STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315471	A. BUILDING _____ B. WING _____	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	**7 RYERSON AVENUE CALDWELL, NJ 07006**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Dates: 12/27/2024 through 1/2/2025 Census: 28 Sample Size: 12 + 1 closed records A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Deficiencies were cited for this survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		1/31/25

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

Electronically Signed | 01/31/2025

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

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F 623	Continued From page 1 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623		

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F 623	Continued From page 2 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to notify the resident's representative and the Office of the Ombudsman in writing for an emergency transfer to [redacted]. This deficient practice was identified for 1 of 1	F 623	The Plan of Correction represents the facility's credible allegation of compliance as of 1/31/2025 ID Prefix Tag F623 Plan of correction Date: 01/31/2025	

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F 623	Continued From page 3 resident, Resident #16, reviewed for NJ Ex Order 26.4(b)(1) On 12/31/24 at 8:15 AM, the surveyor observed Resident #16 during medication administration. The resident was seated in their wheelchair and was NJ Exec O and NJ Exec Order 26.4b1 A review of Resident #16's hybrid (paper and electronic) medical records revealed the following: 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 NJ Exec Order 26.4b1 [redacted] A review of the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b1 reflected that Resident #16 was discharged to NJ Ex Order 26.4(b)(1) with a return anticipated to the facility. A review of a Nurses progress note dated NJ Exec Order 26.4b, revealed that Resident #16 was transferred to NJ Ex Order 26.4(b)(1). A nurses note dated NJ Exec Order 26.4b, revealed that the resident was admitted to NJ Ex Order 26.4(b)(1). On 12/31/24 at 10:15 AM, the surveyor interviewed the US FOIA (b)(6)), who stated she doesn't send a written notification to the resident's representative nor the Ombudsman Office for a letter of emergency transfer. The US FOIA (b) stated that the resident's representative was	F 623	F623, SS=D Notice Requirements before Transfer/Discharge CFR(2): 483.15(3)-(6) (8) 1) CORRECTIVE ACTIONS ACCOMPLISHED FOR THE RESIDENTS WHO MAY HAVE BEEN AFFECTED BY DEFICENT PRACTICE: Resident #16 was identified as not receiving notification of the Resident #16's representative or the Office of the Ombudsman for emergency NJ Ex Order 26.4(b) transfer. Resident #16 was not affected. Resident #16 was returned to the facility and was immediately transferred back to prior room upon return to the facility. Resident #16's representative was notified of NJ Ex Order 26.4(b)(1) transfer back via phone call. The LNHA reinforced to the Social Worker the need for written communication. 2) IDENTIFICATION OF RESIDENTS WHO HAVE HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICENT PRACTICE The facility recognizes that all residents have the potential to be affected by lack of written notification of representative and the Ombudsman in the event a relocation became necessary. The US FOIA (b)(6) received in-service training regarding the facility's policy of	

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F 623	Continued From page 4 notified when a resident is sent out to [NJ Ex O] [redacted]. When the surveyor asked the [US FOIA (b)] [redacted] which department was responsible for sending out the written emergency transfer notification, she stated she doesn't believe that anyone sends out those letters. On 12/31/24 at 10:30 AM, the surveyor interviewed the[US FOIA (b)(6) redacted]) regarding who's the staff responsible for mailing out the emergency transfer letter to the resident's representatives and to the Ombudsman office. The [US FOIA (b)(6)] [redacted] stated that the facility doesn't send out these letters. On 12/31/24 at 1:00 PM, the surveyor discussed the above concerns with the [US FOIA (b)(6)] [redacted] and the [US FOIA (b)(6)] [redacted] The [US FOIA (b)(6)] [redacted] stated that the facility had no policy related to sending out a written emergency letter to the resident's representative or the Ombudsman office when a resident will be transferred to [NJ Ex Order 26.4(b)(1)]. No further information was provided. NJAC 8:39-5.3; 5.4	F 623	transer/discharge including a copy of the notice sent to the State Long Term Care Ombudsman. 3) MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICENT PRACTICE WILL NOT REOCCUR. A copy of the completed notice with reason for transfer/discharge will be kept by the Social Worker, an additional copy to be given to the Administrator. The Social Worker will send a written notification of resident's transfer/discharge to the representative and the Office of the Ombudsman soon after hospital transfer. The notice will include the following: a. The reason for discharge or transfer b. The effective date of the transfer/discharge c. The location to which the resident is transferred or discharged. 4) MONITORING OF CORRECTIVE ACTIONS The Social Worker will meet with the Administrator weekly to review all transfers and discharges. Monthly, The Administrator will review the written notices of resident transferred and/or discharges for completion and date of notification to the resident's representative and to the Office of the	

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F 623	Continued From page 5	F 623	State Ombudsman. 5) IMPLEMENTATION: The new process was set up immediately with the Social Worker on 12/31/2024. During the next QAPI meeting scheduled for 04/23/2025, the Administrator will report compliance to the committee and then on a quarterly basis for at least one year.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		1/31/25

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F 625	Continued From page 6 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that the facility failed to provide the resident or resident representative appropriate written notification of the facility's bed hold and reserve payment policy upon transfer to the hospital for one of one residents (Resident #16) reviewed for NJ Ex Order 26.4(b)(1) The deficient practice was evidenced by the following: On 12/31/24 at 8:15 AM, the surveyor observed Resident #16 during medication administration. The resident was seated in their wheelchair and was NJ Exec O and NJ Exec Order 26.4b1 A review of Resident #16's hybrid (combination of paper and electronic) medical record revealed the following: A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b1, reflected that Resident #16 was discharged to NJ Ex Order 26.4(b)(1)	F 625	The Plan of Correction represents the facility's credible allegation of compliance as of 01/31/2025 Plan of Correction date: 01/31/2025 F 625 SS+D Notice of Bed Hold Policy before/upon transfer CFR(s): 483.15(d)(1)(2) 1) CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS WHO MAY HAVE BEEN AFFECTED BY DEFICENT PRACTICE: Resident # 16 was identified as the facility failed to provide written notification of the facility's bed hold and reserve payment policy upon transfer to the hospital. There was no actual harm to the affected resident as NJ Exec O returned to the facility as soon as hospitalization was completed to NJ Exec prior room. There was no charge necessary to hold the bed. 2) IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE.	

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F 625	Continued From page 7 with a return anticipated to the facility. A review of a Nurses progress note dated [NJ Exec Order 26.4b], revealed that the resident was transported to [NJ Ex Order 26.4(b)(1)]. A nurses note dated [NJ Exec Order 26.4b], revealed that the resident was admitted to [NJ Ex Order 26.4(b)(1)]. On 12/31/24 at 10:15 AM, the surveyor interviewed the [US FOIA (b)(6)]), who stated that she doesn't send out a written letter of emergency transfer or a bed hold letter to the resident's representative or the Ombudsman Office. She stated that the resident's representative are notified when the residents are sent to the hospital. She also stated that the resident's room will always be held for the resident. When the surveyor asked the [US FOIA (b)] if she knows what department is responsible for sending out the emergency transfer letter, she stated that she doesn't believe that anybody sends out these letters. On 12/31/24 at 10:30 AM, the surveyor interviewed the [US FOIA (b)(6)] regarding who's responsible for mailing out written emergency transfer letters and bed hold letters to the resident representatives and the ombudsman office. The [US FOIA (b)(6)] stated that the facility is different from other facilities and that they don't send out these letters. Regarding bed holds, the residents are always guaranteed a bed. On 12/31/24 at 1:00 PM, the surveyor discussed the above concerns with the [US FOIA (b)(6)] and the [US FOIA (b)(6)] The [US FOIA (b)(6)] stated that the facility had no policy that address that a written emergency letters are sent out to the resident's representative or the	F 625	The facility recognizes that all residents have the ppotential to be affected should we not be able to hold a bed. 3) MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DIFICIENT PRACTICE WILL NOT REOCCUR. The [US FOIA (b)(6)] received in-service training of written notification to the resident/representative before or upon transfer each time a resident is transferred, discharged or on theraputic leave. The Administrator educated the [US FOIA (b)(6)] and will reinforce importance of timely and accurate written notification. 4) MONITORING OF CORRECTIVE ACTIONS: The Social Worker will submit weekly reports of notifications to the Administator. Monthly, the Administrator will review all transfer/discharges or therapeutic leaves to ensure written notification to the resident or the resident's representative is completed and sent. The Social Worker will submit the Notifications of bed hold and reserve payment to the Quality Assurance meeting committee quarterly. The Administrator will review at the quarterly Quality Assurance meeting that	

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F 625	Continued From page 8 Ombudsman office. The [US FOIA (D)(6)] further stated that the residents are guarantee a bed upon return from an emergency transfer. She also stated that the facility has a bed hold policy. No further information was provided. A review of the facility policy titles "Bed hold" dated 04/30/24, and was provided by the DON which revealed the following: "1. All residents/representative are provided with written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave.)" N.J.A.C. 8:39-5.1 (a); 5.2 (a)	F 625	all facility bed holds and reserve payment policy letters were sent by the Social Worker to the resident or resident representative in a timely fashion. 5) IMPLEMENTATION: The Social Worker will submit notification of bed hold and reserve payment to the QAPI committee quarterly. The Administrator will review at the Quarterly QAPI meeting that all facility bed holds and reserve payment policy letters were set by the Social Worker to the resident and/or representative in a timely fashion.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set ((MDS), an assessment tool used to facilitate the management of care), in accordance with federal guidelines for 3 of 12 residents, (Resident #23, Resident #28 and Resident #17) reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 12/27/24 at 10:08 AM, the surveyor	F 641	PLAN OF CORRECTION REPRESENTS THE FACILITY'S CREDIBLE ALLEGATION OF COMPLIANCE AS OF 01/31/2025. F641, SS=D Accuracy of assessments CFR(s): 483.20(g) The assessments must ACCURATELY REFLECT THE RESIDENT'S STATUS. 1) CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY	1/31/25

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F 641	Continued From page 9 observed Resident #23 in their bed with their NJ Exec Order 26.4b1 On 12/27/24 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who was the nurse providing care for Resident #23. LPN #1 stated Resident #23 was transitioning off a NJ Exec Order 26.4b1 , also called ' NJ Exec Order 26.4b1 is a way of providing NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 directly into the NJ Exec Order 26.4b1 through an NJ Exec Order 26.4b1 that is placed with its NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1) and is only receiving NJ Exec Order 26.4b1 at this time. Review of Resident #23's Face Sheet (FS) (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but was not limited to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 following NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Review of the ' NJ E section" of the NJ Exec Order 26.4b1 Quarterly MDS for Resident #23 revealed that section NJ Exec Order 26.4b1 " documented under subsection B. NJ Exec Order 26.4b1 While a resident was listed ' NJ Exec O indicating Resident was receiving NJ Exec Order 26.4b1 or NJ Exec Orde via NJ Exec Orde A review of the NJ Exec Order 26.4b1 Physician Orders (PO) revealed a PO dated NJ Exec Order 26.4 to ' NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 every shift for NJ Exec Order 26.4b1 On 12/30/24 at 10:31 AM, the surveyor interviewed the US FOIA (b)(6)) who	F 641	THE DEFICIENT PRACTICE: Resident #23- review of section ' NJ E of the resident's MDS, revealed section ' NJ Exec Order 26 subsection NJ Exec Order 26.4b1 while a resident was coded ' NJ Exec Ord Section NJ E of the MDS was entered incorrectly according to RAI 3.0 Manual page K 11-18. Registered Dietitian reviewed the updated (October 2024) RAI manual and MDS was immediately corrected per RAI manual guidelines. The DON and Administrator reinfored the importance of an MDS' accurate assessment and coding. 2) IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICENT PRACTICE. The facility recognizes that all residents with feeding tubes may have the potential to be affected from an inaccurate MDS. Please refer to Sections Three and Four. 3) MEASURES PUT INTO PLACE OR SYSTEMIC CHANMGES TO ENSURE THAT THE DEFICENT PRACTICE WILL NOT REOCCUR: The US FOIA (b)(6) will be in-serviced and reinforced by administration on importance of accurate coding of the MDS.	

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F 641	Continued From page 10 stated they entered the [NJ Exec Order 26] information in Section [NJ] of the MDS, and the NJ Exec Order 26.4b1 section of section [NJ] was entered incorrectly as Resident #23 is currently receiving NJ Exec Order 26.4b1. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2024) on page K-11-18 ... "According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2024). This item documents to review the medical record to determine if any of the listed nutritional approaches were performed during the look-back period. If none apply, check K0520Z. None of the above ... Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating. The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals. Coding Tip for K0520B Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period is coded in K0520B. K0710B, Average Fluid Intake per Day by IV or Tube Feeding Steps for Assessment 1. Review intake records from the last 7 days. 2. Add up the total amount of fluid received each day by IV and/or tube feedings only. 3. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day. 4.	F 641	As part of the care plan meeting the MDS will be reviewed by the interdisciplinary team for accuracy prior to locking and transmission of the MDS. 4) MONITORING OF CORRECTIVE ACTIONS: As part of the weekly care plan meeting the MDS will be reviewed for accuracy prior to locking and transmission of the MDS. Concerns will be addressed by the Director of Nursing. DON (Director of Nursing) or Designee will audit 10% of completed MDS's for accuracy and report the data to Quality Assurance Committee. The outcome of the data collection will be used for the staff education. 5) IMPLEMENTATION: The dietician will report feeding tube audit to the DON weekly at the IDCP as well as at the next schedule QAPI meeting scheduled for April 23rd, 2025. Thereafter at the quarterly QAPI meetings for at least one year. The QAPI committee will determine the need for further audits and/or action plans. ID Prefix Tag F641, Pages 8-16, CMS-2567	

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	315471	A. BUILDING _____ B. WING _____	01/07/2025

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F 641	Continued From page 11 Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days. Coding Instructions Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was received by the resident, not what was ordered. Code 1: 500 cc/day or less. Code 2: 501 cc/day or more." On 12/30/24 at 11:33 AM, the US FOIA (b)(6) provided the surveyor with a facility policy, "Electronic Signature MDS" with a revised date of NJ Exec Order 26.4b1 The policy stated under the assessment section to, "Ensure documentation of the Interdisciplinary Team's participation coordination of a resident's assessment and to attest to the accuracy of the section of MDS 3.0." On 12/30/24 at 12:30 PM, the surveyor met with the US FOIA (b)(6) and US FOIA (b)(6)) to review the above concern. The US FOIA (b)(6) stated they were aware of the concern and would review all NJ Exec Order 26.4b1 residents. 2. On 12/27/24 at 9:45 AM, the surveyor observed Resident #28 seated in a recliner. The surveyor observed Resident #28's bed did not have any NJ Exec Order 26.4b1 engaged in the NJ Exec Order 26 . The surveyor interviewed Resident #28 regarding the use of NJ Exec Order 26.4b1 for the bed. Resident #28 stated that the NJ Exec Order 26.4 was able to NJ Exec Order 26.4b1 and that he/she used the NJ Exec Order 26.4 to help him/her NJ Exec Order 26.4b1 . A review of Resident #28's FS which reflected that the resident was admitted to the facility with	F 641	Plan of Correction Date: 01/31/2025 1) Actions taken for the resident identified: Resident #28- The MDS coordinator coding of section NJ Exec Order 26.4b1 was used less than daily as a NJ Exec Order 26.4b1 ". Resident #28 had NJ Exec Order 26.4b1 from the inaccurate coding of section " NJ Exec The US FOIA (b)(6) was in-serviced and reinforced regarding the importance of accurate MDS coding, and MDS was immediately corrected per RAI manuel guidelines. Resident #17- The MDS coordinator coding of section NJ Exec Order 26.4b1 was used less than daily as a NJ Exec Order 26.4b1 ". Resident # 17 had NJ Exec Order 26.4b1 from the inaccurate coding of section " NJ Exec The US FOIA (b)(6) was in-serviced and reinforced regarding the importance of accurate MDS coding, and MDS was immediately corrected per RAI manual guidelines. 2) Identification of other residents who have the potential to be affected: The facility recognizes that residents could have the potential to be affected from an inaccurate MDS. Please refer to Sections Three and Four. 3) Systemic Changes and measures that will be made: a. The US FOIA (b)(6) will be in-serviced and reinforced by administration on	

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F 641	Continued From page 12 diagnoses which included but were not limited to [redacted] A review of Resident #28's Admission MDS, an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #28 [redacted] was [redacted] Further review of the MDS indicated under Section [redacted] that the [redacted] was used less than daily as a [redacted]. A review of Resident #28's care plan reflected a focus area that the resident used [redacted] which could be considered as [redacted] however the resident used them to [redacted] and [redacted] in bed and [redacted]. A review of Resident #28's paper medical record reflected a "[redacted] Utilization Assessment" dated [redacted] which indicated that a [redacted] was indicated to provide safety and serve as an enabler to promote [redacted]. The use of the [redacted] was not used as a [redacted] On 12/30/24 at 11:13 AM, the surveyor observed Resident #28 seated in the recliner. The surveyor observed that Resident #28's bed did not have any [redacted] engaged in the [redacted] On 12/30/24 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6) regarding	F 641	importance of proper coding the MDS. b. As part of the weekly care plan meeting the MDS will be reviewed by the interdisciplinary team for accuracy prior to locking and transmission of the MDS. 4) Monitoring mechanisms to assure compliance: a. As part of the weekly care plan meeting the MDS will be reviewed for accuracy prior to locking and transmission of the MDS. Concerns will be addressed by the Director of Nursing. b. Director of Nursing or designee will audit 10% of completed MDS's for accuracy and report date to the Quality Assurance Committee. c. The outcome of the data collection will be used for staff education. 5) Implementation: The MDS coordinator will report to the DON weekly the coding of the siderails in the MDS. The next QAPI meeting is scheduled for April 23rd, 2025 where the statement of deficency and POC will be reviewed. Thereafter it will be reported quarterly at the QAPI meetings for at least one year. The QAPI committee will determine the need for further audits and/or action plans.	

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F 641	Continued From page 13 Resident #28 and the use of [redacted]. The [redacted] stated to the surveyor that the resident had a NJ Exec Order 26.4b1 and that she did not know if the [redacted] was the [redacted]. The [redacted] added that the resident did not have [redacted]. On 12/30/24 at 11:53 AM, in the presence of the survey team, the surveyor, via phone call, interviewed the US FOIA (b)(6) regarding the MDS coding for [redacted] under Section [redacted]. The [redacted] stated that the previous US FOIA (b)(6) stated the [redacted] were used as enabler. The [redacted] also stated that she visited the facility and had a discussion with the current US FOIA (b)(6)) and when they looked at the [redacted] they felt that some of the [redacted] were not "falling into" the category of NJ Exec Order 26.4b1 by definition and their measurements. She added they were considered [redacted] and we decided to code the [redacted] as [redacted]. The [redacted] stated they note that the [redacted] were for [redacted] and helping the residents and the care plan also stated it was used for [redacted]. She acknowledged that in the MDS, the [redacted] were coded as [redacted]. The [redacted] explained that the [redacted] were considered as [redacted] even though they were used for [redacted]. The [redacted] also stated that she followed the RAI manual and went to the State Operations Manual for additional informatio but could not find the exact definition that determined the difference between an enabler and a restraint. On 12/30/24 at 12:59 PM, the surveyor interviewed the [redacted] regarding the process for [redacted]. The [redacted] stated that almost everyone used NJ Exec Order 26.4b1 to [redacted] or to [redacted] themselves. The [redacted] stated that the [redacted] suggested the [redacted] were	F 641		

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F 641	Continued From page 14	F 641		

listed as a [NJ Exec Order 26.4b] in the care plan. The [US FOIA (b)] stated that in her opinion there was no one in the facility that had a [NJ Exec Order 26.4b1]. The surveyor asked the [US FOIA (b)] why Resident #28's MDS was coded as having a [NJ Exec Order 26.4b1]. The [US FOIA (b)] stated that the [US FOIA (b)(6)] insisted that anyone with a [NJ Exec Order 26.4] be coded as a [NJ Exec Order 26.4b1]. The [US FOIA (b)] stated that Resident #28 did not have a [NJ Exec Order 26.4b] and that the resident did not use the [NJ Exec Order 26.4b1] all the time.

On 12/31/24 at 10:49 AM, in the presence of the survey team, the surveyor told the [US FOIA (b)(6)] and [US FOIA (b)] the concern that Resident #28's MDS was not coded accurately and the MDS indicated that the Resident #28's [NJ Exec Order 26.4b1] was a [NJ Exec Order 26.4b] and not used as an [NJ Exec Order 26.4b]. The [US FOIA (b)] stated that she did not agree that the [NJ Exec Order 26] was a [NJ Exec Order 26.4b1]. She added that an assessment of the [NJ Exec Order 26.4] was done [NJ Exec Order 26.4b1] and indicated that it was used as an [NJ Exec Order 26.4b].

3. On 12/27/24, at 09:56 AM, the surveyor observed Resident #17 seated in their wheelchair with [NJ Exec Order 26.4b1].

On 12/31/24 at 9:57 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #17, which revealed the following:

According to the FS, Resident #17 was admitted to the facility with diagnoses that included but were not limited to [NJ Exec Order 26.4b1]).

A review of the quarterly MDS (Q/MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b], reflected that the resident had a BIMS score of [NJ] out of 15, indicating that the resident had [NJ Exec Order 26.4b1]

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F 641	Continued From page 15 NJ Exec Order 26.4b1 Further review of the Q/MDS dated NJ Exec Order 26.4b "Section NJ Exec Order 26.4b1 Used in Bed NJ E NJ Exec Order 26.4b 1. Used less than daily." A review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) revealed there was no physician's order (PO) for NJ Exec Order 26 use. A review of the comprehensive care plan revealed no care plan NJ Exec Order 26.4b1 used. On 12/31/24 at 11:22 AM, the surveyor interviewed the US FOIA (b)(6) regarding the above concern. The US FOIA (b)(6) did not provide further information and added that the facility followed the RAI (Resident Assessment Instrument - a tool that helps gather information about a resident's strengths and needs, which is used to create an individualized care plan) manual. The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) RAI Version 3.0 Manual, updated October 2024. The RAI manual is revealed under Chapter 3, page P-3, Steps for Assessment 1. Review the resident's medical record (e.g., physician's orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period." On 12/31/24 at 11:35 AM, the surveyor interviewed the US FOIA (b)(6)), who confirmed that there is no NJ Exec Order 26.4b in the building and that Resident #17 had no order for NJ Exec Order 26.4b1 NJAC 8:39-11.1, 11.2(e)(1) NJAC 8:39-33.2(d)	F 641		

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to administer NJ Exec Order 26.4b1 according to the physician's order for 1 (one) of 2 residents (Resident #22) reviewed for NJ Exec Order 26.4b1 care. This deficient practice was evidenced by the following: On 12/27/24 at 10:05 AM, the surveyor observed Resident #22 in bed asleep, wearing a NJ Exec Order 26.4b1 [redacted] connected to an NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 On 12/27/24 at 10:25 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #22, which revealed the following: A review of the Admission Record (an admission summary) (AR) reflected that Resident #22 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]	F 695	The Plan of Correction represents the facility's credible allegation of compliance as of January 31, 2025. F695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483:25(I) 1) CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY DEFICENT PRACTICE: Resident #22 no longer resides in the facility. The facility failed to administer NJ Exec Order 26 [redacted] according to the physician's order. Immediately, the physician's order was reviewed, the physician was notified of the NJ Exec Order 26.4b1 on Resident #22's NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 setting was corrected to reflect the physician's order. The licensed nurse did not sign the	1/31/25

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F 695	Continued From page 17 NJ Exec Order 26.4b1. A review of the Admission Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care with an assessment reference date (ARD) (the last day of the observation period) of NJ Exec Order 26.4b, indicated that the facility assessed the residents' NJ Exec Order 26.4b1 using a Brief Interview for Mental Status (BIMS) score of NJ Exe out of 15, which indicated that the resident had an NJ Exec Order 26.4b1. Further review of the A/MDS "Section NJ E - Special Treatments, Procedures, and Programs, C1. NJ Exec Order 26.4b1, B. While a Resident" was coded "NJ Exec Orde A review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) revealed an active physician's order (PO) with an order date of NJ Exec Order 26.4b1 for NJ Exec Order 26 at NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 as needed. The above PO for NJ Exec was transcribed to the NJ Exec Order 26.4b1 electronic Treatment Administration Record (eTAR) and failed to be signed by a nurse, indicating that NJ Exec was administered to Resident #22 on NJ Exec Order 26.4b1. On 12/27/24 at 10:10 AM, the surveyor, in the presence of the US FOIA (b)(6) checked and confirmed that the NJ Exec was set at NJ from the NJ Exec Order 26.4b1. On 12/27/24 at 10:15 AM, the surveyor interviewed the US FOIA (b)(6) who confirmed that Resident #22's is currently on NJ Exec Order 26.4b1 On 12/30/24 at 12:15 PM, the surveyor team met with the US FOIA (b)(6)	F 695	medical record or check the NJ Exec Order 26 concentrator reflecting the liters per minute resulting in not following prescribed physician's order for NJ Exec Order 26 administration, monitoring, and documentation. Policy for oxygen administration orders, concentrator monitoring, and documentation were reviewed by Director of Nursing (DON) immedicatly on 12/27/2024. The licensed nurse was in-serviced on the importance of validating the physician's order and signing the electronic treatment administration record in accordance with the facility policy and procedure. 2) IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICENT PRACTICE. The facility recognizes all residents on oxygen therapy have the potential to be affected. The Director of Nursing (DON) provided immediate education for all the licensed nurses on duty on 12/27/2024. This educatuion will be completed for all licensed nurses by the Nurse Educator. To ensure all licensed nurses understand the requirements for accurate and proper administration of oxygen. 3) MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE	

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F 695	Continued From page 18 ([redacted] and the US FOIA (b)(6) [redacted]). The [redacted] did not provide further information. On 12/30/24 at 1:49 PM, the [redacted] provided a policy titled "Oxygen Administration," effective December 2023 under "Purpose: Administer oxygen therapy in accordance with the attending physician's orders." When an order is written for PRN (as needed), the oxygen will be administered according to the liters prescribed by the Attending Physician. NJAC 8:39-25.2(c)	F 695	THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: The DON reviewed every oxygen dependent resident's plan of care and physician's orders. The DON developed and implemented an audit to check for accuracy of orders for administration of oxygen therapy and that the concentrators are set at correct number of liters per minute each shift. The DON and/or Nurse designee weekly will audit all oxygen dependent's orders to ensure they reflect the specific respiratory needs of each individual. The Electronic Treatment Administration (eTAR) record will be audited weekly to ensure licensed nursing are signing eTAR. 4) MONITORING OF CORRECTIVE ACTIONS: The DON or designee will be ensuring these protocols are in place and adhered to. Procedure was put into effect immediately in the order set for licensed nurse on every shift to check oxygen administration order and verify the correct liters per minute of oxygen flow is reflected on the concentrator and documented. 5) IMPLEMENTATION:	

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F 695	Continued From page 19	F 695	Every Sunday night on the 11-7 shift the licensed nurse on duty will complete an audit of all residents with oxygen in use orders and concentrator checks. The 11-7 licensed nurse on duty will provide the DON with the completed audit checklist every week, indicating any oxygen administration exceptions and remediation. Findings will be reported to the Administrator by the DON weekly, then monthly. Outcomes will be presented in the quarterly Quality Assurance Meeting. The QAPI Committee will determine the need for further audits and/or action plans.	
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation, it was determined that the facility failed to ensure that the Certified Nursing Aide (CNA) received an annual performance review for 5 of 5 CNA files reviewed.	F 730	The Plan of Correction represents the facility's credible allegation of compliance as of January 31, 2025 F730 SS=F Nurse aide Perform review-12hr/yr In-service CFR(s): 483.35	1/31/25

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F 730	Continued From page 20 The deficient practice was evidenced by the following: On 12/27/24 at 12:08 PM, the surveyor requested from the US FOIA (b)(6) the annual performance reviews that were done for 5 randomly selected CNAs. On 12/30/24 at 9:17 AM, the US FOIA (b)(6) stated that the facility did not have any performance reviews for the 5 CNAs. She added that the US FOIA (b)(6) had the forms that were to be used but that she had not done the reviews yet. The facility did not provide any documented evidence that the 5 CNAs received an annual performance review. On 12/30/24 at 12:36 PM, in the presence of the survey team, the surveyor told the US FOIA (b)(6) and US FOIA (b) the concern that the 5 CNAs did not have an annual performance review. On 12/31/24 at 10:44 AM, in the presence of the survey team and the US FOIA (b)(6) stated that she had been at the facility for 7 months and that she had not conducted any performance reviews since she had started. The US FOIA (b)(5) stated that they would "have to get up to speed on that." The facility did not provide any additional information. A review of the facility provided policy titled, "Employee Evaluation Performance" with an effective date of 3/2018, included the following: Policy: Our facility's employee evaluation of performance	F 730	(d)(7) Regular in-service education. 1) CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS WHO MAY HAVE BEEN AFFECTED BY DEFICENT PRACTICE: Five Certified Nursing Assistants (CNAS) were identified as not having current performance reviews. The DON completed performance reviews of the five CNAS. 2) IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICENT PRACTICE. The facility recognizes that all residents and staff have the potential to be affected by missing performance reviews. Employees should receive ongoing feedback regarding how they are performing relative to facility expectations, distributing rewards, identifying development opportunities and addressing performance that does not meet expectation. 3) MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICENT PRACTICE WILL NOT REOCCUR. The Employee Evaluation Performance policy was reviewed by DON and Administator.	

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	315471	A. BUILDING _____ B. WING _____	01/07/2025

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F 730	Continued From page 21 may be scheduled annually. The purpose of effective performance management is for employees to have a clear understanding of the work expected from them, a. To receive ongoing feedback regarding how they are performing relative to the facility's expectations b. Distribute rewards accordingly c. Identify development opportunities, d. And to address performance that does not meet expectations .... Procedure: A facility standard evaluation form is used to guide the performance evaluation process. Employees are scheduled for an evaluation. The employee's review of performance may receive constructive feedback and recommendations for improvement. -Frequency: The policy specifies how often reviews will be conducted, such as annually, bi-annually, or quarterly ... -Rewards and training: The policy outlines guidelines for rewards and training .... N.J.A.C. 8:39-43.17 (b)	F 730	The DON will complete performance reviews monthly to ensure completion of employee evauations timely. 4) MONITORING OF CORRECTIVE ACTIONS: At each quarterly QAPI meeting, the DON will submit the performance reviews of all staff completed that quarter. 5) IMPLEMENTATION: The Administrator will review at the quarterly QAPI meeting next scheduled for April 23, 2025 that all performance reviews are completed in a timely manner.Thereafter, it will be reported quarterly for at least one year.	
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law.	F 811		1/31/25

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F 811	Continued From page 22 §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documentation, the facility failed to ensure facility staff that were utilized to assist residents that needed to be fed were appropriately trained and evaluated as competent to be a paid feeding assistant. This deficient practice was evidenced by the following: On 12/27/24 at 10:01 AM, the surveyor entered Resident #12's room. The surveyor observed a staff member (SM) wearing gloves, holding a bowl and a spoon standing next to Resident #12's bed. After the surveyor introduced herself to Resident #12, the SM put down the bowl and spoon on the tray that was on the resident's over	F 811	The Plan of Correction represents the facility's credible allegation of compliance as of January 31, 2025 F811 SS=D Feeding Assistant/Training/Supervision/Resident CFR CFR(s): 483.60(h)(1)-(3) 1) CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENT FOUND TO HAVE BEEN AFFECTED BY THE DEFICENT PRACTICE: Resident #12 was identified as being assisted with [NJ Exec Order 26] by an untrained feeding assistant with no current job description. The staff member was	

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F 811	Continued From page 23 the bed table and [NJ Exec Order] Resident #12's [NJ Exec Order] with a napkin. The surveyor observed that the bedside table was next to the resident's bed and it was not positioned in front of the resident for the resident to NJ Exec Order 26.4b1. The surveyor observed that the resident did not have any utensil in his/her hand. The surveyor observed the SM's badge which indicated the SM was a US FOIA (b)(6)). The surveyor asked the SM what she was doing and what her title was. The SM stated that she was [NJ Exec Order] the resident and that she was a [US FOIA (b)] and also a nursing student that finished her [NJ Exec Order 26.4b1]. The surveyor interviewed Resident #12 who stated that he/she had a [NJ Exec Order] recently but that NJ Exec Order 26.4b1 [redacted] On 12/27/24 at 10:11 AM, the surveyor interviewed Resident #12's Registered Nurse #1 (RN #1) regarding the SM and Resident #12. RN #1 stated that Resident #12 recently was placed on [NJ Exec Order] services. RN #1 stated that the SM was a nursing student and that SM helped [NJ Exec O] residents. The surveyor asked RN #1 if the SM had a competency done for [NJ Exec Order 26.4b] RN #1 stated that the SM had a competency for [NJ Exec Order 26.4b] A review of Resident #12's Admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident #12's most recent quarterly Minimum Data Set (MDS), an assessment tool	F 811	immediately told to no longer assist with [NJ Exec Order 26.4b] [redacted] The resident no longer resides at the facility. Review of the resident's medical records reveal that Resident #12 was not adversly affected by the deficent practice. 2) INDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICENT PRACTICE: The facility recognizes that all residents may have the potential to be affected by an untrained staff member feeding. The Policy for Paid Feeding Assistants was reviewed by the Director of Nursing (DON) Dietician, and the Administrator. 3) MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICENT PRACTICE WILL NOT REOCCUR: The DON and Administrator will ensure that every staff member has a signed job description. The DON will ensure that only qualified staff will provide feeding assistance. The DON will ensure that non-nursing staff have successfully completed the New Jersey Dining Assistant training program if needed to provide feeding	

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F 811	Continued From page 24 used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #12 was [redacted] On 12/27/24 at 12:42 PM, in the presence of the survey team and [redacted]), the surveyor asked the [redacted] for information regarding the SM. The [redacted] stated that the SM was in her [redacted] and had a CNA (Certified Nurse's Aide) license in the state of [redacted] The [redacted] stated that the SM was hired for clerical work. The surveyor asked the [redacted] if the SM had a signed job description. The [redacted] stated that she did not. The [redacted] stated that the SM came to the facility to help when the SM was on [redacted]. The [redacted] stated that the SM received minimal pay and that she thought that the SM only set up residents for meals. The surveyor requested the SM's personnel file. A review of the SM's personnel file included an "Employee Action Form" which indicated she was a new hire on [redacted] and that the "Current Position" was blank. The form did not indicate what position the SM was hired for. Further review of the SM's personnel file included an "Employee File Checklist" which indicated the hire date was [redacted] and the "Position" was blank. The form did not indicate what position the SM was hired for. There was no documented evidence in the file that indicated the SM had completed a paid [redacted] assistant course or a [redacted] a resident was performed. On 12/27/24 at 12:54 PM, the surveyor verified	F 811	assistance. 4) MONITORING OF CORRECTIVE ACTIONS: The DON will ensure that no other staff member assist with feeding unless properly trained. The DON, Nurse Designee and Dietican will audit mealtimes weekly to ensure all staff feeding are qualified to do so. 5) IMPLEMENTATION: The DON, or Nurse Designee or Dietician effective immediately will audit a meal weekly to ensure all staff feeding is qualified to do so. This will be presented at the next quarterly QAPI committee meeting scheduled for April 23, 2025 and thereafter quarterly for at least one year. A quarterly audit and remediation as necessary of all staff having a signed Job Description will be completed by the Administrator and presented at the QAPI Committee meeting.	

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F 811	Continued From page 25 that the SM was licensed as a CNA in [NJ Exec Order 26.4]	F 811		

On 12/30/24 at 11:46 AM, the surveyor interviewed RN #2 regarding the SM. RN #2 stated that the SM was a nursing student and was a great help. RN #2 stated that in the summer the SM answered phones and transported residents. She added that last Monday the SM was [NJ Exec Order 26.] residents and the nurses were supervising her. The surveyor asked RN #2 how she knew what the SM could do. RN #2 stated that the [US FOIA (b)] had told them what the SM could do.

On 12/31/24 at 9:18 AM, the surveyor interviewed the [US FOIA (b)] regarding the process for residents that needed to be [NJ Exec O] The [US FOIA (b)] stated that the CNAs did the [NJ Exec Order 26.] typically or the nurses. The [US FOIA (b)] stated that they did not have paid [NJ Exec Order 26.] assistants but that she had taken the course to be a trainer. The surveyor asked the [US FOIA (b)] about the SM. The [US FOIA (b)] stated that the SM was here in the NJ Exec Order 26.4b1 . The [US FOIA (b)] stated that the SM worked under her supervision. The [US FOIA (b)] stated that Resident #12 "[NJ Exec Order 26.4b1]" himself/herself and that Resident #12 had a recen[NJ Exec Order 26.4b1) and was on [NJ Exec Order 26.4b] The [US FOIA (b)] stated that the SM was just [NJ Ex Order 26.4(b)(1)] for the resident. The [US FOIA (b)] stated that the [US FOIA (b)(6)] asked the SM to help. The surveyor asked the [US FOIA (b)] if the SM should be helping [NJ Exec O] residents. The [US FOIA (b)] stated that the SM should not be helping to [NJ Exec O] according to her title. The [US FOIA (b)] added that the SM had training in [NJ Exec Order 26.] and was a NJ Exec Order 26.4b1 . The surveyor asked the [US FOIA (b)] if the SM had a NJ Exec Order 26.4b1 by the facility. The [US FOIA (b)] stated no.

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F 811	Continued From page 26 On 12/31/24 at 10:49 AM, in the presence of the survey team, the surveyor told the [redacted] and [redacted] the concern that the SM fed Resident #12 and was not trained to be a [redacted] assistant. On 01/02/25 at 10:49 AM, in the presence of the survey team, the [redacted] stated that she did not have any further responses related to the concern. The facility did not provide any additional information. A review of the facility provided policy titled, "Paid Feeding Assistance" with an effective date of 10/2024, included the following: Policy Paid Feeding Assistant Procedure: 1. In the event of a resident requires assistance with their meals; a. Residents only need encouragement or minimal assistance, which does not require nursing training. b. Properly trained non-nursing personnel could provide this type of assistance. 2. Nurse aides and other nursing staff receive training so that they are able to feed residents with all kinds of feeding problems. 3. A higher level of training is required of nurse aides because nurse aides need to be able to deal with complicated feeding problems. 4. After proper basic training in feeding techniques and working with the elderly, are able to feed residents who do not have complicated feeding problems. 5. in the event of a nurse aide shortage, it is often	F 811		

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F 811	Continued From page 27 the case that residents without complicated feeding problems receive little or no assistance at mealtimes with eating or drinking, while the nursing staff focuses on feeding residents with complicated problems.	F 811		
F 947 SS=F	N.J.A.C. 8:39-17.3(c) Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to ensure that a) Certified Nurses Aides (CNA) received 12 hours of mandatory	F 947	The Plan of Correction represents the facility's credible allegation of compliance as of January 31, 2025. F947 SS=F Required In-service Training	1/31/25

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F 947	Continued From page 28 in-service training for 5 of 5 CNAs reviewed (CNA #1, CNA #2, CNA #3, CNA #4 and CNA #5); and b) CNA education included abuse and resident rights for 1 of 5 CNAs reviewed (CNA #1). This deficient practice was evidenced by the following: On 12/27/24 at 12:08 PM, the surveyor requested from the US FOIA (b)(6) the annual education that was provided to 5 randomly selected CNAs. On 12/30/24 at 8:41 AM, the US FOIA (b)(6) stated that the facility had a book of the education provided which were in person sessions with sign in sheets but that not everyone signed that they attended. She added that the facility did not use a computer-based education system and did not have an educator. On 12/30/24 at 9:11 AM, the US FOIA (b)(6) provided the binder of inservice sign in sheets that the facility had done. The US FOIA (b)(6) stated that capturing everyone was difficult. She added that if the staff did not attend the in person in-service then the staff were to take the material to read and then sign that they done it. She then stated that they all did not sign. The surveyor asked the US FOIA (b)(6) if she could provide 12 hours of education for the 5 CNAs that included the mandatory trainings. The US FOIA (b)(6) stated she could not provide 12 hours of education for each of the 5 CNAs but that she would check about the mandatory trainings. The US FOIA (b)(6) stated that we provided the in-services but that it does not help if the staff did not come. On 12/30/24 at 10:58 AM, the US FOIA (b)(6) provided the surveyor a document titled "Mandatory Inservice's	F 947	for Nurses Aides CFR(s): 483.95(g)(1)-(4) 483.95(g) Required In-service training for nurses aides. In-service training must be sufficent to ensure the continued competence of nurses aides but must be no less than 12 hours per year. 1) CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS WHO MAY HAVE BEEN AFFECTED BY DEFICENT PRACTICE: Five Certified Nursing Assistants (CNAS) were identified as not havig completed the required (12) hour mandatory in-service training annually. The CNAS in-service training course will include the following information: Subject of the CNA training in-service and, Length of Time for each in-service training the CNA completed. The DON/Nurse Educator will complete the mandatory (12) hour in-service training of the five CNAS identified: CNA #1 received (1) in-service, remaining (11) inservices were completed. CNA #2 received (9) in-services, remaining (3) hours of in-service traing was completed. CNA #3 received (8) in-services, the remaining (4) hours of in-service training was completed. CNA #4 received (3) in-services, the	

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F 947	Continued From page 29 2024" for each of the 5 CNAs which did not include any indication to how long each of the in-services listed were conducted for and included the following: CNA #1 with a date of hire (doh) of [NJ Exec Order 26.] had one in-service listed which was "Understanding Dementia". There was no documented evidence that CNA #1 had abuse or resident rights training. CNA #2 with a doh of [NJ Exec Order 26.] had 9 in-services listed which included the mandatory trainings of dementia, abuse, and resident rights. CNA #3 with a doh of [NJ Exec Order 26.4b] had 8 in-services listed which included the mandatory trainings of dementia, abuse, and resident rights. CNA #4 with a doh of [NJ Exec Order 26.4b] had 3 in-services listed which included the mandatory trainings of dementia, abuse, and resident rights. CNA #5 with a doh of [NJ Exec Order 26.4b] had 4 in-services listed which included the mandatory trainings of dementia, abuse, and resident rights. A review of the staff sign in sheets provided indicated that the in-services were one hour or one hour and 10 minutes in length. The facility did not provide documented evidence that the 5 CNAs had annual 12 hours of in-service education. On 12/30/24 at 12:36 PM, in the presence of the survey team, the surveyor told the [US FOIA (b)(6)] and [US FOIA (b)] the concern that the 5 CNAs did not have 12 hours of education and that CNA #1 did not have abuse and resident rights training. On 12/31/24 at 10:42 AM, in the presence of the survey team and the US FOIA (b)(6) stated that she was going to hire a health educator. She added that the facility did provide education but that they had to track the education better. The [US FOIA (b)(6)] confirmed that the 5 CNAs did not have the	F 947	remaining (9) hours of in-service training were completed. CNA #5 received (4) in-services, the remaining (8) hours of in-service training was completed. 2) IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICENT PRACTICE: The facility recognizes that all residents and staff have the potential to be affected by not completing the required (12) hour mandatory in-service training. The Policy and Proce4dure regarding nurse aides education was reviewed by both the DON and newly hired Nurse Educator. The nurse aides will be scheduled throughout the year to receive the mandatory (12) hour in-service training in accordance with F-947 3) MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICENT PRACTICE WILL NOT REOCCUR: The DON and the newly hired Nurse Educator reviewed the revised Education of Nursing Staff policy and procedure that now includes a listing of the required (12) hour mandatory in-service training. 4) MONITORING 0F CORRECTIVE ACTIONS:	

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F 947	Continued From page 30 12 hours of education and that CNA #1 did not have all the required mandatory trainings. The facility did not provide any additional information. A review of the facility provided policy titled "Education Nursing Staff" with a review date of 2023, included the following: Our facility has yearly required scheduled education for our nursing staff. To promote quality of life and quality of care of resident, Staff will be informed in advance of the required staff education. The following are the required staff education to be completed yearly. 1. Abuse/Neglect ... 3. Alzheimer's Disease ... 7. Infection Control (each quarter) 8. Resident Rights ... 12. CPR The policy did not include any information regarding the amount of hours required for CNAs. N.J.A.C. 8:39-43.17 (b)	F 947	At each quarterly QAPI meeting, the DON/Nurse Educator will submit the nurse aides that have received in-service training quarterly. The DON and Nurse Educator will complete monthly in-service education training for the nurse aides to ensure completion of nurse aides in-service education is timely annually. 5) IMPLEMENTATION: The Administrator will review at the quarterly QAPI meeting next scheduled for April 23, 2025 all nurse aide mandatory training were completed to assure timeliness of in-service training of the nurse aides mandatory (12) hour annual training.	

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
315471 Y1	A. Building B. Wing Y2	3/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE CALDWELL, NJ 07006

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 F0623	Correction	ID Prefix F0625	Correction	ID Prefix F0641	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.20(g)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix F0695	Correction	ID Prefix F0730	Correction	ID Prefix F0811	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.35(d)(7)	Completed	Reg. # 483.60(h)(1)-(3)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix F0947	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.95(g)(1)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/31/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/7/2025	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315471	A. BUILDING **01** B. WING _____	**01/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	**7 RYERSON AVENUE** **CALDWELL, NJ 07006**

(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 ST Catherine of Siena is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 1/06/2025 to 1/08/2025, and St. Catherine of Siena facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 3-story building that was built in 1960's, with Resident sleeping rooms on the second floor. It is composed of Type I fire resistant construction. The facility is divided into 3 smoke zones. The facility diesel generator does 100% of the building Per Maintenance Director. The facility has four private fire hydrants and a fire pump.	K 000		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		1/31/25

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

Electronically Signed | 01/31/2025

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

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	315471	A. BUILDING **01** B. WING _____	**01/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 1/6/2025 in the presence US FOIA (b)(6) it was determined that the facility failed to ensure that exit stair landings and exit stair handrails were marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3,7.2.2.5.5.2 and 7.2.2.5.5.3. This deficient practice had the potential to affect all 27 residents and was evidenced by the following: Observations during the tour between 9:15 AM and 3:05 PM in the presence of the US FOIA (b)(6), revealed 3 of 3 exit stairways had no marking stripes on the steps and the upper surface of the handrails were not marked as required by the Code. In an interview at that time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code exit conference on 1/8/2025 at 1:55 PM. NJAC 8:39 31.2 (e)	K 225	1) POTENTIAL HARM FOR RESIDENT: Potential to affect safe emergency exiting for all residents. There was no direct harm to any resident 2) POTENTIAL AFFECT ON OTHER RESIDENTS: Potential to affect the safe stairway exiting during an emergency. There is potential to affect all residents. 3) SYSTEMIC CHANGES: MD (Maintenance Director) applied marking stripes to the railings and the stairs in two of the three stairways identified on 01/08/2025. The third stairwell is outdoors and will have painted marked yellow stripes on the handrails and the stairs. The paint will better endure the elements outside year round. This will be completed as soon as possible pending weather conditions. 4) MONITORING: MD will monitor and report on the sustaining of the stripes on all three stairwells during our quarterly Safety Committee meetings. Any repair(s) needed between the quarterly meeting will be addressed immediately. 5) IMPLEMENTATION: A steering committee of the QAPI is scheduled for April 23rd, 2025 to review the statement of deficency and plan of correction. Thereafter it will be reported	

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K 225	Continued From page 2	K 225	quarterly to the QAPI committee for at least one year.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 1/6/2025 in the presence US FOIA (b)(6) [redacted]), it was determined that the facility failed to provide illumination for the means of egress that was either continuously in operation or capable of automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all 27 residents and was evidence by the following: 1. Observations at approximately 11:35 AM, revealed that First floor North and South corridors lighting for the means of egress were control by the light switch on the wall. Approximately 115 feet in length of the exit access had no lighting when the switch was in the off position. 2. Observations at approximately 10:51 AM, revealed that basement North and South corridors lighting for the means of egress were control by the light switch on the wall. Approximately 115 feet in length of the exit	K 281	1) POTENTIAL HARM FOR RESIDENT: Potential to affect safe visability for all residents when in the hallways on both the 1st floor and basement, especially if needed to exit during an emergency. There was no direct harm to any resident. 2) POTENTIAL AFFECT ON OTHER RESIDENTS: Potential affect regarding safe passageways on both the 1st floor and basement floor identified, especially during an emergency. There is potential to affect all residents. 3) SYSTEMATIC CHANGES: On the first floor, locking light switches will be installed that require a key to switch off. This will keep the current built in nightlights illuminated at all times. The basement lights will be rewired to ensure continuous sufficient lighting that is not operated by a light switch. Both corrections will be completed by a	2/3/25

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K 281	Continued From page 3 access had no lighting when the switch was in the off position. In an interview at the time, the US FOIA (b)(6) confirmed the observations. The US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 1/8/2025 at 1:55 PM. N.J.A.C 8:39-31.2(e)	K 281	contracted licensed electrician. Project to commence on 02/03/2025. All was completed on 02/03/2025. 4) MONITORING: MD will add to his Quality Measures, with monthly checks, as well as daily walking throughout the building to ensure sufficient lighting is on at all times. 5) Implementation: A steering Committee of the QAPI is scheduled for April 23rd 2025 to review this statement of deficency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview from 1/6/2025 to 1/8/2025 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to conduct functional testing of emergency lighting system in accordance with NFPA 101: 2012 Edition, Section 19.2.9.1 and 7.9.3 The deficient practice could affect all 27 residents and was evidenced by the following: Observation on 1/6/25 at approximately10:53AM, revealed Battery back-up emergency lighting	K 291	PLAN OF CORRECTION: it was determined that the facility failed to conduct functional testing of emergency lighting system in accordance with NFPA 101: 2012 Edition, Section 19.2.9.1 and 7.9.3 The deficient practice could affect all 27 residents. 1) POTENTIAL FOR RESIDENT: Potential to affect the safe operation of the emergency lighting system by not testing the back up battery that operates	2/14/25

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K 291	Continued From page 4 system by the emergency transfer switch in the mechanical room. Documentation review on 1/7/25 at approximately 11:25 AM, revealed No document for functional testing of Battery back-up emergency lighting system monthly for not less than thirty seconds, and annually for one and half hours provided. In an interview at 12:02 PM, the [redacted] stated functional testing of emergency lighting system was not conducted. The facility's [redacted] was informed of the deficient practice at the Life Safety Code survey exit on 1/8/25 at approximately 1:55 PM. NJAC 8:39-31.2(e)	K 291	the emergency transfer switch in the mechanical room. There was no direct harm to any resident. 2) POTENTIAL AFFECT ON OTHER RESIDENTS: Potential to affect the correct operation of the the emergency lighting system including the testing of the back up battery. There is the potential to affect all residents. 3) SYSTEMIC CHANGES: Documentation on the functional testing of the emergency lighting system will be logged weekly by the MD. 4) MONITORING: MD will add to his quality measures checklist weekly documentation and monthly audits. 5) IMPLEMENTATION: The Steering Committee of the QAPI is scheduled for April 23rd, 2025 where we will review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one full year.	
K 293 SS=F	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.	K 293		2/26/25

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K 293	Continued From page 5 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/06/25 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure exit and directional exit signs were provided and marked by approved, readily visible signs in all cases where the exit or way to reach the exit was not readily apparent to the occupants in accordance with NFPA 101: 2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect approximately 27 residents and was evidenced by the following: An observation at 12:49 AM, revealed the Kitchen exit access was not provided with an exit or directional sign. In an interview at the time, the US FOIA [redacted] confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 1/08/2025 at 1:55 PM. NJAC 8:39-31.1 (c), 31.2(e)	K 293	1) POTENTIAL FOR RESIDENT: Potential to affect safe evacuation during an emergency. There was no direct harm to any resident. 2) POTENTIAL AFFECT ON OTHER RESIDENTS: Potential to affect safe evacuation during an emergency. There is a potential for all residents to be affected. 3) SYSTEMIC CHANGES: Three doors were noted to be deficient/with no exit signs in the kitchen area. Two reflective signs were installed on two doorways on 01/07/2025. An illuminated Exit sign was ordered and will be installed to the third door after the contracted licensed electrician installs the proper wiring needed. This was completed on 02/10/2025 Will attach the invoice that reflects the completion. 4) MONITORING: MD using Quality Indicators as the monitoring tool will ensure all exit signs are visible and operating (if electrically wired). This will be a monthly check/audit and reported through the quarterly Safety Committee to the quarterly QAPI committee.	

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K 293	Continued From page 6	K 293	5) IMPLEMENTATION: A Steering Committee of the QAPI is scheduled for April 23, 2025 to review the statement of deficency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		3/26/25

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K 321	Continued From page 7 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 1/6/2025 in the presence of U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2,19.3.2.1.3, 8.4 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all 27 residents and was evidenced by the following: Observations with US FOIA (b)(6) From 9:15AM to 3:05 PM, revealed 10 of 11 storage rooms were approximately 80 square feet containing combustibles. The doors were not provided with self-closing device. In an interview at the time, the US FOIA confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 1/8/2025 at 1:55 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 321	Plan of Correction: It was found facility had 10 out of 11 storage rooms that contain combustibles without the doors having a self-closing device. 1) POTENTIAL FOR RESIDENT: There is a potential to affect safe storage areas in the facility. There was no direct harm to any resident. 2) POTENTIAL AFFECT ON OTHER RESIDENTS: The potential to affect safe storage areas in the building does affect all residents in the facility. 3) SYSTEMIC CHANGES: MD (Maintenance Director) purchased 10 door self-closure devices . A vendor was contracted to install these devices by 02/28/2025. Update: All 10 door self closure devices were installed/completed on 02/07/2025. Supporting document/invoice with completion date attached. Updated: New supporting document attached 4) MONITORING: All current self-closure doors are presently monitored monthly using the MD Quality Indicator report. The additional 10 will be added to this document. 5) IMPLEMENTATION: A Steering Committee of the QAPI is	

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K 321	Continued From page 8	K 321	scheduled for April 23rd, 2025 to review statement of deficency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one full year.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interviews from 1/06/2025 to 1/08/2025 in the presence of the [redacted], it was determined that the facility failed to ensure that sprinklers systems were maintained in accordance with NFPA 25: 2011 Edition, Sections 5.2,5.2.1.1.1, and 5.2.1.1.2. This deficient practice had the potential to affect all 27 residents and was evidenced by the following:	K 353	PLAN OF CORRECTION: It was found that facility failed to ensure sprinkles systems were maintained according to NFPA 25: 2011 Edition. 1) POTENTIAL FOR RESIDENT: Potential to affect the safe operations of the fire/sprinkler system for the whole facility	2/14/25

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ST CATHERINE OF SIENA	**7 RYERSON AVENUE** **CALDWELL, NJ 07006**

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K 353	Continued From page 9 An observation on 01/06/2025 at 12:25 PM, revealed a sprinkler head in room #219 contained signs of oxidation. Documentation review on 1/08/2025 at 9:17AM revealed the following: a. Sprinkler quarterly report dated 12/03/2024, Vendor indicated Deficiency #1 The supervisory alarm signal for fire pump was not received at the panel and central station. b. Fire pump monthly test report dated 11/07/2024, Vendor indicated supervisory signals come into panel incorrectly. When pump was OFF panel receives pump RUNNING. No further documentations for repairs were provided. In an interview at that time, the [redacted] acknowledged and confirmed the observation. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 1/08/2024 at 1:55 PM. N.J.A.C 8:39-31.2(e) NFPA 25	K 353	There was no direct harm to any resident. 2) POTENTIAL AFFECT ON OTHER RESIDENTS: Potential to affect the safe operation of the facility fire/sprinkler system. There is potential to affect all residents. 3) SYSTEMIC CHANGES: a. The vendor rectified the deficency #1 on 01/07/2025. The supervisory alarm signal was tested and received at panel and central station. b. The vendor repaired the incorrect signals the fire pump was receiving. When pump is off the panel now reflects that the pump is off. When the pump is running, the supervisory panel now indicates the pump is running. Vendors reports of unsafe operations will addressed immediately. 4) MONITORING: All vendor reports will be reviewed by MD after each visit. MD will notify the Administrator of any concerns identified. 5) IMPLEMENTATION: The Steering Committee of the QAPI is scheduled for April 23rd, 2025 where we will review the statement of deficency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one full year.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC	K 521		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315471	A. BUILDING **01** B. WING _____	**01/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	**7 RYERSON AVENUE** **CALDWELL, NJ 07006**

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K 521	Continued From page 10 Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 1/6/2025 in the presence of US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure 4 of 27 residents bathroom ventilation systems were functionally maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice had the potential to affect 4 residents and was evidenced by the following: Observations during the tour between 9:15 AM and 3:05 PM in the presence of US FOIA (b)(6), revealed in resident rooms #204, #205, #223 and #226, the exhaust systems in the bathroom were not functioning when tested by [redacted] In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 1/8/2025 at 1:55 PM N.J.A.C 8:39-31.2(e)	K 521	PLAN OF CORRECTION: IT WAS DETERMINED THE FACILITY FAILED TO ENSURE 4 OUT OF 27 RESIDENT BATHROOMS VENTILATION SYSTEMS WERE FUNCTIONALLY MAINTAINED. 1) POTENTIAL FOR RESIDENT: Potential to affect the 4 resident's whose rooms (#204, #205, #223, and #226) were identified as having an inoperable bathroom ventilation fan. 2) POTENTIAL TO AFFECT ON OTHER RESIDENTS: Potential to affect the quality/safety of the air in each residents room/bathroom. All other residents can be potentially affected. 3) SYSTEMIC CHANGES: The fans identified were repaired on 1/27/2025. All additional exhaust fan to ensured proper working order. No addition fans were identified as not working/ operating correctly. If a non-functioning ventilator fan is identified, the ventilator fan will be repaired within 2 days. In addition, bi- weekly environmental rounds will now include ensuring	

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K 521	Continued From page 11	K 521	bathroom ventilator fans are operating. 4) MONITORING: Bi-weekly environmental rounds will be conducted and include bathroom ventilator fans to ensure they are operating correctly. A quarterly audit will be conducted by the MD. 5) IMPLEMENTATION: The Steering Committee of the QAPI is scheduled for April 23rd, 2025 where we will review the statement of deficency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year.	
K 918 SS=F	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		2/14/25

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K 918	Continued From page 12 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 documentation review and interview on 1/7/2025 in the presence of US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was tested and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all 27 residents and was evidenced by the following: A review of the facility's generator annual service report dated 10/21/ 2024, provided by the US FOIA [redacted] revealed no record on diesel fuel sample analysis test had been conducted. No further documentation was provided regarding diesel fuel sample analysis test had been conducted. In an interview at 11:20 AM, the US FOIA [redacted] confirmed the findings. The facility's US FOIA (b)(6) was informed of the	K 918	Plan of Correction: It was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was tested and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition). 1) POTENTIAL FOR RESIDENT: The potential to affect the safe operation of the emergency generator. There was no direct harm to any resident. 2) POTENTIAL AFFECT ON OTHER RESIDENTS: The potential to affect the operation of the Emergency Generator for the entire building. There is a potential to affect all residents. 3) SYSTEMIC CHANGES: MD has contacted and requested that the	

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K 918	Continued From page 13 deficient practice at the Life Safety Code survey exit on 1/8/2025 at approximately 1:55 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	annual service contract with the generator vendor include testing the standby generator diesel fuel quality annually to ensure no contamination is present. The MD received an estimate to inspect the emergency generator diesel full by 02/28/2025. Thereafter it will be included during the annual inspection which is sceduled for 04/01/2025. 4) MONITORING: After the initial inspection scheduled for 02/2025, the annual inspection will include the diesel fuel testing to ensure there is no contamination. 5) IMPLEMENTATION: A steering Committee of the QAPI is scheduled for April 23rd, 2025 to review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one full year.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance	K 921		2/14/25

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K 921	Continued From page 14 with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 1/6/2025 and 1/7/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3,10.5.2.1,10.5.2.1.2,10.5.2.5,10.5.3,10.5.6 and 10.5.8. This deficient practice had the potential to affect all 27 residents and was evidenced by the following: Observations on 1/6/2025 from 9:15 AM to 3:05 PM, revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility.	K 921	PLAN OF CORRECTION: It was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition. 1) POTENTIAL FOR RESIDENT: Potential to affect the correct operation/maintanence of all electrical equipment in resident rooms to ensure their safety and wellbeing. There was no direct harm to any resident. 2) POTENTIAL AFFECT ON OTHER RESIDENTS:	

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K 921	Continued From page 15 In an interview at the time, the [US FOIA] confirmed the findings. Documentation review on 1/7/2025 revealed no policy on patient care related electrical equipment. In an interview at that time, the [US FOIA] confirmed the finding and acknowledged that no policy was provided. The facility's [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 1/8/25 at 1:55 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	Potential to affect the safe operation/maintenance of all electrical equipment in resident rooms. There is a potential to affect all residents. 3) SYSTEMIC CHANGES: New electrical policy was been created and will be followed as of 02/01/2025. Included in the policy is the placement of inspection stickers 02/15/2025 on all electrical equipment in each resident room. MD will conduct a quarterly inspection. 4) MONITORING: A bi-weekly environmental rounds checklist will now include checking the electrical equipment in each room. Immediate repairs needed will be complete on same day of inspection or item will be removed from room if electrical equipment is found to be not operating correctly. 5) IMPLEMENTATION: A steering Committee of the QAPI is scheduled for April 23rd, 2025 to review statement of deficency and plan of correction. Thereafter it will be repoerted quarterly to the QAPI Committee for at least one full year.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923		2/14/25

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K 923	Continued From page 16 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/06/2025, in the presence of US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that medical oxygen cylinders were being stored in accordance with NFPA	K 923	PLAN OF CORRECTION: It was determined that the facility failed to ensure that medical oxygen cylinders were being stored in accordance with NFPA 101:2012 Edition. Section 19.3.2.4,8.7 and NFPA	

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K 923	Continued From page 17 101:2012 Edition. Section 19.3.2.4,8.7 and NFPA 99. This deficient practice had the potential to affect all 27 residents and was evidenced by the following: At 12:20PM, the surveyor observed 2 empty cylinders of portable oxygen were not segregated from 6 full portable oxygen cylinders in the oxygen storage closet. There were no signs observed indicating if the cylinders were FULL or EMPTY to avoid confusion in an emergency. In an interview at the time, the US FOIA confirmed the above observation. The facility's US FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 01/08/2025 at 1:55PM N.J.A.C 8:39-31.2(e). NFPA 99.	K 923	99. This deficient practice had the potential to affect all 27 residents. 1) POTENTIAL FOR RESIDENT: Potential to affect the safe storage of portable oxygen tanks. There was no direct harm to any resident. 2) POTENTIAL AFFECT ON OTHER RESIDENTS: Potential to affect the safe storage of both full and empty potable oxygen tanks was apparent. There is the potential to affect all residents in the facility, both regarding the safety of tanks in the storage room as well as the use in an emergency when a full portable tank is needed but not properly labeled as full or empty. 3) SYSTEMIC CHANGES: MD (Maintenance Director) purchased correct Full/Empty signs on 01/08/2025 and placed in medical oxygen storage room. MD also purchased and installed 2 sets of 6 each tank racks. 4) MONITORING: MD will monitor/check bi weekly during Environmental rounds to ensure all portable O2 tanks are being stored properly. An in-service by the Nurse Educator will be given to all clinical staff by 02/13/2025 to ensure all staff who have access to the O2 tanks understand the importance of proper storage. 5) IMPLEMENTATION: A Steering Committee of the QAPI is scheduled for April 23rd, 2025 to review	

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K 923	Continued From page 18	K 923	statenet of deficency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one full year.	

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
315471 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE CALDWELL, NJ 07006

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 K0225	01/31/2025	LSC K0281	02/03/2025	LSC K0291	02/14/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	02/26/2025	LSC K0321	03/26/2025	LSC K0353	02/14/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	02/14/2025	LSC K0918	02/14/2025	LSC K0921	02/14/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	02/14/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/7/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO