STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING _____ B. WING _____	C 04/09/2024

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RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00166492, NJ00168703, NJ00172195, NJ00171859, NJ00169098, NJ00169722, NJ00165993, NJ00171738, NJ00168609, NJ00169823 Survey Date: 4/9/2024 Census: 251 Sample: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
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: NJ #165993 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 2 of 35 residents, Resident #200 and #655 reviewed for accuracy for MDS coding. This deficient practice was evidenced by the	F 641	Runnells Rehabilitation and Health Care Center Facility ID: 315009 Survey date 4-1-2024 F641 SS D ELEMENT ONE: CORRECTIVE ACTION: The Minimum Data Set (MDS), for residents # 200 and #655 were immediately corrected and resubmitted.	4/26/24

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

Electronically Signed | 04/26/2024

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F 641	Continued From page 1 following: 1. On 4/02/24 at 09:33 AM, the surveyor interviewed Resident #200 in their room. Resident #200 NJ ex order 26.4b1 NJ ex order 26.4b1 . On 4/4/24 at 9:10 AM, the surveyor reviewed Resident #200's hybrid (paper and electronic) medical records. The Admission Record (AR) documented the resident had diagnoses that included but were not limited to, NJ ex order 26.4b1 NJ ex order 26.4b1 , NJ ex order 26.4b1 A review of a Annual MDS assessment, dated NJ ex order 26.4b1, indicated in Section NJ E-Medications, under N0415. NJ ex order 26.4b1: Use and Indication, Resident #200 NJ ex order 26.4b1 A review of the Order Summary Report included a physician's order dated NJ ex order 26.4b1 which read, "NJ ex order 26.4b1 " On 4/08/24 at 11:48 AM, the surveyor interviewed US FOIA (B) (6)), who stated all resident who are taking an medication should have that coded in their MDS. The surveyor reviewed with MDSC the annual MDS assessment of Resident #200. MDS coordinator #1 stated the coding was a data entry error. US FOIA (B) (6) stated the MDS assessment would be corrected.	F 641	ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents that have falls or are on Antidepressant medications are at risk. An audit was completed by the MDS coordinator of 3 months MDS submissions on residents with falls and/or on antidepressant medication to ensure coded correctly. ELEMENT THREE: SYSTEMIC CHANGES: Regional MDS educated MDS Coordinators on correct MDS coding. QUALITY ASSURANCE: To maintain and monitor ongoing compliance, Regional MDS Coordinator/designee will audit monthly x3 months 10 residents per unit who are on antidepressants or had a fall in the previous 30 days to ensure coded correctly. Quarterly thereafter, Regional MDS Coordinator/designee will audit 5 charts per unit of residents who are on antidepressants or had a fall, to ensure coded correctly. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Compliance: 4/26/24	

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F 641	Continued From page 2 According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 3-page N7-9-.."N0415C1. Antidepressant: Check if an antidepressant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). N0415C2. Antidepressant: Check if there is an indication noted for all antidepressant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). On 4/9/24 at 9:00 AM, the US FOIA (B) (6) US FOIA (B) (6)) provided the surveyors with a facility policy titles, Electronic Transmission of MDS with a revision date of December 2010. The policy stated under the policy interpretation and implantation section, "The MDS Coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data." On 4/9/24 at 11:30 AM, the survey team met with the US FOIA (B) and US FOIA (B) (6) US FOIA (B) (6) US FOIA (B) to discuss the MDS coding error. The acknowledged the errors and stated they would fix errors that were discovered. No further comment made. 2. On 4/3/23 at 12:30 PM, the surveyor requested for the reportable, incidents, and accidents for Resident #655 from the US FOIA (B) (6) Services.	F 641		

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A review of the incident and accident report (Risk Management Assessment form (RMA; used to document, identify, and control risks) for Resident #655 included the following:

On 8/14/23 at 10:52 PM, the NJ ex order 26.4b1 NJ ex order 26.4b1 by the Certified Nursing Assistant (CNA #1). The resident informed the US FOIA (B) that he/she wanted to get "ice water". The resident was educated to consistently request for assistance.

