overbed table that contained 4 tablets.

At that time, the surveyor called the US FOIA (b)(6) into the resident's room, who acknowledged that there was a medication cup that contained four (4) tablets on the resident's overbed table. The US FOIA (b)(6) stated that he doesn't know how the medication were left on the overbed table and stated it was the nurse's responsibility to assure that medication was not left unattended and to assure that all medication is consumed by the resident. The US FOIA (b)(6) identified the 4 tablets as being a NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 2 (NJ Ex Order), NJ Ex Order 26 (NJ Ex Orde), and NJ Ex Orde (NJ Ex Order 26.4). The US FOIA (b)(6) also acknowledged that he was the nurse that administered the resident's medication that morning and that he assured that the resident consumed all their medications. The US FOIA (b)(6) was unable to answered how the medication ended up on the resident's overbed table.

The surveyor reviewed the medical record for Resident #54

The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26.4b1 NJ Ex Ord), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 and

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NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 .

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4, reflected that the resident had a brief interview for mental status (BIMS) score of NJ E out of 15, indicating that the resident is NJ Ex Order 26.4b1.

A review of the active interdisciplinary care plan revealed that there was no focus area that indicated that the resident could NJ Ex Order 26.4b1 their medications.

A review of the NJ Ex Order 26.4b1 Order Summary Report (OSR) and the Electric Medication Administration Record (e-MAR) revealed the following physician's orders (PO):

1. NJ Ex Order 26.4b1 oral tablet NJ Ex Order 26.4b1 dated NJ Ex Order 2, give 1 tablet by mouth every 12 hours for NJ Ex Order 26.4b1 . Give with food to reduce risk of NJ Ex Order 26.4b1 . Advise resident to NJ Ex Order 26.4b1 to reduce possibility of NJ Ex Order 26.4b1 and hold for NJ Ex Order 26.4b1 . The eMAR also revealed that NJ Ex Order 2 had an administration time of 0900 (9:00AM) and 2100 (9:00 PM) that showed that the medication was signed off as being given at 0900 on NJ Ex Order 2.

2. NJ Ex Order 2 oral tablet NJ Ex Order 26.4b1 dated NJ Ex Order 2, give 1 tablet by mouth two times a day for NJ Ex Order 26.4b1 . Monitor for NJ Ex Order 26.4, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . The eMAR also revealed that NJ Ex Order 26 had an administration time of 0900 (9:00AM) and 1700 (5:00 PM) that showed that the medication

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was signed off as being given at 0900 on NJ Ex Order 26.

3. NJ Ex Order 26.4b1 tablet dated NJ Ex Order 2, give 1 tablet by mouth one time a day for NJ Ex Order 26.4b1 The eMAR also revealed that NJ Exec Order 26.4b1 had an administration time of 0900 (9:00AM) and was signed off as being given on NJ Ex Order 2.

4. NJ Ex Orde Oral Tablet NJ Ex Order 26.4b1 dated NJ Ex Order 26.4, give 1 tablet by mouth in the morning for NJ Ex Order 26.4b1 . The eMAR revealed that NJ Ex Orde had an administration time of 0900 (9:00AM) and was signed off as being given on NJ Ex Order 2.

On 04/03/24 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6)) who acknowledge that medications should never be left unattended and that a nurse should assure that the resident consumed their medication.

On 4/05/24 at 2:30 PM, the surveyor presented the above concerns to the US FOIA (b)(6) and the US FOIA (b)(6)

There was no additional information provided.

A review of the facility's policy for "Medication Administration" dated 09/30/23, which was provided by the US FOIA (b) included the following:

"15. Observe resident consumption of medication."

C). On 4/02/24 at 10:20 AM, the surveyor inspected the NJ Exec floor medication room which contained the facility's AMDS machine. The

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surveyor interviewed the second floor US FOIA (b)(6) who stated that the AMDS counts were checked once a day between the 7-3 (7AM-3PM) shift and the 3-11(3PM-11PM) shift. She showed the surveyor the AMDS April 2024 daily count narcotic back-up sheet. The sheet revealed that the narcotic count was performed on 4/1/24. The surveyor requested the daily count narcotic back-up sheets for March and February 2024. The US FOIA (b)(6) stated that the US FOIA (b) had the daily count sheets from March and February.

On 4/02/24 at 10:30 AM, the surveyor reviewed the facility's DEA 222 forms and asked the US FOIA (b) if she could provide the surveyor with signed off logs showing that narcotics were being accounted for in the facility's AMDS.

On 4/02/24 at 12:15 PM, the surveyor went to the US FOIA (b)(6)) office where the US FOIA (b) was seated. The surveyor requested the facility daily count narcotic back-up sheets. The US FOIA (b) was only able to show that the AMDS narcotic counts were performed on 3/28/24 and 3/29/24. The US FOIA (b) was unable to provide any accountability and narcotic counts for the AMDS machine prior to 3/28/24.

At that time, the surveyor interviewed the US FOIA (b)(6) who stated that the facility just created a new form on 4/1/24 for daily counts of narcotics and controlled substances in the AMDS machine.

On 4/8/24 at 9:00AM, the surveyor interviewed the US FOIA (b) who stated that it's important to perform a daily inventory counts for controlled substances which includes narcotic because it assures accountability, and that medication is not being

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diverted.

On 4/05/24 at 2:30 PM, the surveyor presented the above concerns to the US FOIA (b)(6) [redacted] and the US FOIA (b)(6) [redacted]

There was no additional information provided.

A review of the facility's policy for "BLOOD GLUCOSE MONITORING" reviewed on 10/2023, revealed the following:
1."Check physician's order for blood glucose testing frequency and coverage if needed."
10. "Monitor resident for signs of hypo-or hyper-glycemia."
11. "Record findings in the Medication Administration Record. Report any abnormal findings to the MD."

A review of the facility's policy for "Controlled Substances Policy" dated 08/31/23, which was provided by the DON included the following:

"Accounting for Back-up stock Controlled Substances.
1. Back-up Controlled Substances will be counted daily by incoming and outgoing unit manager/nurse supervisor/designee for accuracy of number of doses currently on hand.
2. An immediate investigation will be initiated to resolve any discrepancy. The DON and the Administrator will be notified of all unresolves discrepancies immediately."
A review of the facility's policy for "CUBEX Station Medication Policies and Procedures" that was undated which was provided by the DON included the following:
"J. Discrepancy Reporting and Documentation

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F 755	Continued From page 44 9. A narcotic activities report will be printed daily according to established facility procedures that will track access of medications from the CUBEX station for E-Kit/Starter doses purposes. The report will include the name of the patient, nurse's name, prescriber name, medication, dose, quantity, date, and time of removal. The reports representing these activities will be retained per Federal Regulations for ten (10) years at the facility and pharmacy."	F 755		
F 804 SS=D	NJAC 8:39-11.2 (b), 29.2 (d) (n) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: NJ #159787 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of foods served to the residents. This deficient practice was identified for 5 of 5 residents interviewed during the Resident Council meeting and confirmed during the lunchtime meal service on 04/05/24 for 1 of 3 nursing units ([redacted] Floor unit) tested for food temperatures and was evidenced by the	F 804	1. The Facility cannot retroactively respond to the test tray temperatures. No residents were affected by the concern. 2. The facility acknowledged that all residents could be affected by the identified concern. 3. The FSD or designee will in-service the staff on ensuring that the trays are at the appropriate temperature when food is	5/20/24

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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 804	Continued From page 45 following: On 03/27/24 at 10:51 AM, the surveyor met with five residents for a resident council meeting. Three out of five residents resided on the [NJ Ex O] floor. Two out of five residents resided on the [NJ Ex O] floor. Five of five residents agreed that the food trays were not warm. On 04/05/24 at 11:14 AM, the surveyor calibrated a state issued digital thermometer via the ice bath method to 32 degrees Fahrenheit (F) in the presence of the survey team. On 04/05/24 at 12:24 PM, the surveyor observed the lunch truck arrive to the 2nd floor. The [US FOIA (b)(6)]) met the food truck. A [NJ Ex Order 26.4b1] tray (Resident #120) was removed and verified by the surveyor and the [US FOIA (b)(6)] The tray was placed at the nurse's station. At 12:25 PM, the [US FOIA (b)(6)] called the kitchen and ordered a replacement tray for Resident #120. The nursing staff began delivering the resident's food trays. At 12:35 PM, the last tray was delivered. The surveyor tested the food temperatures on the reserved tray in the presence of the [US FOIA (b)(6)] The temperatures were as follows: Roast Beef 3 oz & gravy 2 oz: 122.5 degrees F roasted potatoes 4 oz.: 121.0 degrees F Capri veg blend 1/2 cup:115.9 degrees F cream of tomato 6 oz: 144.0 degrees F fruit cup 1/2 cup (watermelon): 53.3 degrees F 1% milk 8oz: 54.3 degrees F	F 804	prepared and prior to the trays leaving the kitchen. The Food Service Director or designee will monitor the food temperatures on 5 trays daily prior to delivery and document results for 3 months. The FSD or designee will test temperatures on 5 trays weekly on the units to ensure the food is palatable prior to serving. The test tray will be replaced with new trays after testing. Any issues will immediately be addressed. 4. Results of the audits will be reported at QAPI monthly for 3 months and follow up will occur as needed.	

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On 04/05/24 at12:45 PM, the surveyor interviewed the US FOIA (b)(6)), who stated that the lunch tray line was set up at approximately "10:55 AM-11:00 AM." He then stated that food temps were taken just prior to the first tray being pulled at approximately "11:00 AM to 11:10 AM." The US FOIA (b)(6) stated the 4th floor gets delivered first, then the 2nd floor and then the 3rd floor. The US FOIA (b)(6) provided the surveyor with the "Service Line Checklist" which revealed that at the time of service the temperaturyes were as follows: Roast Beef was 176 degrees F, roasted potatoes was 178 degrees F, Broc/Caulif (broccoli/cauliflower) was 178 degrees F, watermelon was 34 degrees f, and the tomato soup was 181 degrees F.

On 04/05/24 at 01:52 PM, during a follow up interview with the US FOIA (b)(6) in the presence of the survey team, he stated that the 2 cooks verify the food temperatures. He verified that "yes, everything (in the kitchen) was functioning properly today." The surveyor reviewed the above mentioned temperatures observed on the NJ Exec floor with the US FOIA (b)(6) He stated he takes temperatures of the food that has been on the truck the longest before the truck is ready to leave the kitchen, but he does not record it. The US FOIA (b)(6) stated that they use pellets (keeps hot food at safe temperatures) on their trays. He stated the purpose of taking the food temperatures were to ensure the food was palatable and consistent.

On 04/05/24 at 02:56 PM, the above findings were presented to the US FOIA (b)(6) in the presence of the survey team.

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F 804	Continued From page 47 A review of the undated facility's policy "Cold Food Policy" revealed "Policy: The kitchen will receive and deliver cold foods to residents at a temperature of 41 degrees Fahrenheit or lower. 6. Food will be delivered to residents at a temperature of 41 degrees or lower." A review of the undated facility's policy "Hot Food Policy" revealed "Policy: All managers are responsible for training dietary staff on how to take and monitor food temperatures on a daily basis. For quality assurance. Food temperature will be monitored, and test tray temperature will be monitored. 7. The Food Service Director ...will monitor test tray temperatures." NJAC 8:39-17.2(g);17.2 (a)(2)	F 804		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to ensure foods were provided in accordance with physician's orders and resident preferences identified in their plan of care. This deficient practice was identified for 2 of 4 residents reviewed for nutrition	F 808	1. The facility cannot retroactively respond to the tray accuracy concern. No residents were affected by the concern. 2. The facility acknowledged that all residents could be affected by the identified concern.	5/20/24

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F 808	Continued From page 48 (Resident #114 and #120). This deficient practice was evidenced by the following: 1. On 3/27/24 at 10:57 AM, the surveyor observed Resident #114 seated in a wheelchair at a table in the dining area drinking water. On 3/28/24 at 12:18 PM, the surveyor observed the resident's lunch tray. The meal ticket indicated the tray items should have included four ounces (oz.) of red bean chili, a creamy peanut butter and jelly sandwich, a NJ Ex Order 26.4b1 [redacted], a ½ cup of green peas, one piece of cornbread, six oz. chicken orzo soup, one serving of a NJ Ex Order 26.4b1, ½ cup of fruit cup, one vanilla ice cream, a four oz. cranberry juice, eight oz. of whole milk and six oz. of tea. There was no evidence of a NJ Ex Order 26.4b1 [redacted], the NJ Ex Order 26.4b1 and there was a chocolate ice cream (not vanilla) on initial observation. On 3/28/24 at 12:35 PM, the surveyor reviewed the meal ticket versus items on the lunch meal tray with the US FOIA (b)(6) [redacted] who acknowledged there were no NJ Ex Order 26.4b1 (white rice was served), no NJ Ex Order 26.4b1 and a chocolate ice cream instead of NJ Ex Order 2 on the tray. On 4/1/24 at 12:15 PM, the surveyor observed the resident seated in the dining area. The surveyor observed his/her tray placed on the table and the US FOIA (b)(6) sat next to the resident to assist. Prior to that, the surveyor observed an opened empty container of NJ Ex Order 26.4b1 in his/her room.	F 808	3. The FSD or designee will in-service the dietary staff on tray accuracy and preparation of fortified foods. The FSD or designee will audit 5 trays weekly for accuracy prior to trays being delivered to the units for 3 months. The FSD or designee will observe the cooks, 3 times per week for 3 months, to ensure that they are preparing the fortified food as per the policy. 4. the FSD or desingee will be reported at the monthly QAPI meetings for 3 months or until compliance is met and follow up as needed.	

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Review of Resident #114's Admission Record (an admission summary) reflected the resident had diagnoses which included but were not limited to; NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 (NJ Ex Order 26.4 ... NJ Ex Order 26, and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).

Review of the residents Admission Minimum Data Set (MDS), a tool to facilitate the management of care, dated NJ Ex Order 26.4b1 reflected the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated his/her NJ Exec Order 26.4b1 was NJ Ex Order 26.4b1. It also reflected the resident received a NJ Ex Order 26.4b1 NJ Ex Order 26.4b1).

Review of the NJ Ex Order 26.4b1 Order Summary Report (OSR) reflected physician's orders (PO) for a NJ Ex O with lunch and dinner and NJ Ex Order 26.4b1 with meals, both with a start date of NJ Ex Order 2.

Review of the electronic Medication Administration Record's (eMAR) for NJ Ex Order 26.4b1 through NJ Ex Order 26.4b1, reflected the PO's noted above.

Review of the Nutrition Care Plan initiated NJ Ex Order 26.4b1, reflected the above PO's as interventions.

Review of the US FOIA (b)(6)) initial evaluation dated NJ Ex Order 26.4b1, reflected that the resident 'NJ Ex Order 26.4b1 " and it would be provided with lunch and dinner.

Review of the US FOIA (b Nutrition Note dated NJ Ex Order 2, reflected that 'NJ Ex Order 26.4b1" would be

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provided with lunch and dinner.

On 3/28/24 at 12:35 PM, the surveyor interviewed the US FOIA (b)(6) who acknowledged that the missing tray items on the lunch tray were NJ Ex Order 26.4b1 interventions that were part of the resident's plan of care to promote NJ Ex Order 26.4b1.

On 3/28/24 at 12:43 PM, the surveyor interviewed RD #1 and reviewed the items that were not provided on Resident #114's lunch tray. She acknowledged that the NJ Ex Order 26.4b1 and NJ Ex Order 26.4b were part of the resident's plan of care which provided NJ Ex Order 26.4b1 to NJ Ex Order 26.4b. She could not speak to why these items were not provided and that there should have been an employee in the kitchen that checked the tray for accuracy before delivery to the resident.

On 3/28/24 at 1:16 PM, the surveyor interviewed the US FOIA (b)(6)). He acknowledged that there were no NJ Ex Order 26.4b1 in the facility.

On 4/05/24 at 12:45 PM, the surveyor interviewed Regional RD #2 (RRD) in the presence of the survey team. She stated that NJ Ex Order 26.4b1 were one of the NJ Ex Order 26.4b1 available. And that these foods were NJ Ex Order 26.4b1 interventions to NJ Ex Order 26.4b1 or NJ Ex Order 26.4 because they were NJ Ex Order 26.4b1. The US FOIA (b) further stated that this was part of the resident's individualized plan of care. She stated that there would have been a PO and there was accountability on the eMAR. She could not speak to which kitchen employee was responsible to ensure tray accuracy but acknowledged that someone should have been responsible.

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2. On 03/25/24 at 11:23 AM, the surveyor observed Resident #120, who was [NJ Exec Order 26.4b] and offered [NJ Ex Order 26.4b1].

On 4/05/24 at 12:35 PM, the surveyor observed the residents lunch tray and reviewed the meal ticket versus items on the tray with the [US FOIA (b)(6)]. The meal ticket indicated the resident should have received [NJ Ex O] [NJ Ex Orde], however there was oz. on the plate; there should have been a dinner roll, however a slice of bread was provided; eight oz. of whole milk should have been provided instead the resident received one percent milk; and there was supposed to be a four oz. juice and eight oz. of coffee on the tray, neither of which were provided.

Review of resident #120's Admission Record, reflected the resident had diagnoses that included but were not limited to; [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1] ([NJ Ex Order 26.4b1]).

Review of the residents Admission MDS dated [NJ Ex Order 26.4], reflected a BIMS score of [NJ Ex] out of 15 which indicated the resident had [NJ Ex Order 26.4b1]. It also reflected the resident was on a [NJ Ex Order 26.4b1].

Review of the [NJ Ex Order 26.4b] Care Plan initiated [NJ Ex Order 2], included the intervention [NJ Ex Order 26.4b1]."

Review of the [US FOIA (b)(6)]) initial evaluation dated [NJ Ex Order 2], reflected that the resident had a history of [NJ Ex Order 26.4b1] and would be provided [NJ Ex Order 26.4b1] at

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meals as per his/her preference.

On 4/05/24 at 12:45 PM, the surveyor interviewed the [US FOIA (b)] who stated that the cook or the "caller" position checked the meal trays to ensure accuracy and that if an item was not available, he should have been notified. He stated that if the meal ticket indicated coffee, whole milk and a dinner roll that is what should have been provided. The [US FOIA] then stated he was aware that the facility was "out of whole milk."

On 04/05/24 at 1:05 PM, the surveyor interviewed the [US FOIA (b)] who stated she should have been notified if there was no whole milk available. She further stated that a [NJ Ex Order 26.4b1] was [NJ Ex Orde] oz. and if the meal ticket indicated [NJ Ex Order 26.4] portions, the resident should have received [NJ Ex] oz.

On 4/05/24 at 1:52 PM, the surveyor interviewed the [US FOIA (b)] who stated that if a meal ticket indicated a NJ Ex Order 26.4b1, the resident should have received [NJ Ex Orde] oz. He stated that one of the cooks should have checked the trays for accuracy today and could not state whether or not any employee ensured lunch tray accuracy for the lunch meal service. He acknowledged he had not assigned anyone this task.

On 4/05/24 at 2:56 PM, the US FOIA (b)(6) acknowledged the concerns regarding tray accuracy.

On 4/08/24 at 11:30 AM, the [US FOIA (b)(6)] stated there was no additional information to present for above mentioned concerns.

Review of the undated facility policy "Medical Nutrition Therapy Documentation" included that

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medical nutrition therapy for each individual was the responsibility of the RD and the FSD.

Review of the undated facility policy "Therapeutic Diets" included that all residents would be given foods based on their diet order which was prescribed by the physician. In addition, the policy included that the purpose of a therapeutic diet was to "eliminate or decrease specific nutrients in the diet or provide food that a resident is able to consume."

Review of the undated facility policy "Fortified Foods and Supplements" included "Fortified foods and supplements will be given inn accordance with the orders of a physician or registered or licensed dietitian." In addition, the policy included that "The supplement or fortified food item is then added to the resident's meal tray card ticket to be prepared, served and delivered accordingly."

Review of the undated facility policy "Dining and Food Preferences" included "Individual dining, food and beverage preferences will be identified, accommodated, and followed for all residents." It further included that all preferences will be added to the meal tray card ticket.

Review of the undated facility policy "Tray Accuracy" included the following:

- "Each residents individual meal tray will be set up and made according to the resident's personal meal tray card ticket. All items described on this ticket will be present on the tray. The defined diet and the individual needs and food preferences will be present on the tray including likes and dislikes in accordance with the

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F 808	Continued From page 54 compliance guidelines." - "All trays will be checked by the Dietary representative calling the tray line and setting up each tray. Each tray will then be checked by a Dietary management team member prior to being sent to the unit." - "Once received on the unit, the healthcare professional will check the tray prior to serving it to the resident." Review of a signed and undated "Cook" job description included that the cook was responsible and accountable for following menus and special diet instructions. Review of a signed "Dining Services Director" job description dated 2/27/24, included the following responsibilities: - "Prepare food for regular and therapeutic diets according to the planned menu and written doctor's orders." - "Purchase food, supplies, and equipment, as required to meet the needs of the department." - "Ensure that a stock of staple/non-staple food, supplies, equipment, etc., is maintained at adequate levels at all times to perform departmental functions." NJAC 8:39-17.4(a)(1)	F 808		
F 922 SS=F	Procedures to Ensure Water Availability CFR(s): 483.90(i)(1) The facility must--	F 922		5/20/24

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F 922	Continued From page 55 §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and pertinent facility documents it was determined that the facility failed to maintain the designated emergency supply of water needed for residents in the event of a loss of normal water supply. This deficient practice was evidenced by the following: On 3/25/24 at 09:00 AM, the survey team entered the facility and was made aware by the US FOIA (b)(6) [redacted] that the facility was licensed for 180 beds and the facility census was 123 (the number of residents who currently resided at the facility). On 03/25/24 at 10:10 AM, the surveyor toured the kitchen with the facility's US FOIA (b)(6) [redacted] and the US FOIA (b)(6) During the initial tour, the surveyor was escorted to a storage room which contained the emergency water and food supply. In the presence of the surveyor and the facility's US FOIA (b) the regional US FOIA stated that he had 22 cases of emergency water which contained 6 gallons of water per case. He stated that there was a total of 132 gallons of emergency water in the facility available in the event of an emergency. The surveyor inquired how much water should he have based on today's census, and he stated that there should be a water supply of 1 gallon per resident for 3 days. He further stated that he had to throw some water out because it had expired, and that he had already placed an order to replenish the water that was discarded. He informed the surveyor that the previously ordered	F 922	1. The emergency water was ordered by the Food Service Director on 3/25/24 to increase the supply as required per the regulation. 2. The facility acknowledged that all residents could be affected by the identified concern. 3. The Food Service Director or designee will inspect the emergency water supply monthly for adequate water supply levels/expirations for 3 months. Orders will be immediately placed, by the FSD, with the appropriate vendor to replenish the inventory as needed. The Administrator will inspect the emergency supply monthly to ensure that the water supply is adequate for the census and staff for any discrepancies for 3 months. 4. The Food Service Director will report all findings at the monthly QAPI meeting for 3 months or until compliance is met.	

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emergency water supply would be delivered to the facility on 03/28/24. The surveyor requested an invoice that showed that the emergency water supply had been ordered prior to surveyor inquiry.

On 03/26/24 at 09:36 AM, in the presence of the survey team and the US FOIA (b)(6) . The US FOIA (b)(6) provided the surveyor with an invoice order dated 3/25/24 from [name redacted]and an invoice from [name redacted] dated 03/27/24. Review of both invoices did not reveal that water had been ordered. The surveyor inquired again about the emergency water supply that was observed on 3/25/24. The US FOIA (b)(6) acknowledged that the emergency water supply that was in the facility on 03/25/24 was not enough based on the resident census of 123. The regional US FOIA (b) also stated that the first time he saw the emergency water supply was with the surveyor on 03/25/24.

On 03/26/24 at 10:11 AM, in the presence of the survey team, the surveyor interviewed US FOIA (b)(6) The surveyor inquired about the invoice dated 03/27/24 from [name redacted]. The US FOIA (b)(6) clarified that the invoice date of 3/27/24 was the delivery date. She confirmed that an order was placed on 03/25/24 at 12:25pm by phone and was scheduled to be delivered on 03/27/24. She also acknowledged that she approved the purchase order for additional emergency items.

On 03/27/24 at 02:07 PM, in the presence of the survey team, the surveyor interviewed the facility's US FOIA (b) The facility's US FOIA (b) stated that he had knowledge of emergency preparedness. He stated that the purpose of the emergency water and food supply was so that if there was a "situation" that the facility was unable to obtain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. BUILDING _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

(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 922	Continued From page 57	F 922		

food and water, the facility had a supply of emergency food and water in storage at the facility. The [redacted] stated that the facility was required to have 1 gallon of water per resident for three days. He stated that he was responsible for ensuring that there was enough food and water for emergency use.

On 03/27/24 at 09:04 AM, the [redacted] provided the surveyor with invoices from the contracted vendor [name redacted] that additional water had been delivered for the emergency water supply.

On 03/27/24 at -2:30 PM, the surveyor presented the above concerns to the [redacted] in the presence of the survey team. The [redacted] stated that it was the responsibility of the facility's [redacted] to ensure that the emergency supply is sufficient based on the census. She further stated that she and the regional [redacted] were responsible for approving food orders and that there was no delay in approval or delivery. She stated, "I get emails regarding food ordering and orders come to my phone if I am not here." She stated that if there was an emergency, the requirement was that the facility had 1 gallon of water per resident for 3 days in storage.

There was no additional information provided to the surveyor.

Review of an undated facility policy "VENETIAN EMERGENCY WATER POLICY AND PROCEDURE" under PROCEDURE revealed the following:
- "The Venetian will have 3 gallons of water per resident for 3 days time according to current census."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. BUILDING _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

(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 922	Continued From page 58 - "If more water is needed, our contracted vendor will deliver water within 24 hours or sooner in case of an emergency." Review of an undated facility policy "EMERGENCY AND DISASTER PLANNING POLICY", included under PROCEDURE revealed the following: 2." The Food Service Director will be responsible for ensuring 3-day emergency supply (as per emergency supplies list attached) is located in the facility with Inventory List, noting expiration date of items." 4. "The Food Service Director will maintain Inventory Check List monthly to check that all documentation is completed correctly, and all stock is accounted for. NJAC 8:39-31.6 (n)	F 922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12035	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

(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) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: NJ #159787, #161847 Based on interviews, 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: 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,	S 560	1. The facility cannot retroactively respond to the staffing levels prior to the survey. No residents were affected by the staffing levels. The Administrator/DON did an immediate review of the staffing levels based on the state staffing ratios. 2. The facility acknowledged that all residents could be affected by the identified concern. 3. The Director of Human Resources implemented an expedited on-boarding process for all new hires. Interviews for new hires will be conducted immediately, and contingent offers will be made. Online ads are placed on recruitment sites for	5/20/24

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

Electronically Signed | 05/01/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12035	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. A review of the "Nurse Staffing Report" completed by the facility for the 2 weeks from 11/13/2022 to 11/26/22 revealed that the facility was deficient in CNA staffing for residents on 13 of 14-day shifts and was deficient in CNA staffing for 1 of 14 evening shifts as follows: -11/13/22 had 11 CNAs for 128 residents on the day shift, required at least 16 CNAs. -11/14/22 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -11/15/22 had 6 CNAs for 124 residents on the day shift, required at least 15 CNAs. -11/16/22 had 6 CNAs for 124 residents on the day shift, required at least 15 CNAs. -11/18/22 had 10 CNAs for 128 residents on the day shift, required at least 16 CNAs. -11/19/22 had 5 CNAs for 128 residents on the day shift, required at least 16 CNAs.	S 560	open positions. The staffing coordinator will contact all staff daily for any open shifts to fill them. The DON/designee will review all call outs daily and proactively make every effort to replace staff members. Licensed nurses from the nursing management team will assist in covering shifts as needed. The facility offers bonuses to nurses and CNAs as needed. The Director of Human Resources will contact nursing and CNA schools to recruit nurses and CNAs. The Director of Nursing will contact nursing schools to partner to be a training facility for nursing and CNA students and offer positions once students graduate. The DON/Designee will monitor staffing ratios daily and document a review of staffing weekly for 3 months. 4. The audits will be presented to the Administrator weekly. The audits will be discussed at the monthly QAPI meetings to determine if continued auditing is needed. Once compliance is achieved, for 2 consecutive months, the plan will be amended as needed.	

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VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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S 560	Continued From page 2 -11/20/22 had 7 CNAs for 128 residents on the day shift, required at least 16 CNAs. -11/20/22 had 5 CNAs to 13 total staff on the evening shift, required at least 6 CNAs. -11/21/22 had 11 CNAs for 128 residents on the day shift, required at least 16 CNAs. -11/22/22 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -11/23/22 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. -11/24/22 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -11/25/22 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. -11/26/22 had 11 CNAs for 130 residents on the day shift, required at least 16 CNAs. 2. A review of the "Nurse Staffing Report" completed by the facility for 1 week from 02/19/2023 to 02/25/23 revealed that the facility was deficient in CNA staffing for residents on 7 of 7-day shifts and deficient of total staff for residents on 1of 7 evening shifts, and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -02/19/23 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/20/23 had 7 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/21/23 had 9 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/21/23 had 7 CNAs to 15.5 total staff on the evening shift, required at least 7 CNAs. -02/22/23 had 9 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/23/23 had 11 CNAs for 144 residents on the day shift, required at least 18 CNAs. -02/24/23 had 10 CNAs for 144 residents on the day shift, required at least 18 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12035	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 -02/24/23 had 13.5 total staff for 144 residents on the evening shift, required at least 14 total staff. -02/25/23 had 8 CNAs for 143 residents on the day shift, required at least 18 CNAs 3. A review of the "Nurse Staffing Report" completed by the facility for 2 weeks prior to survey from 03/10/2024 to 03/23/24 revealed that the facility was deficient in CNA staffing for residents on 14 of 14-day shifts and deficient of total staff on 2 of 14 evening shifts as follows: -03/10/24 had 7 CNAs for 126 residents on the day shift, required at least 16 CNAs. -03/11/24 had 7 CNAs for 125 residents on the day shift, required at least 16 CNAs. -03/12/24 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs. -03/13/24 had 9 CNAs for 124 residents on the day shift, required at least 15 CNAs. -03/13/24 had 8 CNAs to 18 total staff on the evening shift, required at least 9 CNAs. -03/14/24 had 9 CNAs for 124 residents on the day shift, required at least 15 CNAs. -03/15/24 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. -03/16/24 had 7 CNAs for 126 residents on the day shift, required at least 16 CNAs. -03/17/24 had 7 CNAs for 126 residents on the day shift, required at least 16 CNAs. -03/17/24 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -03/18/24 had 8 CNAs for 126 residents on the day shift, required at least 16 CNAs. -03/19/24 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs. -03/20/24 had 9 CNAs for 122 residents on the day shift, required at least 15 CNAs. -03/21/24 had 10 CNAs for 122 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12035	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 4 day shift, required at least 15 CNAs. -03/22/24 had 6 CNAs for 122 residents on the day shift, required at least 15 CNAs. -03/23/24 had 10 CNAs for 122 residents on the day shift, required at least 15 CNAs. During an interview with the surveyor on 04/08/24 at 10:48 AM, the Staffing Coordinator (SC) expressed knowledge regarding the New Jersey state mandated Certified Nursing Assistant (CNA) to resident ratios and acknowledge that at this time the facility is not meeting the ratios.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315518 Y1	A. Building B. Wing Y2	6/5/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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 E0015	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(b)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/20/2024	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	
4/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315518 Y1	A. Building B. Wing Y2	6/5/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0677	Correction	ID Prefix F0686	Correction	ID Prefix F0688	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	05/20/2024	LSC	05/20/2024	LSC	05/20/2024
ID Prefix F0694	Correction	ID Prefix F0755	Correction	ID Prefix F0804	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	05/20/2024	LSC	05/20/2024	LSC	05/20/2024
ID Prefix F0808	Correction	ID Prefix F0922	Correction	ID Prefix	Correction
Reg. # 483.60(e)(1)(2)	Completed	Reg. # 483.90(i)(1)	Completed	Reg. #	Completed
LSC	05/20/2024	LSC	05/20/2024	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	
4/10/2024	☐ 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
12035 Y1	A. Building B. Wing Y2	6/5/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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	05/20/2024	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	
4/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. BUILDING **01** B. WING _____	**04/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	**275 JOHN T O'LEARY BOULEVARD** **SOUTH AMBOY, NJ 08879**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 004/09/2024 and 04/10/2024, 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 The facility is a four-story building that was built in 2015. It is composed of Type II protected construction. The facility is divided into 9-smoke zones. The generator covers 100% of the facility. The facility is Licensed for 180 beds. The census was 126.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 04/09/2024 and 04/10/2024 in the presence of facility management, it was determined that the facility failed to provide nine (9) illuminated exit signs to clearly identify the exit access path to reach an	K 293	1. Maintenance Director called electrical contractor to schedule the installation of the exits signs. The electrician was at the facility on 5/1/24 to assess the situation. We are currently waiting for the estimate to complete the work.	5/20/24

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

Electronically Signed | 05/03/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. BUILDING **01** B. WING _____	**04/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	**275 JOHN T O'LEARY BOULEVARD** **SOUTH AMBOY, NJ 08879**

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K 293	Continued From page 1 exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in	K 293	2. The facility acknowledges that all residents can be affected by the identified concern. 3.Maintenance Director called vendor to schedule the installation of the exits signs on 4/29/24. The electrician was at the facility on 5/1/24 to assess the situation. We are currently waiting for the estimate for the istallation of the exit signs. 4.The Maintenance Director or designee will ensure that the exit signs are installed and operational.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. BUILDING **01** B. WING _____	**04/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	**275 JOHN T O'LEARY BOULEVARD** **SOUTH AMBOY, NJ 08879**

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K 293	Continued From page 2 an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 04/09/2024 (day one of survey) during the survey entrance at approximately 8:59 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a four-story (4)building with Common areas and Resident sleeping rooms on the 2nd, 3rd, and 4th floors. Starting at approximately 9:20 AM on 04/09/2024 and continued on 04/10/2024 in the presence of the US FOIA a tour of the building was conducted. During the two (2) day building tour of the facility, the surveyor observed nine (9) locations that failed to have illuminated exit signs to clearly identify the exit access route for Residents, Visitors and Staff to reach an exit in the following locations, On 04/09/2024: 1) At approximately 10:01 AM, the surveyor observed in the 4th floor "Short hall corridor," near Elevator #4 and Resident room #NJ Ex Ord failed to have an illuminated exit sign to clearly identify the exit access route. 2) At approximately 10:18 AM, the surveyor observed in the 4th floor "Short hall corridor," near Elevator #1 and Resident room #NJ Ex O, failed to have an illuminated exit sign to clearly identify the exit access route.	K 293		

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	315518	A. BUILDING **01** B. WING _____	**04/10/2024**

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K 293	Continued From page 3 3) At approximately 10:31 AM, the surveyor observed in the 4th floor "Short hall corridor," near Elevator #3 and Center Nursing station, failed to have an illuminated exit sign to clearly identify the exit access route. 4) At approximately 11:02 AM, the surveyor observed in the 3rd floor "Short hall corridor," near Elevator #4 and Resident room #[redacted], failed to have an illuminated exit sign to clearly identify the exit access route. 5) At approximately 11:16 AM, the surveyor observed in the 3rd floor "Short hall corridor," near Elevator #1 and Resident room #[redacted], failed to have an illuminated exit sign to clearly identify the exit access route. 6) At approximately 11:33 AM, the surveyor observed in the 3rd floor "Short hall corridor," near Elevator #3 and Center Nursing station, failed to have an illuminated exit sign to clearly identify the exit access route. On 04/10/2024: 7) At approximately 9:50 AM, the surveyor observed in the 2nd floor "Short hall corridor," near Elevator #4 and Resident room #[redacted], failed to have an illuminated exit sign to clearly identify the exit access route. 8) At approximately 10:08 AM, the surveyor observed in the 2nd floor "Short hall corridor," near Elevator #1 and Resident room #[redacted], failed to have an illuminated exit sign to clearly identify the exit access route. 9) At approximately 10:16 AM, the surveyor	K 293		

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K 293	Continued From page 4 observed in the 2nd. floor "Short hall corridor," near Elevator #3 and Center Nursing station, failed to have an illuminated exit sign to clearly identify the exit access route. The US FOIA confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the deficiency during the Life Safety Code survey exit on 04/10/2024 at approximately 12:20 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as	K 324		5/15/24

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K 324	Continued From page 5 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation on 04/09/2024 and 04/10/2024, in the presence of facility management, it was determined that the facility failed to inspect the kitchen range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. The deficient practice was evidenced by the following: On 04/09/2024 (day one of survey) during the survey entrance at approximately 8:59 AM, a request was made to the US FOIA (b)(6) to provide all mandatory inspections from the last Re-Certification survey of 10/2022 through 03/2024 for review later. At approximately 12:25 PM, a review of the facility's range-hood fire suppression system inspections for the previous 18 months identified the system had three (3) semi-annual inspections on the following dates: - February 21, 2023, October 26, 2023, and April 04, 2024 Later at approximately 1:35 PM, a request was made to the US FOIA (b)(6) and US FOI if the facility	K 324	1. The facility can not retroactively respond to the concern relating the the kitchen suppression systems not being inspected every 6 months. 2. The facility acknowledges that all residents can be affected by the identified concern. 3. The Maintenance (MD) Director will develop a log documenting the dates of the inspections for the kitchen supression system inspections to be reviewed monthly and contact the vendor to ensure inspections are done timely.The US FOIA (b)(6) will be educated by the Administrator on ensuring that the kitchen suppression system inspections are completed timely. 4. The Administrator or designee will review all inspection reports monthly and determine what inspections are due to ensure inspections are performed as required.	

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K 324	Continued From page 6 could provide any additional kitchen hood semi-annual inspections. The US FOIA (b)(6) and US FOIA told the surveyor that there had been no additional semi-annul Kitchen suppression system inspections between 02/21/2023 and 10/26/2023. The facility did not semi-annually inspect the kitchen suppression system for the 8 months between February 21, 2023 and October 26, 2023. The US FOIA confirmed the finding at the times of review. The US FOIA (b)(6) was informed of the deficiency during the Life Safety Code survey exit on 04/10/2024 at approximately 12:20 PM. NFPA 101, NFPA 96 NJAC 8:39-31.2(e)	K 324		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or	K 914		5/15/24

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K 914	Continued From page 7 equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and documentation review on 04/09/2024 and 04/10/2024, in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced by the following: On 04/09/2024 (day one of survey) during the survey entrance at approximately 8:59 AM, a request was made to the US FOIA (b)(6) [redacted] to provide all mandatory inspections from the last Re-Certification survey of 10/2022 through 03/2024 for review later. At approximately 12:25 PM, during the documentation review for the previous 18 months identified the facility had one (1) annual electrical inspection performed on November 10, 2022. This inspection report did not include the room numbers, indicating the required testing for grounding, polarity, and blade tension in accordance with NFPA 99. During the two (2) day building tour on	K 914	1. The facility can not retroactively respond to the concern of the electircal inspection not being completed as per the regulations. 2. The facility acknowledges that all resdients care be affected by the identified concern. 3.The Maintenance Director will develop a log documenting the dates of the inspections for electrical inspections to be reviewed monthly and contact the vendor to ensure inspections are done timely. The US FOIA (b)(6) [redacted] will be educated by the Administrator on ensuring that the electical inspections are completed timely. 4. The Administrator or designee will review all inspection reports monthly and determine what inspections are due to ensure inspections are performed as required.	

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K 914	Continued From page 8 04/09/2024 and 04/10/2024, the surveyor confirmed the outlets were non-hospital grade. Later on 04/09/2023 at approximately 1:35 PM, during an interview with the US FOIA (b)(6) and US FOIA the surveyor requested if the facility had conducted an Annual Electrical Inspection for 2023. Both the US FOIA (b)(6) and US FOIA told the surveyor an Annual Electrical Inspection had not been performed for 2023. The US FOIA (b)(6) was informed of the deficiency during the Life Safety Code survey exit on 04/10/2024 at approximately 12:20 PM. NJAC 8:39-31.2(e) NFPA 99	K 914		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		5/15/24

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K 918	Continued From page 9 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and document review on 04/09/2024 and 04/10/2024, it was determined the facility failed to a.)Exercise the Emergency Generator for at least 30 minutes in 20- to 40-day intervals; and b.) Document the time needed by the generator to transfer power to the building was within the 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. Findings included: On 04/09/2024 (day one of survey) during the survey entrance at approximately 8:59 AM, a request was made to the US FOIA (b)(6) if the facility had an emergency generator, what type of fuel and how often does the facility run the emergency generator. The US FOIA told the surveyor, yes we have a Diesel Emergency Generator, we run it weekly and we run under a load monthly and keep a logbook.	K 918	1. The facility can not retroactively respond to the load test not being completed. 2. The facility acknowledges that all residents can be affected by the identified concern. 3. The Maintenance Director will complete the load tests as required and document in the log. The Administrator will educate the US FOIA (b)(6) on ensuring that the load tests are done per the regulation. 4. The Administrator or designee will review the load tests monthly for 3 months to ensure the load tests are being completed as required.	

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K 918	Continued From page 10 The surveyor asked the US FOA to provide the logs for the last 18 months (October 2022, November 2022, December 2022, January 2023, February 2023, March 2023, April 2023, May 2023, June 2023, July 2023, August 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024 and March 2024) for review later. Later at approximately 12:25 PM a review of the "Emergency Generator Monthly Log" for the previous 18 months identified the following documented monthly load dates, - 10/16/2022, Transfer Time to Emergency Power: 3 seconds. - 11/03/2022, Transfer Time to Emergency Power: 3 seconds. - 12/15/2022, Transfer Time to Emergency Power: 3 seconds. - 01/12/2023, Transfer Time to Emergency Power: 3 seconds. - 02/09/2023, Transfer Time to Emergency Power: 3 seconds. - 06/01/2023, Transfer Time to Emergency Power: 3 seconds. - 07/06/2023, Transfer Time to Emergency Power: 3 seconds. - 08/03/2023, Transfer Time to Emergency Power: 3 seconds. - 09/21/2023, Transfer Time to Emergency Power: 3 seconds. - 10/05/2023, Transfer Time to Emergency Power: 3 seconds. - 11/09/2023, Transfer Time to Emergency Power: 3 seconds. - 12/20/2023, Transfer Time to Emergency Power: 3 seconds. - 01/18/2024, Transfer Time to Emergency Power: 3 seconds.	K 918		

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K 918	Continued From page 11 - 02/14/2024, Transfer Time to Emergency Power: 3 seconds. - 03/14/2024, Transfer Time to Emergency Power: 3 seconds. There were no documented monthly load test for: March, April and May 2023. On 04/09/2024, at approximately 1:30 PM, the surveyor made a request to the US FOIA if he could provide any additional emergency generator monthly log for March, April and May 2023. The US FOIA could not provide any monthly load test for three (3) months. There was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load tests were conducted every 20 to 40 days under load for 30 minutes for March, April and May 2023. The US FOIA confirmed the finding at the time of review and interview. The US FOIA (b)(6) was informed of the deficiency during the Life Safety Code survey exit on 04/10/2024 at approximately 12:20 PM. NFPA 110. NJAC 8:39-31.2(g)	K 918		

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
315518 Y1	A. Building 01 - VENETIAN B. Wing Y2	6/5/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	05/20/2024	LSC K0324	05/15/2024	LSC K0914	05/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	05/15/2024	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	
4/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO