

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

PRINTED: 09/29/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2022
NAME OF PROVIDER OR SUPPLIER RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaints : NJ155108, NJ155950, NJ156092, NJ156587, NJ156808 Census: 284 Sample : 5 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		8/19/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/19/2022

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

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, as well as review of pertinent facility documents on 8/9/22 and 8/10/22, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) a staff to resident allegation of abuse and follow the facility policy "ABUSE REPORTING" for 1 of 2 residents (Resident #3) reviewed for incident and accident. This deficient practice is evidenced by the following: During the tour with the Unit Manager (UM #1) on 8/9/22 at 11:15 am, she stated that Resident #3 was interviewable. During an interview with Resident #3 on 8/9/22 at 11:26 am, Resident #3 revealed that on [REDACTED] during 11:00 to 7:00 am, a female aide (no name) put [REDACTED] into his/her [REDACTED] and male aide (Certified Nursing Assistant #1) punched him/her on the [REDACTED] and had called the police. He/she further added that the aforementioned incident was reported to the Director of Nursing (DON) on the same day (unable to recall time). Resident #3 further stated that he/she felt violated and abused. According to the "ADMISSION RECORD (AR)" form, Resident #3 was admitted to the facility on	F 609	F609-Reporting of Alleged Violations 1. The following corrective actions have been accomplished for the identified deficiency: -The Department of Health was notified of the alleged abuse via the reportable hotline on [REDACTED] and emailed the reportable event form on [REDACTED]. -There was no negative outcome for identified resident #3. 2. All residents with allegations of abuse have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: -All Licensed Nurses and Nursing Administration were re-educated in regard to ensuring that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident's funds are reported immediately but not later than 2 hours after the allegation is made to the Administrator or Director of Nursing at the facility in order to appropriately report to the Dept of Health and other authorities as needed regardless of resident with known		

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F 609	<p>Continued From page 2</p> <p>██████ with diagnoses that included but was not limited to: ██████.</p> <p>The Minimum Data Set (MDS), an assessment tool dated ██████, showed that Resident #3's ██████ required extensive assistance from staff in Activities of Daily Living (ADL).</p> <p>The Care Plan (CP), initiated on ██████ and revised on 7/19/22, showed that Resident had behavior problem of ██████ related to ██████. The CP further showed that on ██████ at 6:30 am, Resident #3 reported to the Residents Representative (RR) that a male aide ██████ his/her ██████ and hit him/her on the ██████, and a female aide wiped his/her ██████ with the ██████ that was used to wipe his/her ██████.</p> <p>The Progress note (PN) dated ██████ at 07:23 am, Licensed Practical Nurse (LPN #1) documented the assigned nurse to Resident #3 during 11:00 pm to 7:00 am shift. The PN documentation indicated that at 6:45 am, LPN #1 heard that Resident #3 was ██████. LPN #1 entered Resident #3's room, the Resident reported that the two aides were rough during care. The PN further indicated that on ██████ at 5:17 pm, LPN #2 documented the assigned nurse to Resident #3 during 7:00 am-3:00 pm shift. LPN #2 documented that around 11:10 am, the police arrived at the facility because Resident #3 reported that the overnight staff ██████ him/her on the ██████. Resident #3's skin had no ██████ or ██████ during the assessment.</p> <p>Futhermore, the PN showed that on ██████ at</p>	F 609	<p>accusatory behavior prior to admission to the facility.</p> <p>4. The Administrator or designee will review the nursing reports and grievance logs weekly x 90 days to ensure all allegations of abuse are appropriately being reported within the guidelines of regulations. The findings will be reported to the QAPI committee on a monthly basis x 3 months.</p> <p>Completion Date: 8/19/2022</p>		

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F 609	<p>Continued From page 3</p> <p>2:13 pm, documented by the Director of Nursing (DON), the PN showed that the office of ombudsman was made aware of Residents #3's behavior of accusing staff of abuse and calling 911.</p> <p>The Medical record (MR) showed no documented evidence to indicate that the aforementioned incident was reported to the NJDOH.</p> <p>LPN #2 was interviewed on 8/9/22 at 12:50 pm, she confirmed the aforementioned incident, an allegation of abuse on [REDACTED] involving Resident #3. LPN #2 stated that she reported the incident to UM #1 and to the DON on the aforementioned date (unable to recall time) because it is consider an allegation of abuse.</p> <p>UM # 1 was interviewed on 8/9/22 at 1:11 pm, she confirmed the aforementioned incident, an allegation of abuse on [REDACTED] involving Resident #3. UM #1 stated that she reported the incident to the DON on [REDACTED] because it was an allegation of abuse. She further added that she did not further investigate because she reported the aforementioned incident to the DON.</p> <p>Vice President Clinical (VPC) was interviewed on 8/9/22 at 1:33 pm, VCP stated that the aforementioned incident was not reported to NJDOH which was not according to the facility. The VPC further added that any allegation of abuse had to be investigated and reported to the NJDOH.</p> <p>The surveyor conducted a telephone interview with the DON on 8/10/22 at 11:02, she confirmed the aforementioned incident involving Resident #3 was reported to her, however, she did not report</p>	F 609			

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F 609	<p>Continued From page 4 to the NJDOH.</p> <p>The facility's policy titled "Your Rights and Protections as a Nursing Home Resident", undated, showed "...Be Free from Abuse and Neglect...You have the right to be free from verbal, sexual, physical, and mental abuse. Nursing Homes can't keep you apart from everyone else against your will. If you feel you have been mistreated (abused) ...report this to the nursing home...local Long-Term Care Ombudsman, or State Survey Agency. The nursing home must investigate and report all suspected violation...within 5 working days of the incident to the proper authorities..."</p> <p>The facility's policy titled "ABUSE REPORTING", dated 1/4/21, showed "...When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility Administrator, or his/her designee, will notify the following persons or agencies of such incident asap [as soon as possible] but not longer than 2 hours; a. State Licensing and Certification Agency. b. Ombudsman ...5...d. Physical abuse is defined as hitting, slapping, pinching, kicking...9. A completed copy of the initiated abuse investigation and written statements from witnesses, if any, must be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident."</p> <p>NJAC 8:39-9.4 (f)</p>	F 609			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315009	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 8/22/2022	Y3
NAME OF FACILITY RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 F0609	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.12(c)(1)(4)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	08/19/2022	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/10/2022		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		