On 8/20/23 at 6:57 PM, the Resident informed CNA #2 that he/she NJ ex order 26.4b1 NJ ex order 26.4b1. The resident was educated and redirected. The physician was informed, who then ordered NJ ex order 26.4b1 NJ ex order 26.4b1

On 8/30/23 at 3:41 PM, an Unsampled Resident reported to the US FOIA (B) (6) that while outside, he/she observed Resident #655 NJ ex order 26.4b1 in the presence of the resident's NJ Exec Ord After returning to the facility, the family member did not report the resident's NJ ex. The resident was assessed upon return, and the US FOIA (B) documented that there were NJ ex order 26.4b1 At that time, the NJ Exec Ord was interviewed and stated that the resident NJ ex order 26.4b1, the resident's NJ ex order 26.4b1 NJ ex order 26.4b1. The NJ Exec Ord was educated to inform the facility of any incident.

On 9/4/23 at 7:24 AM, the resident NJ ex order 26.4b1 NJ ex order 26.4b1 by LPN#2. The resident informed LPN#2 that he/she went to the rest room, and while trying

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F 641	Continued From page 4	F 641		

to get back onto the bed, he/she NJ ex order 26.4b1 NJ ex order 26.4b1. The US FOIA (B) (6) documented that the resident was NJ ex order 26.4b1 [redacted]

The surveyor reviewed Resident #655's hybrid medical record.

A review of Resident #655's Admission Record (AR) (an admission summary) reflected that the resident was admitted to the facility with diagnoses which NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted].

A review of Resident #655's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4 [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ ex [redacted] out of 15, which indicated that Resident #655's NJ ex order 26.4b1.

Further review of section NJ Exec Order 2 [redacted], Any NJ Exec O [redacted] since Admission/Entry or Re-entry or Prior Assessment, whichever is more recent reflected NJ ex [redacted] which indicated NJ ex [redacted].

On 4/8/23 at 9:30 AM, during an interview with the surveyor, the US FOIA (B) (6) [redacted] stated that the quarterly MDS information was based of the nurses' progress notes (PN). The qMDS for NJ ex order 26.4b [redacted], encompassed information from NJ ex order 26.4b [redacted] to NJ ex order 26.4b [redacted]

At that time, the surveyor asked the US FOIA (B) (6) why

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F 641	Continued From page 5	F 641		

the documented falls on the PN that occurred on NJ ex order 26.4b1, were not reflected on the qMDS dated NJ ex order 26.4b

At that time, the US FOIA (B) (6) stated that she had signed the qMDS for NJ ex order 26.4b for completion however the US FOIA (B) (6)) who completed and signed section for for that qMDS should have included the data.

At that time, the US FOIA (B) (6) informed the surveyor that US FOIA (B) (6) was not in the facility that day but would reach out for more information as to why it was not included.

At that time, the US FOIA (B) (6) stated that the accuracy of the MDS was important for care plan and other assessment for their residents.

A review of the resident's Care Plan reflected focus, goal and interventions for the NJ ex ord that occurred on NJ ex order 26.4b1, and NJ ex order 26.4

On 4/8/23 at 11:53 AM, the US FOIA (B) (6) US FOIA (B) (6) confirmed with the surveyor that section NJ Exec Order 2 of the qMDS for NJ ex order 26.4b1, was missed, and informed the surveyor that the qMDS for NJ ex order 26.4b1, would be revised for correction after surveyor inquiry.

A review of the facility policy provided, Electronic Transmission of the MDS revised December 2010, included the following:
Policy Statement
All MDS assessments ...will be completed electronically encoded into our facility's MDS information system and transmitted to CMS QIES Assessment Submission and Processing (ASAP)

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F 641	Continued From page 6 system in accordance with current OBRA regulations governing the transmission of MDS data. Policy Interpretation and Implementation 6. The MDS Coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking.	F 641		
F 712 SS=D	NJAC 8:39-11.1, 11.2(e)(1) Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 712		4/26/24

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F 712	Continued From page 7 Based on interview and record review, it was determined that the facility failed to ensure that the primary physician responsible for supervising the care of residents conducted face to face visits and wrote progress notes at least once every sixty days. This deficient practice was identified for 1 of 35 (Resident #658) reviewed for NJ ex order 26.4b1 NJ ex order and was evidenced by the following: On 4/4/24 at 12:40 PM, the surveyor reviewed the closed paper and electronic medical record for Resident #658. The Admission Record (a summary of important information about a resident) documented that Resident #658 had diagnoses that included but NJ ex order 26.4b1 . A review of physician progress notes revealed the following: On NJ ex order 26.4b, a medical visit note was completed by the resident's primary physician. On NJ ex order 26.4b, a medical visit note was completed by the US FOIA (b)(6) On NJ ex order 26.4b, a medical visit note was completed by the US FOIA (b)(6)). On NJ ex order 26.4b1, a medical visit note was completed by the US FOIA (b)(6)). On NJ ex order 26.4b a medical visit note was completed by the US FOIA (b)(6)). There was no documented evidence that the primary physician visited and examined Resident #658 at least every 60 days. On 4/4/24 at 1:50 PM, the surveyor interviewed the US FOIA (B) (6) about the physician	F 712	Runnells Rehabilitation and Health Care Center Facility ID: 315009 Survey date 4-1-2024 F712- D ELEMENT ONE: CORRECTIVE ACTION: Resident # 658 NJ ex order 26.4b1 NJ ex order 26.4b1 . The Physician on record for resident # 658 NJ ex ord NJ ex order 26.4b1 with US FOIA (B) US FOIA (B) (6) . ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: Any resident which is assigned to a physician with an alternating Advance Nurse Practitioner has the potential to be affected. An audit was completed by the Administrator, DON, and Unit Managers of the last 30 days of physician visits to ensure that all monthly physician visits were completed by their primary designated physician or alternating with the assigned physicians APN's. ELEMENT THREE: SYSTEMIC CHANGES: RN/LPN's, Physicians and APNs were educated on the facilities policy "regarding Physician and APN monthly visits". A certified letter was also sent to all Primary Physicians/APN's to ensure they received a copy of the policy.	

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F 712	Continued From page 8 progress notes for Resident #658. US FOIA (B) (6) US FOIA (B) (6) acknowledged physicians were to conduct face-to-face visits at least every 30 days or at least every 60 days when alternating visits with an US FO. On 4/8/24 at 10:07 AM, the surveyor interviewed the US FOIA (B) (6) about the physician visits and documentation for Resident #658. The US FOIA (B) stated there should be documentation by the primary physician for the resident and would look to provide further information. On 4/8/24 at 11:18 AM, the surveyor called to speak with the primary physician over the phone and left a message with the office for a call back. On 4/8/24 at 12:21 PM, the surveyor received a return telephone call from the US FO who worked in collaboration with the resident's primary physician. The US FO informed the surveyor that she visited the residents at least monthly. The US FO stated when alternating with the physician, the physician would be required to visit quarterly, every three months. On 4/9/24 at 11:50 AM, the survey team met with the US FOIA (B) (6), US FOIA (B), US FO US FOIA (B) (6), and regional staff. The surveyor informed the facility of the concern of the physician conducting face-to-face visits at least every 60 days when alternating with an US FO. There was no additional information provided by the facility. A review of the provided facility policy titled "Physician Visits", under Policy Interpretation and Implementation read: "After the first ninety (90) days, if the Attending Physician determines that a	F 712	QUALITY ASSURANCE: To maintain and monitor ongoing compliance, Administrator/DON and or designee will audit monthly x3 months 10 random residents per unit and quarterly thereafter to ensure all primary physicians monthly visits with an assigned APN are complying with the alternating monthly visits with their APN. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Compliance: 4/26/24	

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F 712	Continued From page 9 resident need not be seen by him/her every thirty (30) days, an alternate schedule for visits may be established, but not to exceed every sixty (60) days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation ..." NJAC 8:39 - 23.2 (d)	F 712		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		4/26/24

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F 758	Continued From page 10 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Complaint NJ #165993 Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to adequately monitor the target behaviors for the number of episodes, behavioral interventions, and its outcomes for the use of psychotropic medications (mood altering medications) in accordance with facility policy. This deficient practice was identified for one (1) of six (6) residents (Resident #656) NJ exorder 26.4b1 NJ exorder 26.4b1 , and was evidenced by the following: A review of the reportable event record/report	F 758	Runnells Rehabilitation and Health Care Center Facility ID 315009 Survey date 4-1-2024 F758- D ELEMENT ONE: CORRECTIVE ACTION: resident #656 has NJ exorder 26.4b1 NJ exorder 26.4b1 . Nursing staff were re-educated on behavior monitoring documentation including correct documentation on number and types of behaviors and interventions and the outcome of interventions including non -pharmacological interventions. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents who are on psychotropic	

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F 758	Continued From page 11 (FRI; Facility Reported Incident) that was called in on NJ exorder 26.4b1 at 1:10 PM. The FRI occurred on NJ exorder 26.4b, at approximately 11:22 AM, and was reported an NJ exorder 26.4b1 NJ exorder 26. The event description included the following: At around 11:22 AM on NJ exorder 26.4b, the US FOIA (B) (6) was in the hallway by her medication cart when she witnessed Resident #656, and Resident #657 NJ exorder 26.4b1 NJ exorder 26.4b. The LPN witnessed Resident #656 NJ exorder 26.4b1 #657 NJ exorder 26.4b NJ exorder 26.4b1 The LPN NJ exorder 26.4b1 ... A review of Resident #656's Admission Record (AR) (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ exorder 26.4b1 NJ exorder 26.4b1 A review of Resident #656's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ exorder 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ exo out of 15, which indicated that Resident #656's NJ exorder 26.4b1 NJ exorder 26. Additionally, section NJ Ex NJ exorder 26.4b1 A review of the Order Summary Report contained Physician Orders that were active orders for NJ exorder NJ exorder which included the following: -NJ exorder 26.4b1	F 758	medication have the potential to be affected. An audit was completed by the Administrator, DON, and Unit managers of each unit to ensure that all behavior monitoring orders are thorough and accurate including correct documentation on number and types of behaviors and interventions and the outcome of interventions including non -pharmacological interventions. ELEMENT THREE: SYSTEMIC CHANGES: Nursing was educated on behavior monitoring documentation, which included, correct documentation on number and types of behaviors and interventions and the outcome of interventions including non -pharmacological interventions. Audit of 10 random residents per unit will be completed by every nurse manager or designee for a total of 60 residents for each month of April, May, and June, then every other month x3 months and quarterly thereafter to ensure proper behavioral documentation is accurate on all MARS. QUALITY ASSURANCE To maintain and monitor ongoing compliance, Administrator/ DON or designee will audit completed audits submitted monthly. Needed corrections and further in servicing will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance	

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F 758	Continued From page 12 -Behavior Monitoring for medication: NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] A review of the Progress Notes from NJ ex order 26.4 [redacted], NJ ex order 26.4b1, revealed behaviors were observed, NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 for the following dates: 1) NJ ex order 26.4 [redacted] at 9:54 PM 2) NJ ex order 26.4 [redacted] at 12:48 PM 3) NJ ex order 26.4 [redacted] at 12:49 PM 4) NJ ex order 26.4 [redacted] at 12:35 AM 5) NJ ex order 26.4 [redacted] at 12:35 AM 6) NJ ex order 26.4 [redacted] at 12:29 AM 7) NJ ex order 26.4 [redacted] at 12:29 AM 8) NJ ex order 26.4 [redacted] at 12:28 AM 9) NJ ex order 26.4 [redacted] at 12:28 AM 10) NJ ex order 26.4 [redacted] at 1:54 PM 11) NJ ex order 26.4 [redacted] at 1:54 PM 12) NJ ex order 26.4 [redacted] at 12:38 PM 13) NJ ex order 26.4 [redacted] at 12:39 PM 14) NJ ex order 26.4 [redacted] at 12:26 PM (not reflected on the eMAR) 15) NJ ex order 26.4 [redacted] at 2:57 PM (not reflected on the eMAR) 16) NJ ex order 26.4 [redacted] at 2:57 PM (not reflected on the eMAR) 17) NJ ex order 26.4 [redacted] at 12:11 PM 18) NJ ex order 26.4 [redacted] at 12:11 PM 19) NJ ex order 26.4 [redacted] at 2:50 PM 20) NJ ex order 26.4 [redacted] at 12:07 AM	F 758	Improvement team for review and action as necessary. Date of Compliance: 4/26/24	

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21) NJ ex order 26.4b at 12:07 AM
22) NJ ex order 26.4b at 7:00 PM
23) NJ ex order 26.4b at 7:00 PM

A review of the electronic Medication Administration Record (eMAR) for NJ ex order 26.4b1 included the following orders:

-NJ ex order 26.4b1 with a start date NJ ex order 26.4b1 and end date of NJ ex order 26.4b1):
NJ ex order 26.4b1 of
NJ ex order 26.4b1 The
NJ ex order 26.4b1
NJ ex order 26.4b1 , NJ ex order 26.4b1 on the following dates:

1) NJ ex order 26, for the day shift (7:00 AM to 3:00 PM)
2) NJ ex order 26, for the night shift (11:00 PM to 7:00 AM)
3) NJ ex order 26.4, for the night shift
4) NJ ex order 26.4b, for the night shift
5) NJ ex order 26.4b, for the day shift
6) NJ ex order 26.4b, for the day shift
7) NJ ex order 26.4b for the night shift
8) NJ ex order 26.4b, for the night shift

-NJ ex order 26.4b1
NJ ex order 26.4b1
-NJ ex order 26.4b1
. NJ ex order 26.4b1
NJ ex order 26.4b1
and NJ ex order 26.4b1
NJ ex order 26.4b1 on the following dates:

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1) NJ ex order 26.4b1 for the day shift (7:00 AM to 3:00 PM)
2) NJ ex order 26.4b1 for the night shift (11:00 PM to 7:00 AM)
3) NJ ex order 26.4b1 for the night shift
4) NJ ex order 26.4b1 for the night shift
5) NJ ex order 26.4b1 for the day shift
6) NJ ex order 26.4b1 for the night shift
7) NJ ex order 26.4b1 for the day shift
8) NJ ex order 26.4b1 for the night shift

A review of the Order Summary Report contained Physician Orders that were active orders for NJ ex order 26.4b1 which included the following:

NJ ex order 26.4b1

NJ ex order 26.4b1

NJ ex order 26.4b1

NJ ex order 26.4b1

A review of the Progress Notes from NJ ex order 26.4b1, to NJ ex order 26.4b1, revealed behaviors were observed, but did not indicate whether the NJ ex order 26.4b1 on the following dates:

1) NJ ex order 26.4b1 at 1:41 PM
2) NJ ex order 26.4b1 at 1:42 PM
3) NJ ex order 26.4b1 at 9:52 PM
4) NJ ex order 26.4b1 at 9:52 PM
5) NJ ex order 26.4b1 at 2:07 PM
6) NJ ex order 26.4b1 at 2:07 PM
7) NJ ex order 26.4b1 at 12:52 PM

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8) NJ ex order 26.4b at 12:53 PM
9) NJ ex order 26.4b at 11:40 PM
10) NJ ex order 26.4b at 11:44 PM
11) NJ ex order 26.4b at 11:42 PM
12) NJ ex order 26.4b at 11:43 PM
13) NJ ex order 26.4b at 12:43 PM
14) NJ ex order 26.4b at 12:43 PM
15) NJ ex order 26.4b at 12:19 AM
16) NJ ex order 26.4b at 12:20 AM
17) NJ ex order 26.4b at 12:10 AM
18) NJ ex order 26.4b at 12:10 AM
19) NJ ex order 26.4b at 6:36 PM
20) NJ ex order 26.4b at 6:36 PM

A review of the electronic Medication Administration Record (eMAR) for NJ ex order 26.4b1 included the following orders:

-NJ ex order 26.4b1

-NJ ex order 26.4b1 The reflected that behaviors were documented without the number of episodes, without an intervention (non-pharmacological), and without the outcome of the intervention on the following dates:

1) NJ ex order 26.4b1
2) NJ ex order 26.4b1

-NJ ex order 26.4b1

-NJ ex order 26.4b1 . The BMFM reflected that behaviors were documented without the

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number of episodes, without an intervention (non-pharmacological), and without the outcome of the intervention on the following dates:
1) NJ ex order 26, for the night shift
2) NJ ex order 26.4b, for the night shift
3) NJ ex order 26.4b, for the night shift
4) NJ ex order 26.4b, for the day shift
5) NJ ex order 26.4b, for the night shift
6) NJ ex order 26.4b, for the night shift
7) NJ ex order 26.4b, for the night shift

A review of the NJ Exec Order 26.4b1 Follow-Up Form dated NJ ex order 26.4b included the following NJ ex order 26.4b1 NJ ex order 26.4b1 .NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 ...

A review of the NJ Exec Order 26.4b1 Follow-Up Form dated NJ ex order 26.4b included the following: NJ ex order 26.4b1 ..

On 4/8/24 at 10:43 AM, during an interview with the surveyor, the US FOIA (B) (6) US FOIA (b)(6) could not explain why the behaviors under the progress note was not specific to the behavior, the number of episodes, interventions made were not specified, and the outcome of a non-pharmacological intervention(s) were not reflected on certain dates on NJ ex order 26.4b1 and NJ ex or NJ ex order of the eMAR. The concerns were communicated with the US FOIA (B) (6).

On 4/8/23 at 12:37 AM, during an interview with the surveyor, the US FOIA (B) (6)

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stated that she had reviewed the eMAR for the discussed concerns with the [US FOIA (b)(6)] and interviewed four (4) nurses who had indicated Yes for behavior on the eMAR without documentation of the number of episodes, interventions made, and the non-pharmacological intervention outcome.

At that time, the [US FOIA (6)] informed the surveyor that the nurses who had marked yes, on the eMAR meant that they had administered the medication to the resident and did not understand how to properly use the [NJ Exec Order 2] The [US FOIA (6)] acknowledged that the order was for NJ Ex Order 26.4b1, not administration of the medication and the documentation on the [NJ Exec Order] was incorrect.

At that time, the [US FOIA (6)] stated that a facility wide in-service/education for behavior monitoring documentation would be conducted to increase the nurses' understanding.

A review of the undated facility provided policy, Behavioral Assessment and Monitoring included the following:
Policy Statement
Problematic behaviors will be identified and managed appropriately with minimal complications using non-pharmacological and/or pharmacological approaches as appropriate.
Monitoring
1. Exception charting will be used to document the occurrence of any problematic behaviors, interventions implemented, and the resident response to interventions when these behaviors occur.

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #NJ172195 Complaint #NJ171859 Complaint #NJ169722 Complaint #NJ169823 Complaint #NJ165993 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the	S 560	Runnells Center for Rehabilitation Facility ID 315009 S560 Element One - Corrective Action: Facility currently working on employee engagement to aide in employee retention. In addition, the facility has an on the spot hiring program, and in addition to utilizing [redacted] has recently initiated Indeed to aid in increasing pool of job candidates. The facility is currently engaging in aligning itself with local nursing schools as use for clinical rotation for student nurses thus introducing them to facility and encouraging and engaging students to have facility be their first	4/26/24

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

Electronically Signed | 04/26/24

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S 560	Continued From page 1 Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when	S 560	choice upon graduation. Element Two Identification of At-Risk Residents: All residents have the potential to be affected. Element Three Systemic Changes: The Administrator/Human Resources is responsible for staff recruitment. The facility is currently working on employee engagement to aide in employee retention. In addition, the facility has an on the spot hiring program, and in addition to utilizing Apploi, has recently initiated Indeed to aid in increasing pool of job candidates. The facility has developed a rolling orientation program to aid in immediate onboarding of staff. The facility is currently engaging in aligning itself with local nursing schools as use for clinical rotation for student nurses thus introducing them to facility and encouraging and engaging students to have facility be their first choice upon graduation. If it were determined that there was insufficient staff to meet the needs of our residents, we would implement the emergency staffing plan. QUALITY ASSURANCE To maintain and monitor ongoing compliance, HR director/designee will monitor open positions weekly and report to Administrator for follow up. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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S 560	Continued From page 2 the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for 3 segment dates that related to the standard survey and complaints revealing the following: 1. For the week of Complaint staffing from 01/08/2023 to 01/14/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -01/08/23 had 32 CNAs for 270 residents on the day shift, required at least 34 CNAs. -01/09/23 had 30 CNAs for 270 residents on the day shift, required at least 34 CNAs. -01/11/23 had 31 CNAs for 270 residents on the day shift, required at least 34 CNAs. -01/14/23 had 30 CNAs for 272 residents on the day shift, required at least 34 CNAs. 2. The facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -01/15/23 had 25 CNAs for 275 residents on the day shift, required at least 34 CNAs. -01/16/23 had 31 CNAs for 275 residents on the	S 560	Date of Completion: 4/26/24	

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day shift, required at least 34 CNAs.
-01/20/23 had 33 CNAs for 274 residents on the day shift, required at least 34 CNAs.
-01/21/23 had 32 CNAs for 274 residents on the day shift, required at least 34 CNAs.

3. For the week of Complaint staffing from 07/23/2023 to 07/29/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:

-07/23/23 had 30 CNAs for 269 residents on the day shift, required at least 34 CNAs.
-07/24/23 had 32 CNAs for 269 residents on the day shift, required at least 34 CNAs.
-07/26/23 had 30 CNAs for 269 residents on the day shift, required at least 34 CNAs.
-07/28/23 had 30 CNAs for 275 residents on the day shift, required at least 34 CNAs.
-07/29/23 had 30 CNAs for 275 residents on the day shift, required at least 34 CNAs.

4. For the 2 weeks of Complaint staffing from 12/10/2023 to 12/22/2023, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows:

-12/10/23 had 19 CNAs for 261 residents on the day shift, required at least 33 CNAs.
-12/11/23 had 26 CNAs for 261 residents on the day shift, required at least 33 CNAs.
-12/12/23 had 19 CNAs for 261 residents on the day shift, required at least 33 CNAs.
-12/14/23 had 30 CNAs for 259 residents on the day shift, required at least 32 CNAs.
-12/15/23 had 28 CNAs for 259 residents on the day shift, required at least 32 CNAs.

-12/17/23 had 24 CNAs for 259 residents on the day shift, required at least 32 CNAs.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALT	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 -12/18/23 had 27 CNAs for 258 residents on the day shift, required at least 32 CNAs. -12/19/23 had 28 CNAs for 258 residents on the day shift, required at least 32 CNAs. -12/20/23 had 27 CNAs for 258 residents on the day shift, required at least 32 CNAs. 5. For the week of Complaint staffing from 03/10/24 to 03/16/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -03/10/24 had 28 CNAs for 250 residents on the day shift, required at least 31 CNAs. -03/11/24 had 29 CNAs for 250 residents on the day shift, required at least 31 CNAs. -03/13/24 had 20 CNAs for 249 residents on the day shift, required at least 31 CNAs. 6. For the 2 weeks of staffing prior to survey from 03/17/2024 to 03/30/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -03/17/24 had 27 CNAs for 149 residents on the day shift, required at least 31 CNAs. -03/24/24 had 28 CNAs for 248 residents on the day shift, required at least 31 CNAs. On 4/5/24 at 10:16 AM, the surveyor discussed the staffing ratio concerns with the Licensed Nursing Home Administrator (LNHA) and Vice President of Clinical Services. The LNHA replied, "we're trying very hard to meet the daily facility staffing needs required." The LNHA added, "we're continuously working on improving the staffing issue."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315009	A. Building B. Wing	5/24/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

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 F0641 Reg. # 483.20(g) LSC	Correction Completed 04/26/2024	ID Prefix F0712 Reg. # 483.30(c)(1)-(4) LSC	Correction Completed 04/26/2024	ID Prefix F0758 Reg. # 483.45(c)(3)(e)(1)-(5) LSC	Correction Completed 04/26/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
22001L		5/24/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/26/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 04/03/24. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 04/03/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Runnells Center for Rehabilitation & Healthcare is a three-story building with a basement that was built in 1970's. It is composed of Type II protected construction. The facility is divided into nine - smoke zones. The generator does approximately 100 % of the building per the Maintenance Director. The current occupied beds are 246 of 297.	K 000		
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	K 281		4/26/24

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

Electronically Signed | 04/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 281	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one out of seven stairways was illuminated in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.8.1.2. This deficient practice had the potential to affect all 246 residents who resided at the facility. Findings include: An observation on 04/03/24 at 1:04 PM revealed the light fixture on the second-floor landing in stairway number six was not illuminated. During an interview at the time of the observation, the US FOIA (b)(6) confirmed there was no illumination because the light was not connected to any power. NJAC 8:39-31.1(c), 31.2(e)	K 281	Runnells Rehabilitation and Health Care Center Facility ID 315009 Survey date 4-3-2024 K281 Element One - Corrective Action: The facility permanently connected power to the light fixture on the second-floor landing in stairway number six and the light fixture is now illuminated. Element Two Identification of At-Risk Residents: Residents have the potential to be affected by this deficient practice. The Administrator and Maintenance Director completed an audit to ensure that stairwell light fixtures are illuminated. Element Three Systemic Changes: The maintenance staff was educated on ensuring that stairwell light fixtures are illuminated. The Maintenance Director or Designee will monitor stairwell light fixtures during environment of care rounds and correct any concerns noted immediately. QUALITY ASSURANCE To maintain and monitor ongoing compliance, The Administrator and Maintenance Director will review these audits on a monthly basis. Needed corrections and further in servicing will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 281	Continued From page 2	K 281	Improvement team for review and action as necessary. Date of Completion: 4/26/24	
K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the linen chute opened into a one-hour fire rated room in accordance with NFPA 101 Life Safety Code (2012 Edition)	K 541	Runnells Rehabilitation and Health Care Center Facility ID 315009 Survey date 4-3-2024	4/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 541	Continued From page 3 Section 19.5.4.1. This deficient practice had the potential to affect all 53 residents who resided on the second floor at the facility. Findings include: An observation on 04/03/24 at 1:08 PM of the linen chute which opened into a two-hour fire rated room (W 201) across from the nurse's station, revealed the south wall's drywall had three holes of 3 inches x 5 inches, 4 inches x 4 inches and 4 inches x 6 inches. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the holes were present in the south wall. NJAC 8:39-31.2(e) NFPA 82	K 541	K541 Element One - Corrective Action: The (W 201) Linen chute□s south wall drywall area with three holes was replaced on 4/03/24. Element Two Identification of At-Risk Residents: 53 residents on the unit have the potential to be affected. The Administrator and Maintenance Director completed an audit to ensure that no other holes were identified in the drywall in linen chute rooms. Element Three Systemic Changes: The maintenance staff was educated on ensuring that drywall in linen chute rooms do not have any holes. The Maintenance Director or Designee will monitor drywall in linen chute rooms quarterly and correct any concerns noted immediately. QUALITY ASSURANCE To maintain and monitor ongoing compliance, The Administrator and Maintenance Director will review these audits on a monthly basis. Needed corrections and further in servicing will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Completion: 4/26/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 246 residents who resided at the facility. Findings include: A review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence that the facility's fire doors were inspected. An observation of the facility's fire doors on 04/03/24 from 11:08 AM to 01:15 PM revealed the doors lacked the required inspection tags to	K 761	Runnells Rehabilitation and Health Care Center Facility ID 315009 Survey date 4-3-2024 K761 Element One - Corrective Action: All fire doors in the facility were inspected for compliance on 4/25/2024. Element Two Identification of At-Risk Residents: All residents have the potential to be affected. The Administrator and Maintenance Director completed an audit to ensure that there were no concerns noted with the fire doors. Element Three Systemic Changes: The	4/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 5 be placed on the doors after completed inspections. During an interview at the time of each observation, the US FOIA (b)(6) confirmed the fire doors had not been inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	maintenance staff was educated on ensuring that fire doors are inspected. The Maintenance Director or Designee will inspect fire doors quarterly. Any noted concerns will be corrected immediately. QUALITY ASSURANCE To maintain and monitor ongoing compliance, the Administrator and Maintenance Director will review these audits on a monthly basis. Needed corrections and further in servicing will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Completion: 4/26/24	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315009	A. Building 01 - MAIN BUILDING 01 B. Wing	5/24/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 04/26/2024	ID Prefix Reg. # NFPA 101 LSC K0541	Correction Completed 04/26/2024	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 04/26/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO