STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315418	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	**99 EAST MAIN STREET MARLTON, NJ 08053**

(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 #:NJ00171237, 00172349,00172381,00173377,00171237 Survey Date: 9/23/2024-9/27/2024 Census: 50 Sample: 17 + 1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 604		10/22/24

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

Electronically Signed | 10/18/2024

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F 604	Continued From page 1 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a.) identify the medical symptom that warranted the use of [NJ Exec Order 26.4b1] b.) perform an assessment and evaluation for [NJ Exec Order 26.4] use; c.) obtain a consent with disclosure of risk versus benefits for use the of a [NJ Exec Order 26.4b] d.) conduct on-going evaluations for the continued use of the [NJ Exec Order 26.4b1] e.) monitor the residents during the use of the [NJ Exec Order 26.4b1] f.) document interventions to decrease and/or discontinue the use of the [NJ Exec Order 26.4b1] and; g.) release the [NJ Exec Order 26.4b1] during supervised activities. This deficient practice was identified in 1 (one) of 1 (one) residents reviewed for [NJ Exec Order 26.4b1] (Residents #19) and was evidenced by the following: Review of the Admission Record indicated that Resident #19 was admitted to the facility with the diagnoses which included but was not limited to: NJ Exec Order 26.4b1 [redacted] The significant change of status Minimum Data Set (MDS), an assessment that facilitates a resident's care dated [NJ Exec Order 26.4b1], reflected that Resident #19 had	F 604	F604 The following corrective actions have been implemented: F604 Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) Residents identified Resident # 19 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. [NJ Exec Order 26.4] was discontinued for Resident #19. New policy was created and contains the process for initiating use of a [NJ Exec Order 26.4b1] assessment for appropriateness of use of a [NJ Exec Order 26.4b] including physician order, frequency of assessment and ongoing monitoring of [NJ Exec Order 26.4b] All staff involved were in-serviced by the Staff Educator.	

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F 604	Continued From page 2 NJ Exec Order 26.4b1 . The MDS also indicated that the resident required NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 with NJ Exec Order 26.4 and NJ Exec Order 26.4b1 The MDS did not reflect that the resident utilized a NJ Exec Order 26.4b1 when in the chair or out of bed. On 09/23/24 09:14 AM, during tour, the surveyor observed Resident #19 NJ Exec Order 26.4b1 in the wheelchair (w/c), at the activities wearing a NJ Exec O . The surveyor asked the resident if he/she could NJ Exec Order 26.4b1 and the resident stated, "NJ Exec Order 26.4b1 ." The resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the surveyor what the purpose of the NJ Exec Order 26.4b was. The surveyor reviewed the resident's electronic medical records (EMRs) which revealed the following: The physician's orders dated NJ Exec Order 26.4b1 reflected a PO for a NJ Exec Order 26.4b1, apply every shift while in the w/c and to check for placement every shift. The EMR reflected that the resident was admitted to the hospital on NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 and was readmitted to the facility on NJ Exec Order 26.4b1 . The PO dated NJ Exec Order 26.4b1 contained a PO for a NJ Exec Order 26.4b1, apply every shift while in the w/c and to check for placement every shift. A review of Resident #19's comprehensive Interdisciplinary Care Plan (CP) indicated that the resident had the NJ Exec Order 26.4b1 was applied on NJ Exec Order 26.4b1 There was no	F 604	2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents using seatbelts have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were in-serviced by the Staff Educator on the following, identifying the medical symptoms warranting the use of a seatbelt, assessment and evaluation for use of seatbelt, obtaining a consent with disclosure of risk versus benefits for use of a seatbelt including order for seatbelt, care planning for seatbelt, conduct ongoing evaluation of use of seat belts including discontiuation, documentation and use of a seatbelt. Seatbelt policy was created and reviewed with all nursing staff. All new hires will also be in-serviced on orientation and ongoing by the Staff Educator. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

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F 604	Continued From page 3 documentation that the resident was assessed that NJ Exec Order 26.4b1 on request at the time the NJ Exec Order 26.4b1 applied. There was no supporting clinical documentation or medical symptom being treated or ordered for the use of the specific type of NJ Exec Order 26.4b1 There was no evidence that ongoing reevaluation or documentation of the medical symptoms and use of the NJ Exec Order 26.4b1 for the least amount of time possible found in the medical record, and there was no documentation that the NJ Exec Order 26.4b1 could be released during supervised activities. The Certified Nursing Assistant CP (CNACP) indicated that the resident had a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 There was no documentation on the CNACP that the NJ Exec Order 26.4b1 could be released at intervals or during supervised activities. The surveyor could not find any documentation in the progress notes any assessments or evaluations for the use of NJ Exec Order 26.4b1 the medical symptom that warranted the use of NJ Exec Order 26.4b1 a consent with disclosure of risk versus benefits for use the of a NJ Exec Order 26.4b1 documentation of on-going evaluations for the continued use of the NJ Exec Order 26.4b1 documentation that the resident was monitored during the use of the NJ Exec Order 26.4b1 documentation of interventions to decrease and/or discontinue the use of the NJ Exec Order 26.4b1 or that the NJ Exec Order 26.4b1 was released during supervised activities The NJ Exec Order 26.4b1) dated NJ Exec Order 26.4b1 indicated that the resident was a NJ Exec Order 26.4b1 for NJ Exec Or however the intervention section of the NJ Exe did not indicate that the facility applied the NJ Exec Order 26.4b1 even though the facility received a physician's order dated NJ Exec Order 26.4b1 to	F 604	Any resident using a seatbelt will be assessed each month for the ability to demonstrate capability of self-releasing the seat belt. Audits will be performed on all residents using seat belts by the Quality Assurance Performance Improvement(QAPI) Coordinator monthly for three months and then Quarterly until 100% compliance is achieved. Results will be reported monthly to the Director of Nursing (DON) and the Quality Assessment Assurance (QAA) committee. The DON will review audits monthly. The QAA committee meets quarterly. The QAA committee/DON will determine when the problem is resolved or if more training is required.	

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apply a NJ Exec Order 26.4b1 every shift while the resident was in the wheelchair.

On 09/23/24 at 11:27 AM, the surveyor interviewed the resident's US FOIA (b)(6) who stated that she did not know the last time Resident #19 had NJ Exec Order The US FOIA (b stated that Resident #19 had a NJ Exec Order 26.4b on for safety. The US FOIA (b stated that the resident was able to NJ Exec Order and could possibly NJ Exe so therefore the NJ Exec Order 26.4b1 the resident from being able to NJ Exec Order 26.4b1. The US FOIA (b stated that she "believed" that the resident was able to NJ Exec Order 26.4 the NJ Exec on his/her own with instructions. The US FOIA (b accompanied the surveyor to observe Resident #19 who was sitting at the activity table wearing a NJ Exec Order 26.4b1. The US FOIA (b asked the resident if NJ Ex could NJ Exec Order 26.4 the NJ Exec Order 26.4b1 and the resident responded that NJ Ex was NJ Exec Order 26.4 to NJ Exec Order 26.4 the device on his/her own. Resident #19 stated, NJ Exec Order 26.4b1 When the surveyor asked the US FOIA (b if the NJ Exec O was removed throughout the day, the US FOIA (b stated that the NJ Exec Order 26.4b1 when the resident was OOB and that the NJ Exec Order 26.4b was not removed as long as the resident was out of bed. The US FOIA (b stated that there should be a consent from the family or responsible party for the use of the NJ Exec Order 26.4 but did not know where in the medical record it could be found.

On 09/23/24 at 11:40 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she had been employed in the facility for approximately NJ Exec Order 26.4b1. The US FOI explained that Resident #19 was NJ Exec Order 26.4b1 and could NJ Exec Order 26.4b1 US FOI continued to explain that the resident used to be NJ Exec Order 26.4b1 however NJ Exe

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NJ Exec Order 26.4b had improved since NJ Ex had been treated for a NJ Exec Order 26.4b1. She stated that Resident #19 had not had any NJ Exec Order 26.4b issues since then. The US FOI stated that the resident's family was very NJ Exec Order 26.4 and visited daily. She continued to explain that the resident had NJ Exec Order 26. NJ Exec Order 2 and was NJ Exec Order 26.4b1 of NJ Exec Order 26. and NJ Exec Order 2 She stated that the resident had the current NJ Exe prevention interventions; NJ Exec Order 26.4b1 in the bed and that the bed was NJ Exec Order 26.4b1. The US FOI stated that she thought that to use the NJ Exec O that the facility would need consent from the family because it would be considered a NJ Exec Order 26.4b1 She stated that the resident had NJ Exec Order 26.4b1 issues and did not even realize the NJ Exec Order 26.4b was in place. She stated that the only physician order documented in the Medication Administration Record (MAR) was for the nurse to sign out that the NJ Exec Order 26.4b was in place. No other physician orders were required.

The surveyor reviewed the MAR and there was an order for a NJ Exec Order 26.4b1, apply every shift while in the w/c and to check for placement every shift, however there was no diagnoses for the use of the NJ Exec Order 26.4b, nor were the staff documenting that the NJ Exec Order 26.4b was being routinely released.

On 09/23/24 at 11:56 AM, the surveyor interviewed the US FOIA (b)(6)) who explained that NJ Exec Order 26.4b1 were utilized as NJ Exec Order 26.4b1 interventions and as long as the resident was able to NJ Exec Order 26. the NJ Exec Order 26. it would not be considered a NJ Exec Order 26.4b1 She stated that there must be documentation in the resident's medical record that the resident was

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F 604	Continued From page 6	F 604		

able to [redacted]. She stated that there would be documentation in the nurses note on the day the [redacted] was applied that the resident was assessed and was able to [redacted] the [redacted] The [redacted] reviewed the residents medical record in the presence of the surveyor and admitted that there was no documentation that the resident could [redacted] the [redacted] on request and there was no assessment completed when the device was applied on [redacted] The [redacted] revealed that that facility did not need consent from the family, however the nurses let the family know verbally. The [redacted] reviewed Resident #19's medical record in the presence of the surveyor and admitted that the [redacted] was applied [redacted] and put on the resident's CP on [redacted] The [redacted] stated that she was the nurse that added the [redacted] to the resident's CP on [redacted]

On 09/24/24 at 10:24 AM, the surveyor interviewed the [redacted]) who stated that she had been employed in the facility for [redacted] and the [redacted] regarding [redacted]. The [redacted] stated that [redacted] were utilized as [redacted] devices, for [redacted] or for a [redacted] which is a [redacted] reminder on not to [redacted]. The [redacted] explained that before application the interdisciplinary team evaluated the [redacted] to determine the best intervention to prevent the [redacted] The process for application of [redacted] [redacted] would be determined if the resident could demonstrate [redacted] at the time of application. She stated that this was determined because the resident continued to [redacted] the [redacted] and continued to [redacted] in [redacted] when it was applied but has since readmission to the

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facility on [redacted] had not tried to [redacted] and [redacted] of the w/c. She stated that at the time the [redacted] was applied the nurse should have assessed and documented that the resident had demonstrated that he/she could [redacted] the [redacted] The US FOIA (b)(6) stated that the CP interventions were reviewed each quarter to determine if the CP goals and interventions were still appropriate. The US FOIA (b)(6) stated that the nurses did not get verbal or written consent from the family because when the [redacted] was applied it was not being used as a [redacted] The [redacted] admitted that there was no clinical documentation to determine why the [redacted] was being used. The [redacted] reviewed the residents medical record in the presence of the surveyor and a physician's order was obtained [redacted], discontinued on [redacted] when the resident was discharged to the hospital and then reordered when the resident returned from the hospital on [redacted]. The [redacted] coordinator stated that a [redacted] assessment should have been completed on [redacted] when an PO was received to apply the NJ Exec Order 26.4b1. The US FOIA (b)(6) both admitted that the resident should have had continued assessment for the continued use of the [redacted] and that since it was brought to their attention that the [redacted] was discontinued.

On 09/27/24 at 10:00 AM, the US FOIA (b)(6) [redacted] did not provide any additional information.

According to the facility policy titled, "Restraints-Physical" dated 04/23/19 indicated that restraints shall only be used for safety and well-being of a resident after all other alternatives have been utilized. Prior to use of any restraint, except emergencies, it was the facility policy to

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inform the resident and/or representative of the behaviors creating a risk of injury; describe alternatives that have been employed to address the risk and their lack of success and advise on the risk and benefits of such devices and interventions and request consent for their use. A restraint would only be used as it is medically necessary and with a physician's order. The restraint would be least restrictive for the least amount of time with ongoing evaluation of need for use. The restraint would only be used when other alternatives fail and were documented. Medical symptoms or problems that can't be controlled must be documented in the medical record and on the Care Plan. Verbal or written consent must be obtained. The potential or risk were to be explained. The policy also indicated that the facility should attempt to remediate the resident's condition or lessen the need for the restraint and if the use of restraints is needed beyond 1 (one) week the following should be done:
-The need for the continued use of restraints should be implemented only as part of the physician's medical care plan.
-Every resident in restraints should be assessed by a RN at least every 48 hours for continued use of restraints.
-Interdisciplinary review of the record of any resident whose assessment indicated the need for continued use of restraint. This should occur within 30 days of the initiation to the use of restraints.
-Recommendation will be documented on the IDCT restraint review form.
-At regular interval and as needed the nursing staff were responsible to release restraints at least every two hours to assess for circulation, perform skin care, provide an opportunity to

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F 604	Continued From page 9 perform range of motion exercises, assess the need for toileting or incontinence care, ensuring adequate fluid intake, adequate nutrition, assisting with bathing and ambulation if feasible. Review of the facility RN and LPN orientation dated 06/13, indicated that restraints such a seat belts may be ordered for upper trunk control support and should be removed during meals and activities with supervision.	F 604		
F 610 SS=D	NJAC 8:39-19.4(h), (i), (j) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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: Complaint # NJ172381 and NJ173377 Based on interview, record review and document	F 610	F610 The following corrective actions have been implemented:	10/22/24

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F 610	Continued From page 10 review it was determined that the facility failed to maintain documentation and ensure that a complete and thorough investigation was conducted for residents that had NJ Exec Order 26.4b1 . This deficient practice was identified for 2 (two) of 2 Residents (Resident #5 and #45) reviewed for NJ Exec Order 26.4 of NJ Exec Order 26.4b1 and was evidenced by the following: 1.) According to the quarterly Minimum Data Set dated NJ Exec Order 26.4b1 an assessment that facilitates a resident's care, indicated that Resident #5 had the diagnoses that included but was not limited to NJ Exec Order 26.4b1 . The MDS also indicated that the resident was NJ Exec Order 26.4b1 ct. On 09/23/24 at 10:03 AM, Surveyor #1 reviewed the Facility Reportable Event (FRE) dated NJ Exec Order 26.4b1 which revealed that Resident #5 had an NJ Exec Order 26.4b1 in the resident's NJ Exec Ord on NJ Exec Order 26.4b1 . The FRE indicated that while Resident #5 was trying to get something in the nightstand, the wheelchair (w/c) NJ Exec Order 26.4b1 from him/her and the resident NJ Exec The resident complained of NJ Exec O in the NJ Exec Order 26.4 and was sent NJ Exec to the hospital where the resident was diagnosed with a NJ Exec Order 26.4 . On 09/23/24 at 10:05 AM during tour, Surveyor #1 interviewed Resident #5 who stated that on NJ Exec Order 26.4b1 , he/she was trying to NJ Exec Order 26.4b1 the front of the bed and NJ Exec Resident #5 stated that he/she was NJ Exec Order 26.4b1 and did not ask for assistance at the time of the NJ Exec The surveyor reviewed Resident #5's electronic medical record (EMR) which revealed the	F 610	F610 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) Residents identified Resident # 5 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All Nursing staff involved and including US FOIA (b) were inserviced by Staff Educator on documentation with all incidents and obtaining witness statements from all involved. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff including US FOIA (b) were in-serviced by Staff Educator on all required documentation for all incidents and obtaining	

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F 610	Continued From page 11 following information: The Nurse's note dated NJ Exec Order 26.4b1 at 20:48 (08:48 PM), indicated that staff heard Resident #5 NJ Exec Order 26.4b1 from the resident's room. The nurse and 2 (two) Certified Nursing Assistance observed that Resident #5 was not in w/c and found the resident on the NJ Exec O on his/her NJ Exec O . The resident told the staff he/she was trying to get into the nightstand when he/she NJ Exec Order 26.4b1 The staff observed the NJ Exec Order 26.4b1 to be halfway off w/c. The resident complained of NJ Exec Order 26.4b1 and the resident's NJ Exec Order 26.4b1 . The resident was transported to the hospital by emergency medical services (EMS) at 08:45pm. On 09/24/24 at 09:56 AM, Surveyor #1 reviewed the FRE and NJ Exec Order 26.4b1 form, root cause analysis and the care plan which was updated with new interventions after the resident returned from the hospital. The FRE did not contain any statements from the staff the that observed the resident NJ Exec Order 26.4b1 . On 09/25/24 at 09:55 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN #1) who stated that she had been employed in the facility for NJ Exec Order 26.4b1 . The LPN revealed that she was the nurse that had entered the resident's room after the resident had NJ Exec Order The LPN stated that she had filled out the incident event in the computer and admitted that she did not recall filling out a witness statement form. She also stated that she did not remember if the CNAs that entered the resident's room with her, filled out witness statements. The LPN also explained that the US FOIA (b)(6)) or someone in	F 610	witness statements from all staff involved. All new hires will be in-serviced on orientation and on-going by the Staff Educator on all required documentation for all incidents and obtaining witness statements from all staff involved. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. All events will be reviewed at the morning round up meeting the morining following the incident and/or the Monday following the incident by the IDT to ensure documentation and witness statements are complete. All documentation regarding falls will be given to the DON after morning meeting for review. Results will be reported by the DON to the QAA Committee monthly for 3 months and then quarterly. This will be ongoing. The QAA committee meets quarterly and will review audits. The QAA committee/DON will determine when the problem is resolved or if more training is required. Resident # 45 1. How the corrective action will be accomplished for those residents	

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F 610	Continued From page 12 administration assured that the witness statements were completed when they reviewed the investigation. On 09/25/24 at 10:07 AM, Surveyor #1 interviewed a Certified Nursing Assistant (CNA #1) who stated that she recalled that when Resident #5 was NJ Exec Order 26.4b1, the resident indicated that he/she was NJ Exec Order 26.4b1 out of the bedside drawer and NJ Exec Order 26.4b1 of the w/c. She stated that a US FOIA (b)(6)) on duty had her write a witness statement. She stated that after she wrote a statement, she brought it to the front desk and sat it on the desk and told the supervisor that the report was placed at the front desk. On 09/25/24 at 10:24 AM, Surveyor #1 interviewed CNA #2 who stated that Resident #5 had NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 for something on the table and 'NJ Exec Order 26.4b1 forward and NJ Exec CNA #2 could not recall if she was asked to fill out a witness statement form. On 09/25/24 at 10:30 AM, Surveyor #1 interviewed the Registered Nurse (RN #1) that CNA #1 stated had her write a witness statement. RN #1 stated that she was not present in the facility when Resident #5 NJ Exec The RN explained the investigative process when a resident had an NJ Exec Order 26.4b1 in the facility. She stated that an incident report, NJ Exec Order 26.4b1, NJ Exec O assessment, NJ Exec Order 26.4b1 were all to be completed for an NJ Exec Order 26.4b1 She explained that all findings were documented in the medical record, progress, and incident (risk management) report. She stated that the supervisor's role was to assure the incident report was completed. She continued to add that the RN would complete the	F 610	found to have been affected by the deficient practice. All Nursing staff involved and including US FOIA (b) were inserviced by Staff Educator on documentation with all incidents and obtaining witness statements from all involved. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff including US FOIA (b) were in-serviced by Staff Educator on all required documentation for all incidents and obtaining witness statements from all staff involved. All new hires will be in-serviced on orientation and on-going by the Staff Educator on all required documentation for all incidents and obtaining witness statements from all staff involved. 4. How the facility will monitor its	

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F 610	Continued From page 13 assessment and report to the Interdisciplinary Care Team (ICD) team in morning meeting. She stated that the IDC team was to assure that if the NJ Exec was NJ Exec Order 26.4b1 the nurse would be responsible to complete a witness statement and the CNAs involved would also complete a statement. RN #1 revealed that anyone involved in the incident would have to write a statement. She stated that a statement would be important to obtain so that that facility had all information regarding what, why, when, and how the NJ Exe might have occurred. On 09/26/24 at 12:44 PM, Surveyor #1 interviewed the US FOIA (b)(6)) who stated that the nurse on duty was to be notified of any resident NJ Exe that occurs. The US FOIA (b) explained that if a resident NJ Exec the nurse performed an assessment of the resident and if the resident was NJ Exec Order 26.4b1, ask the resident what happened. She stated that the nurse was responsible to fill out the incident report. The US FOIA (b) stated a witness statement form was to be complete by the nurse. She stated that the nurse in charge was responsible to obtain a handwritten statement from the CNA who was involved. She stated that the facility goes back so many hours and obtain a statement from the nurse and the CNA who cared for the resident at that time. She stated that it was important to obtain statement to see what happened and if there was anything that needed to be addressed to prevent further reoccurrence or future NJ Exec Or On 09/27/24 at 10:48 AM, the US FOIA (b) admitted that the NJ Exec Order 26.4b1 was not completed due to lack of statements regarding the CNAs that were present in the residents room after the resident had NJ Exec Order 26.4b1	F 610	corrective actions to ensure that the deficient practice is being corrected and will not recur. All events will be reviewed at the morning round up meeting the morining following the incident and/or the Monday following the incident by the IDT to ensure documentation and witness statements are complete. All documentation regarding falls will be given to the DON after morning meeting for review. Results will be reported by the DON to the QAA Committee monthly for 3 months and then quarterly. This will be ongoing. The QAA committee meets quarterly and will review audits. The QAA committee/DON will determine when the problem is resolved or if more training is required.	

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A review of the Facility Reported Event (FRE) dated [redacted] revealed that Resident #45 sustained a [redacted] that resulted in a [redacted]. Further review of the FRE did not include a thorough investigation that included staff statements and maintain documentation that the investigation was thoroughly investigation that included the progress notes of the sequence of events leading to the [redacted]

On 9/23/24 at 8:34 AM, Surveyor #2 observed Resident #45 in bed eating breakfast.

On 9/26/24 at 9:24 AM, Surveyor #2 attempted to speak with Resident #45 regarding the [redacted] When asked if they [redacted] Resident #45 stated, "[redacted]". The resident was [redacted] to [redacted] the events leading up to or after the [redacted]

The surveyor reviewed the medical record for Resident #45.

A review of the Admission Record revealed that Resident #45 had diagnoses which included, but were not limited to, [redacted]

A review of the quarterly MDS dated 7/18/24, included the resident had a Brief Interview for Mental Status score of [redacted] out of 15; which indicated a [redacted].

A review of Resident #45's Electronic Medical Record (EMR) Nursing Progress Note revealed an entry dated [redacted] at 10:30 AM that stated, "Alerted by team nurse that resident had [redacted] in

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bathroom. NJ Exec Order 26.4b1 . Unable to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Notified US FOI and NJ Exec Order 26.4b1 {name redacted} that resident will be evaluated at {name redacted}. EMS transfer". Another EMR Nursing Progress Note entry dated NJ Exec Order 26.4b1 11:08 AM revealed, "Team nurse notified this nurse that resident was found on the NJ Exec Order 26.4b1. NJ Exec Order 26.4b1. Resident NJ Exec Order 26.4b1 . US FOI and NJ Exec Order 26.4b1 notified of NJ Exe and possible NJ Exec Order 26.4b1. Sent to{name redacted} ER for evaluation".

Further review of the EMR Progress Notes identified an Interdisciplinary Care Team Note on NJ Exec Order at 9:59 AM that revealed, "Round up review of NJ Exe on NJ Exec at 10:20 AM. Resident was NJ Exec Order 26.4b1 in NJ Exe bathroom. Resident was NJ Exec Order 26.4b1 in front of sink and NJ Exec Order 26 NJ Exec Order 26.4b Reported NJ Exec Order 26.4b1, sent to ER and admitted with NJ Exec Order 26.4b1. Will address care plan upon readmission".

A review of Resident #45's Risk Assessments did not reveal any assessments for the NJ Exe dated NJ Exec Order 2

During an interview on 9/25/24 at 10:27 AM, Registered Nurse (RN #1) stated that NJ Exe residents are first assessed before being moved. RN #2 explained that an assessment included documentation of vital signs (blood pressure, heart rate, respirations, level of consciousness, pain, neurological check). The nurse should also document the NJ Exec Order 26.4b1 and how the resident NJ Exec Order 26.4b1. RN #2 identified that a NJ Exec Order 26.4b1 should have a full investigation, which included a risk management assessment in the electronic

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medical record and a paper based incident assessment that would have a drawing and statements. RN #2 advised that the NJ Exec investigation are completed by the supervisor.

During an interview on 9/25/24 at 1:42 PM, the Certified Nursing Aide (CNA #3) confirmed that they were the CNA at the time of the Resident #45 NJ Exec Order 26.4b1. CNA #3 stated that she found the resident NJ Exec Order 26.4b1 and immediately got assistance. CNA #3 indicated that the registered nurse did an assessment and the resident was transferred to the hospital. When asked if they were required to write a full statement, CNA #3 responded that they only had to fill out a prompted questionnaire.

During an interview on 9/26/24 at 11:17 AM, the Licensed Nurse Practitioner (LPN #2) advised that the facility expectation for NJ Exe documentation is that a patient assessment should be completed, which included vital signs (respirations, pulse, pulse ox, blood pressure, pain), range of motion, level of consciousness and if the resident was stable, then could then be transferred to position of comfort. LPN #2 stated that a NJ Exe assessment contained two parts a risk assessment and then an incident investigation. LPN #2 reviewed the EMR nursing progress notes for the dates of Resident #45's NJ Exec LPN #2 confirmed that the progress notes did not contain vital signs, NJ Exec Order 26.4b1, how the resident was NJ Exec Order no orders. LPN #2 also confirmed that there was no Risk Assessment completed for the date of the NJ Exe on NJ Exec Order, which also should have been completed.

During an interview on 9/27/24 at 10:34 AM, the US FOIA (b)(6 in the presence of the survey team,

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confirmed that a thorough [redacted] investigation was not completed based on the fact that statements were not obtained and documentation of the progress notes of how the patient was found, vital signs, and completion of the incident packet.

A review of the undated facility provided document titled, "Fall Events Process" directed that, "2. Supervisor or Team Leader must completed the "Falls Investigation Form". This includes the Supervisor or Team Leader interviewing the staff involved, drawing a diagram of the scene, sequence of events, contributing factors and the root cause of the fall Why?? Did it happen ....."

On 9/27/24, the facility provided the following untitled documented dated 8/8/19 that directed, "We will begin using a new [redacted] report form in PCC [point click care] starting next week crossed off and handwritten with 8/16/19] [...] 6. You will choose either witnessed or unwitnessed fall [...] In addition, the paper [redacted] investigation form has been updated and must be completed ...

A review of the undated facility provided document titled, "RN and LPN Orientation" with a Revision date 06/13 indicated that, "incident reports [...] get all witness statements immediately [...] care of the falling resident (assessment & documentation) ..."

A review of the facility provided policy titled, "Charting" with a revision date of 6/2010, revealed under, "Policy" that "all services provided to the resident or any changes in the resident condition shall be recorded in the resident's medical record". The policy further revealed under "Procedure" that, "All treatments

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F 610	Continued From page 18 must be signed out on Treatment Administration Record ..." NJAC 8:39-9.4(f)	F 610		
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: Complaint # NJ00171237 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to accurately assess the status of a resident in the Minimum Data Set (MDS). This deficient practice was identified for 1 of 22 sampled residents, (Resident #37) and was evidenced by the following: On 6/11/2021 at 9:34 AM, the surveyor observed Resident #11 in the hallway with a [NJ Exec Order 26.4b1] on his/her [NJ Exec Order 26.4b1]. On 09/23/24 at 08:53 AM, the surveyor observed Resident #37 in the room. The surveyor did not observe an [NJ Exec Order 26.4b1] device. According to the Admission Record, Resident #37 was admitted with diagnoses including but not limited to [NJ Exec Order 26.4b1]). A review of the Order Summary Report with active orders as of [NJ Exec Order 26.4b1] for Resident #37,	F 641	F641 The following corrective actions have been implemented: F641 Accuracy of Assessments CFR(s): 483.20(g) Residents identified Resident # 37 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. MDS was modified and resubmitted for resident #37. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same	10/22/24

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F 641	Continued From page 19 did not include a physician's order for an NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 Treatment Administration Record for Resident # 37 did not include a physician's order for an NJ Exec Order 26.4b1 A review of the Quarterly MDS dated NJ Exec Order 26.4b1 for Resident # 37, indicated under Section NJ Exec Order 2 for NJ Exec Order 2 was coded as NJ indicating there was a NJ Exec Order 26.4b1 used daily. During an interview on 09/25/24 12:24 PM, the US FOIA (b)(6) stated that the NJ Exec Order 26.4b1 for Resident #37 was discontinued when resident went to the hospital on NJ Exec Order 2 The US FOIA (b) stated the Quarterly MDS dated NJ Exec Order 26.4b1 was coded incorrectly. NJAC 8:39-11.1	F 641	deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were in-serviced by the Staff Educator to ensure that residents with wander guards have a current order. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. MDS Coordinator will review all MDS's at time of closure for accuracy. MDS Coordinator will report results to the DON and the QAA committee monthly. The DON will review monthly for three months and then quarterly. The QAA committee meets quarterly and will review audits quarterly. This will be ongoing. The DON/QAA committee will determine when the problem is resolved or if more training is required.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		10/22/24

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F 656	Continued From page 20 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 21 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to develop and implement a comprehensive interdiciplinary care plan that a.) specified a resident's preferences for care and; b.) meets the medical needs identified on the comprehensive assessment for 2 (two) of 17 residents reviewed for comprehensive interdiciplinary care plans, (Resident #40 and #48). This deficient practice was evidenced by the following: 1.) According to the Admission Record (AR), Resident #40 was admitted to the facility with the diagnoses which included but was not limited to; NJ Exec Order 26.4b1 The quarterly Minimum Data Set (MDS), an assessment that facilitates a resident's care dated NJ Exec Order 26.4b1 indicated that Resident #40 had NJ Exec Order 26.4b1 and did NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1. On 09/23/24 at 09:02 AM during tour, Surveyor #1 interviewed Resident #40 who appeared NJ Exec O and NJ Exec Order 26.4 and was able to NJ Exec Order 26.4 his/her NJ Exec Order and NJ Exec Order 2 The resident stated that he/she was NJ Exec Order 26.4b1 and NJ Exec O daily. The resident stated, "NJ Exec Order 26.4b1 " and had made complaints multiple time regarding getting NJ Exec Order 26.4b due to staff members coming	F 656	F656 The following corrective actions have been implemented: F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) Residents identified Resident # 40 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #40 care plan was updated to reflect NJ Exe preferences for care which is to not be NJ Exec Order 26.4b1 . All staff involved were in-serviced by Staff Educator regarding care planning and following care plan for resident preferences. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same	

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F 656	Continued From page 22 into his/her room throughout the NJ Exec Order 26.4b1 him/her up. Resident #40 stated that the staff told him/her that they are NJ Exec Order 26.4b1 up at night due to safety, however he/she felt that the staff could just observe him/her without moving and adjusting the bed. The resident also stated that the staff continue to leave the door open at night after they leave. He stated that he/her did not think that the staff communicated his/her needs to have privacy at night and that due to different staff members, all staff don't know that he/she did not want to be NJ Exec Order 26.4b1 . The surveyor reviewed Resident #40's comprehensive Interdisciplinary Care Plan (ICP) and there was no indication in the ICP that the resident's preference was not to be disturbed or NJ Exec Order 26.4b1 . The Interdisciplinary Team Note (IDC) dated NJ Exec Order 26.4b1 at 13:43 (01:43 PM), did not indicated that the IDC team were aware of the resident's preference that he or she did not want to be NJ Exec Order 26.4b1 . Surveyor #1 reviewed the NJ Ex Order 26.4b1 Note dated NJ Exec Order 26.4b1 at 17:24 (05:24 PM) did not reflect that the US FOIA (b)(6)) was aware of Resident #40's preference not to be NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 . On 09/25/24 at 12:44 PM, Surveyor #1 interviewed the residents US FOIA (b)(6) who stated that Resident #40 had mentioned it NJ Exec Order 26.4b1) to her that staff had been coming into his/her room during sleeping hours and NJ Exec Order 26 him/her NJ Exec The US FOI stated that she explained to the resident that the nurses conducted one-hour rounds and were responsible	F 656	deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All members of the interdisciplinary team, all charge nurses, and nursing staff were in-serviced by the Staff Educator on developing and implementing a comprehensive interdisciplinary care plan that is specific to a resident's preferences for care. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Ten charts will be audited by Staff educator monthly for 3 months and then quarterly to ensure care plans reflect the residents specific preferences for care. This will be ongoing. Audits will be reported monthly to the DON and to the QAA committee. The DON will review monthly for 3 months and then quarterly. The QAA committee meets quarterly and will review audits quarterly. This will be ongoing. The DON/QAA committee will determine when the problem is	

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F 656	Continued From page 23 to check on him/her. The US FOIA stated that she did not report this resident's concern to anyone or document the resident's concern in the medical record. On 09/25/24 at 12:49 PM, Surveyor #1 interviewed the day shift US FOIA (b)(6) who stated that Resident #40 was NJ Exec Order 26.4b1 however the resident had been complaining about the staff NJ Exec Order 26.4b1 since admission to the facility. She stated that staff were aware and that the night shift was aware, but she did not work at night and was not sure what they were doing about it. She stated that Resident #40 was NJ Exec Order 26.4b1, and the staff were required to NJ Exec Order 26.4b1 the resident at night. The US FOIA stated, "Am I wrong, or should we not change him/her at night." The surveyor explained that the resident should be able to make the decision if he wanted the staff to NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 The surveyor asked the US FOIA if a conversation was had with the resident concerning his/her preference and if he/she wanted to be NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 when NJ Exec Order 26.4b1 The US FOIA (b)(6) did not know if the staff had a conversation with the resident regarding the residents' preferences not to be woken up at night. The US FOIA stated that the resident was NJ Exec Order 26.4b1 and continued to NJ Exec Order 2 the same NJ Exec Order 26.4b1. The US FOIA then admitted that the resident did not have a Care Plan developed according to NJ Exe preferences regarding not to be NJ Exec Order 26.4b1. On 09/25/24 at 01:18 PM, Surveyor #1 interviewed the US FOIA (b)(6)) who stated that the resident had no complaint regarding the staff NJ Exec Order 26.4b1 a not being able to get a NJ Exec Order 26.4b1. The US FOIA stated that if	F 656	resolved or if more training is required. Resident # 48 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents interdisciplinary care plan (ICP) was updated to include documentation of a ICP focus area and interventions for the care of an NJ Exec Order 26.4b1. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with indwelling urinary catheters have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All ICP care team members were in-serviced by Staff Educator on careplans focusing on resident specific needs/care. 4. How the facility will monitor its corrective actions to ensure that	

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F 656	Continued From page 24 this was a concern for the resident and the staff knew about it then it should have been brought to her attention so that the resident and the staff could come up with ideas to help make sure the resident NJ Exec Order 26.4b1 . The US FOIA also stated that it would be important to include this preference in the resident's ICP. On 09/25/24 at 01:43 PM, Surveyor #1 interviewed a US FOIA (b)(6)) who stated that Resident #40 was slightly NJ Exec Order 26.4b1 however he/she was NJ Exec O to NJ Exec Order 26.4b1 his/hers NJ Exec Order and NJ Exec Order 2 The US FOIA (b stated that the resident was occasionally NJ Exec Order 26.4b1 however utilized the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 during the day and would let the staff know if he/she had an NJ Exec Order 26.4b1 She stated that the resident was NJ Exec Order 26.4b1 . The US FOIA (b stated that Resident #40 only required NJ Exec Order 26.4b1 with activities of daily living (ADLs) and NJ Exec Order 26.4b1 around the facility NJ Exec Order 26.4b1 She stated that he/she utilized his/her call bell appropriately. The US FOIA (b stated that the resident did not have any complaints to her regarding the staff NJ Exec Order 26.4b1 . She stated that she was not the resident's regular US FOIA (b but that the resident did not complain to her today while under her care. On 09/26/24 at 01:02 PM, Surveyor #1 interviewed the US FOIA (b)(6)) who stated that it would have been importance that the staff had a meeting regarding the resident's preferences. She stated that resident's preferences should have been documented on the resident's Care Plan and on the 24-hour report so that all shifts were aware that the resident did NJ Ex Order 26.4b1 at night.	F 656	the deficient practice is being corrected and will not recur. All care plans by the IDT were audited to ensure the care plans included specific focus of resident needs/care. Five care plans will be audited by the MDS coordinator monthly for three months, then quarterly to ensure the careplan has specific focus to resident needs/care. This will be ongoing. Audits will be reported monthly by the MDS Coordinator to the DON and to the QAA committee. The DON will review monthly for three months and then quarterly. The QAA committee meets quarterly and will review audits quarterly. This will be ongoing. The DON/QAA committee will determine when the problem is resolved or if more training is required.	

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2. A review of Resident # 48's AR revealed that, Resident # 48 was admitted with but not limited to NJ Exec Order 26.4b1 [redacted].

A review of the Resident #48's admission MDS dated NJ Exec Order 26.4b1 revealed under section [redacted] that the resident had an NJ Exec Order 26.4b1 [redacted]).

A review of the current ICP for Resident #48 did not include documentation of a ICP focus area or interventions for the care of NJ Exec Order 26.4b1.

During an interview on 09/26/2024 at 09:53 AM, Surveyor #2 interviewed the US FOIA (b)(6) [redacted] who stated, "how and when to clean , any precautions, when the NJ Exec Order 26.4 needs to be NJ Exec Order 26.4b1 and that there should be a NJ Exec Order 26.4b1", when asked what should be on the CP for a resident with an NJ Exec Order 26.4b1. When asked if there should be a focus on the NJ Exec Order 26.4b1 NJ Exec Order 26.4 on the resident's baseline CP, LPN #3 replied. "yes".

During an interview on 09/26/2024 at 12:30 PM with Surveyor #2, the US FOIA (b) stated, "that they have a NJ Exec Order 26.4b1 what care needs to be done, and how often it is to be NJ Exec Order 26.4b1 when asked what should be on the ICP for a resident with an NJ Exec Order 26.4b1. When asked if there should be a focus on the NJ Exec Order 26.4b1 on the

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F 656	Continued From page 26 resident's baseline ICP, The [US FOIA (b)] replied, "yes". A review of a facility provided policy titled "Resident Assessment and Care Planning" revealed under section "Policy" that, "Dependent upon the assessment, the care plan is developed or updated in order to meet the resident's needs. NJAC 8:39-27.1(a)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to a.) follow physician's order to remove a NJ Exec Order 26.4b1 during the day and b.) ensure that there was an active order for a NJ Exec Order 26.4b1 for 1 of 17 residents reviewed for accuracy of physician's orders (Resident #8) c.) supervise the administration of medications for 1 of 4 residents (Resident #27) reviewed for medications and evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through	F 658	F658 The following corrective actions have been implemented: F658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) Residents identified Resident # 8 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident physician orders for [NJ Exec Ord] [NJ Exec Order 2] were clarified and entered in the electronic medical	10/22/24

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F 658	Continued From page 27 such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: On 9/23/2024 at 8:20 AM, during initial tour, the surveyor observed Resident #8 in the area of the nursing wing with a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 On 9/24/2024 at 12:26 PM, the surveyor observed Resident #8 in the main dining room with NJ Exec Order 26.4b1 on both the NJ Exec O and NJ Exec NJ Exec Orde On 9/25/2024 at 9:11 AM, the surveyor observed Resident #8 in the television area of the nursing wing with the NJ Exec Order 26.4b1 on both NJ Exec O and NJ Exec Order 26.4b. The surveyor reviewed Resident #8's medical	F 658	record (EMR). 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who use palm guards have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff and IDT were in-serviced by Staff Educator on physician orders and ensuring that the residents care plan reflects the physician orders. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. All resident charts were audited by the IDT to ensure the resident care plan reflects the physician orders. Moving forward Five charts will be audited monthly by Staff Educator for three months and then quarterly on physician orders using palm guards. This will be ongoing. Results will be reported monthly to the DON	

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F 658	Continued From page 28 Record: A review of the Admission Record revealed that Resident #8 had diagnoses which included, but were not limited to, NJ Exec Order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, reflected a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated that the resident was NJ Exec Order 26.4b1. A review of Resident #8's Order Summary Report identified the following active physician's order (PO): NJ Exec Order 26.4b1 [redacted] Upon review of the NJ Exec Order 26.4b1 Treatment Administration Record (TAR) the PO was located with a "check mark" and initials. A review of the individualized comprehensive care plan (ICCP) included a focus area area dated NJ Exec Order 26.4b1 for "NJ Exec Order 26.4b1 in [activities in daily living] related to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [...]. Interventions included: NJ Exec Order 26.4b1 on at bedtime, off in morning. The Care Plan did not specify any treatment for the NJ Exec Order 26.4b1. A review of Resident #8 "Nurse's Aide Information" Care Plan revealed an entry under section titled Adaptive Equipment: NJ Exec Order 26.4b1 [redacted]. The Nurse's Aide	F 658	and the QAA committee. The DON will review audits monthly for three months and then quarterly. The QAA committee meets quarterly and will review audits quarterly. The DON/QAA committee will determine when the problem is resolved or if more training is required. Resident # 27 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nurse involved was re-in-serviced on medication administration by staff educator and med pass observation done by pharmacy consultant. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who receive medication have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were re-in-	

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F 658	Continued From page 29 Care Plan did not specify any treatment for the right hand. During an interview with the surveyor on 9/25/2024 at 9:54 AM, the Certified Nursing Aide (CNA #1) stated that every resident has a resident care plan that can be viewed in their wardrobe. This care plan would identify their preferences and care needs. When asked about care needs and specialized adaptions, CNA #1 indicated that nursing was responsible for putting on and taking off any specialized equipment and ensuring specialized equipment is in use after therapy provides training and instruction. CNA #1 stated that the resident has a NJ Exec Order 26.4b1 that is on during the day and is off when sleeping. During an interview with the surveyor on 9/25/2024 at 12:10 PM, the US FOIA (b)(6) informed the surveyor they were familiar with the resident and that the physician's order incorrectly identifies the resident's NJ Exec Order 26.4b1, which I really don't like because are NJ Exec Order 26.4b1". The US FOIA (b) confirmed that there is only an order for the NJ Exec Order 26.4b1 "and that would make more sense for me because that NJ Exec Order 26.4b1 ". The US FOIA (b) further stated that the NJ Exec Order 26.4b1 would not have an NJ Exec Order 26.4b1 since that NJ Exec Ord has NJ Exec Order 26.4b1 use. During an interview with the survyeor on 9/25/2024 at 12:38 PM, the surveyor requested Registered Nurse (RN #1) to visit the room of Resident #8. At this time, RN#1 confirmed that NJ Exec Order 26.4b1 were on the resident. Upon reviewing the physicians orders, RN #1 acknowledged that the order was identified for a NJ Exec Order 26.4b1 that should have been removed.	F 658	serviced on medication administration by staff educator. All nursing staff will continue to have med pass observation done annually by pharmacy consultant. All new staff will have med pass observation done by pharmacy consultant upon hire during orientation. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. On a monthly basis staff educator will observe at least six nurses during a med pass. Audits will be reported monthly by the Staff Educator to the DON and to the QAA committee. The DON will review monthly for three months and then quarterly. The QAA committee meets quarterly and will review audits until 100% compliance is achieved. The QAA committee/DON will determine when the problem is resolved or if additional training is needed.	

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F 658	Continued From page 30 RN #1 further identified that there was no order for a NJ Exec Order 26.4b1. During an interview with the surveyor on 9/26/2024 at 11:14 AM, the surveyor requested Licensed Nurse Practitioner (LPN #1) to visit the main dining room where Resident #8 was engaged in activities. LPN #1 confirmed that Resident #8 was NJ Exec Order 26.4b1 LPN #1 confirmed that based on the physician order, the NJ Exec Order 26.4b1 should not be on and that there should not be a NJ Exec Order 26.4b1 on the right since there was not a physician's order. LPN #1 confirmed that this NJ Exec Order 26.4b1 was not a NJ Exec Ord and that it should have been clarified by nurses. During an interview with the surveyor on 9/27/2024 at 9:34 AM, the US FOIA (b)(6) , in the presence of the survey team, confirmed that the NJ Ex Order 26.4b1 was being applied without an order and that the NJ Ex Order 26.4b1 was not being taken off during the day. A review of the facility provided policy titled, " Physicians Orders" with an unknown revision date revealed under, "Procedure" that, "Medications, diets, therapy, or any other treatment may not be administered to the resident without the written approval from the attending physician /nurse practitioner..." A review of the facility provided policy titled, "Charting" with a revision date of 6/2010, revealed under, "Policy" that "all services provided to the resident or any changes in the resident condition shall be recorded in the resident's medical record". The policy further	F 658		

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revealed under "Procedure" that, "All treatments must be signed out on Treatment Administration Record ..."

2.) On 09/24/2024 at 7:40 AM, during medication administration surveyor # 2 observed the Registered Nurse (RN #1) prepare an NJ Exec Order 26.4b1 to Resident #27 in a disposal paper cup. Resident #27 said to RN #1 that he/she did not want to take the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Resident #27 NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Resident #27 kept the disposal paper cup with the NJ Exec Order 26.4b1 inside placing it on his/her bedside table. The RN #1 walked out of Resident #27 bedroom to the medication cart leaving the medications in the disposal paper cup in Resident #27's room on the bedside table. Surveyor #2 asked RN #1 does she always leave medications at residents' bedside, RN #1 stated, " I will come back in 10 minutes as the resident does this all the time". RN #1 then went back into Resident # 27's bedroom and removed the medications from the bedside table.

During an interview with surveyor #2 on 09/24/2024 at 09:17 AM, he US FOIA (b)(6) Resident #27 should not have medications left in the bedroom on the bedside table.

During an interview with surveyor #2 on 09/24/2024 at 1:27 PM, the Registered Nurse

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F 658	Continued From page 32 Charge Nurse (RNCN #1) said medications should not be left in a resident's room. A reviewed of the facility policy and procedure on oral medication administration under special considerations number 10 revealed, "Administer medication and remain with resident after medication swallowed. a.) Never leave a medication in a resident's room, except for residents with bedside storage and self-administer orders." NJAC 8:39-29.2(d)	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		10/22/24

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F 690	Continued From page 33 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that an NJ Exec Order 26.4b1 was secured in a manner to prevent contamination for 1 of 1 resident reviewed for a NJ Exec Order 26.4b1, (Resident #48). The deficient practice was evidenced by the following: During the initial tour of the unit on 09/23/2024 at 08:44 AM, Resident #48 was in bed with a NJ Exec Order 26 in contact with the floor, with no NJ Exec Order 26.4b1, and visible from the hallway. It was not secured to the bed frame. A review of Resident # 48's admissions record revealed that, Resident # 48 was admitted with but not limited to NJ Exec Order 26.4b1	F 690	F690 The following corrective actions have been implemented: F690 Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) Residents identified Resident # 48 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #48 NJ Exec Order 26.4b1 was secured to the bed, NJ Exec Order 26.4b1 the floor and covered with NJ Exec Order 26.4b NJ Exec O All staff involved were in-serviced by Staff Educator on the care of a resident with NJ Exec Order 26.4b1, proper placement of the NJ Exec Order 26	

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	315418	A. BUILDING _____ B. WING _____	C 09/27/2024

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F 690	Continued From page 34 NJ Exec Order 26.4b1 A review of the Resident #48's admission Minimum Data Set (MDS) dated NJ Exec Order 26.4b1 revealed under section [redacted] that the resident had an NJ Exec Order 26.4b1. During an interview on 09/25/2024 at 12:51 PM with the surveyor, the US FOIA (b)(6) nurse stated, "NJ Exec Order 26.4b1 should be [redacted] below the [redacted] or NJ Exec Order 26.4b1 of the bed so they don't touch the floor." When asked if there should be a NJ Exec Order 26.4b1 the [redacted] replied, "in their rooms we don't have NJ Exec Order 26.4b1, when out of the room they do." During an interview on 09/25/2024 at 01:12 PM with the surveyor, the US FOIA (b)(6)) stated, "the NJ Exec Order 26.4b1 should be hung on the side, never on the floor and should have [redacted] at all times." A review of a facility policy title "Using Urinary Catheter Leg Drainage Bags" revealed under "In Changing Leg Bag to Foley Bag" that, "All foley drainage bags will be covered and positioned off the floor." N.J.A.C. 8:39-19.4(a)	F 690	NJ Exec Order 26.4b1 and use of NJ Exec Order 26.4b1. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with indwelling urinary catheters have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were in-serviced by Staff Educator on the care of a resident with an indwelling urinary catheter and proper placement of the indwelling urinary catheter bag. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Weekly Audits will be done by the day shift charge nurse on all residents with indwelling urinary catheters to ensure indwelling urinary catheter drainage bags are properly placed and use of a privacy cover for the urinary catheter drainage bag is utilized.	

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F 690	Continued From page 35	F 690	This will be ongoing unil 100% compliance is achieved. Results will be reported weekly by the charge nurse to the DON and the QAA committee. The DON will review audits weekly. The QAA committee meets quarterly and will review audits. This will be ongoing unitl 100% compliance is achieved. The DON/QAA committee will determine when the problem is resolved or if more training is required.	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that appropriate assistive devices were provided to residents (Resident #8) to maintain and improve their NJ Exec Order 26.4b1 for 1 of 3 residents reviewed for activities of daily living. The deficient practice was evidenced by the following: On 9/23/2024 at 8:20 AM, during initial tour, the surveyor observed Resident #8 with NJ Exec Order 26.4	F 810	F810 The following corrective actions have been implemented: F810 Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) Residents identified Resident # 8 1. How the corrective action will be	10/22/24

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F 810	Continued From page 36 NJ Exec Order 26.4b1 attached to the right side of resident's chair. The NJ Exec Order 26.4b1 of the NJ Exec Orde was observed to be NJ Exec Order around itself and the NJ Ex was not located near the resident's NJ Exec Order 26 leaving the resident NJ Exec Order 26.4b1 . On 9/24/2024 at 12:22 PM, the surveyor observed Resident #8 in the main dining room being assisted during lunch. The resident's NJ Exec Orde was not observed attached to the resident's chair. A staff member approached holding a new NJ Exec Orde and asked what the resident would like. At 12:41 PM, the resident was observed being removed from the main dining room to their room with NJ Exec Order 26.4b1. On 9/25/2024 at 9:11 AM, the surveyor observed Resident #8 in the television area of the nursing wing. The resident's NJ Exec Order 26.4b1 was not observed attached to the resident's chair. A review of the Admission Record revealed that Resident #8 had diagnoses which included, but were not limited to, NJ Exec Order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, reflected a brief interview for mental status (BIMS) score of NJ Ex out of 15, which indicated that the resident was NJ Exec Order 26.4b1. A review of the individualized comprehensive care	F 810	accomplished for those residents found to have been affected by the deficient practice. Staff involved were educated by Staff Educator regarding securing NJ Exec Order 26.4b1 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who use assistive devices for drinking have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were in-serviced by the Staff Educator regarding securing water bottle and positioning straw so resident is able to drink independently. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Team nurse will check for proper	

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F 810	Continued From page 37 plan (ICCP) included a focus area area dated NJ Exec Order 26.4b1 for "risk related [diagnosis] of NJ Exec Order 26.4b1 ...]" . Interventions included: NJ Exec Order 26.4b1 attached to wheelchair for NJ Exec Order 26.4b1 A review of Resident #8 "Nurses Aide Information" Care Plan revealed an entry under section titled Adaptive Equipment: NJ Exec Order 26.4b1 with NJ Exec Ord to [wheelchair]- NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1. A review of the facility requested Occupational Notes revealed a note dated NJ Exec Order 26.4b1 "[...] spoke to nursing regarding having pt's NJ Exec Order 26.4 NJ Exec within reach for NJ Exec Order 26.4b1 [...] modification to NJ Ex Order 26.4b1 [...]". A review of Resident #8's Electronic Medical Record (EMR) Nursing Progress Note revealed an entry dated NJ Exec Order 26.4 at 09:55 AM that stated, "Discussed placement of NJ Exec Order 26.4b1. Will add to the care plan to ensure NJ Exec Orde is placed properly for NJ Exec Order 26.4b1. Care Plan reviewed and updated". During an interview on 9/25/2024 at 9:54 AM, the Certified Nursing Aide (CNA #1) stated that every resident has a resident care plan that can be viewed in their wardrobe. This care plan would identify their preferences and care needs. When asked about care needs and specialized adaptions, CNA #1 indicated that nursing was responsible for putting on and taking off any specialized equipment and ensuring specialized equipment is in use after therapy provides training and instruction. The surveyor inquired if CNA #1 was familiar with Resident #8, CNA #1	F 810	placement of water bottle and straw at each meal to ensure resident is able to drink independently. Staff educator will do a monthly audit on all residents with water bottle to check for placement of water bottle and straw. Results will be reported monthly by Staff Educator to the DON and the QAA committee. The DON will review audits monthly for three months and then quarterly. The QAA committee meets quarterly and will review audits quarterly until 100% compliance is achieved. The DON/QAA committee will determine when the problem is resolved or if more training is required.	

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F 810	Continued From page 38	F 810		

confirmed and stated that they have a NJ Exec Order [redacted] that should be positioned by the resident's NJ Exec Ord so that they can NJ Exec Order 26.4b1 CNA #1 specified that Resident #8 does not like the NJ Exec Orde in front of them, but rather to the side.

During an interview on 9/25/2024 at 12:10 PM, the US FOIA (b)(6) [redacted]) informed the surveyor that based on a previously held Interdisciplinary Team Meeting, Resident #8's NJ Exec should be at their side at level of NJ Exec Orc as it allowed the resident to NJ Exec Order 26.4b1 [redacted]. The US FOIA (b) confirmed that nursing should have been made aware of this intervention. When asked if it should be available at mealtimes, the US FOIA (b) stated that it should absolutely be there during meals so that they can NJ Exec Orc at will.

During an interview on 9/25/2024 at 12:38 PM, the surveyor requested Registered Nurse (RN #1) to visit the room of Resident #8. At this time, RN#1 confirmed that the NJ Exec Order 26.4b1 is not on the chair and that it is the responsibility of the nursing staff to ensure that it is on the chair and that the resident has accessibility to drink.

During an interview on 9/26/2024 at 11:09 AM, the Licensed Nurse Practitioner (LPN #1) confirmed that Resident #8's NJ Exec Order 26.4b1 should be available at their preference. The surveyor explained that on NJ Exec Order 26.4b1 a staff member approached the resident to inquire about the NJ Exec Order 26.4b1 but it was never given to them and the resident was brought to their room without the NJ Exec Order 26.4b1 LPN #1 indicated that Resident #8 does enjoy having access to their NJ Exec Order 26.4b1 and that she recalled the resident asking for the

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F 810	Continued From page 39 [redacted] on Tuesday and it should have been given to them right away. A review of the facility provided policy titled, "Accommodation of needs and preferences and homelike environment" with an unknown revision date of 7/22/2023 revealed under, "Procedure" that "[the facility] will assess and interview [the] resident to make reasonable accommodations such as: [...] adaptive devices necessary to maintain/restore resident at their highest level of functioning ..." During an interview on 9/27/2024 at 9:34 AM, the [redacted], in the presence of the survey team, acknowleged that the [redacted] should be accessible at all times.	F 810		
F 812 SS=F	NJAC 8:39-27.5(b) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		10/22/24

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F 812	Continued From page 40 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 09/23/2024 from 07:57 AM to 08:27 AM the surveyor, accompanied by the US FOIA (b)(6)), observed the following in the kitchen: 1. The surveyor observed a dietary worker walking around the kitchen with a full beard and no beard guard. 2. In refrigerator #1 an unopened package of hot dogs with a use- by-date of 09/18/2024. There was also a large metal tray of raw salmon covered with plastic wrap that was not labeled or dated. The US FOI removed and discarded items. 3. In refrigerator # 9 there was a plastic container of hard-boiled eggs, a plastic container of feta cheese, a plastic container of mozzarella cheese, and a plastic container of grilled chicken all with the use by date of 09/21/2024. There was also an open carton of potato salad in a plastic bag with no date. There was also a plastic container or peeled mandarin oranges with a use by date of 09/22/2024. The US FOI removed and discarded all	F 812	F812 The following corrective actions have been implemented: F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) Residents identified All Residents 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Food Service Director and Assistant Food Service Director in-serviced all dining staff responsible for food preparation (cooks, cold prep, and dining aides) on the policy and procedure of dating/labeling and storing food. The in-service, performed by the Food Service Director, also focused on the procedure when food items are out of code and the immediate disposal of those items. The dining aides, cold prep and cooks were also in-serviced by the Food Service Director on policy regarding head and facial	

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F 812	Continued From page 41 items. 4. In refrigerator # 7 there were 2 tray metal trays of raw chicken wrapped in plastic labeled 9/14-12/14. When asked what those dates meant the US FOI stated, "I am not sure what that means and removed and discarded the trays. Also found was a large plastic bin of sliced ham with a metal pan of chunks of ham inside of it all wrapped in plastic with no label or date. The US FOI said the ham was prepped yesterday and should have been labeled. There were also 3 crates of milk cartons directly on the floor. 5. In the walk-in freezer there was an opened bag of pepperoni slices wrapped in plastic with no label or date. The US FOI removed and discarded the items. During an interview on 09/23/2024 at 11:09 AM with the surveyor, the US FOIA (b)(6) stated, "Everything in the fridge and freezer should be labeled and removed after the use-by-dates." When asked if staff with beards should be wearing beard guards in the kitchen, the US FOIA (b replied, "yes". When asked about milk cartons being directly on the ground the US FOIA (b replied "No they shouldn't be on the ground." During an interview on 09/25/2024 at 12:49 PM with the surveyor the US FOIA (b)(6) stated, "In the kitchen I go in early and look for anything on the floors, check the fridge temps, hairnets, that they are washing their hands." when asked what the process for surveilling the kitchen was. When asked if staff with beards should be wearing a beard guard, the US F replied "Yes". A review of an undated facility provided policy	F 812	covers. All department heads in-service all staff that any person entering food preparation areas must wear hair covers. And any staff with facial hair is required to wear beard guards. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Dining Staff (cooks, cold prep, dining aides) are in-serviced by the Food Service Director and Assistant Food Service Director quaterly regarding the policy for label/dating and storing food as well as our policy regarding hair and facial hair coverings. The in-services are recorded and filed in the event an employee has a reocurrance. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being	

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F 812	Continued From page 42 titled " Employee Sanitary Practices", revealed under " Procedure" that "All employes will: 1. Wear restraints (hairnet, hat and or beard restraint) to prevent hair from contacting exposed food. A review of an undated facility provided policy titled "Food Storage" revealed under "Procedure:" that "10. Food should be stored at a minimum of 6 inches above the floor, 18 inches from the ceiling and 2 inches from the wall with adequate space on all sides of stored items to permit ventilation ... 13. Refrigerated food storage: f. All foods should be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. 14. Frozen foods: c. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. N.J.A.C. 8:39-17.2(g)	F 812	corrected and will not recur. Daily audits for labeling and dates on all resident food items are being done by the Assistant Food Service director and Dietary Clerk then reported to Food Sevice Director for any discrepancies or items that are out of code. The audits are reported quarterly by the AFSD to the QAA committee along with the Food Service Director. The QAA meets quarterly and will review audits quarterly. This will be ongoing. The QAA then determines if additional in-service and/or training needs to be provided to the dining staff which would be facilitated by the Food Service Director and the Assistant Food Service Director.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 883		10/22/24

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F 883	Continued From page 43	F 883		

contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the

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F 883	Continued From page 44 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the NJ Exec Order 26.4b1 was offered to all residents upon admission to the facility to prevent incidence of NJ Exec Order 26.4b1 for 2 of 5 residents (Resident #4, Resident #32) reviewed for NJ Exec Order 26.4b1 administration. This deficient practice was evidenced by the following: 1. On 9/23/2024 at 8:38 AM, during the initial tour of the facility, the surveyor observed Resident #4 sleeping in bed in their room. A review of Resident #4's Admission Record revealed that the resident was admitted to the facility with diagnosis which included, but were not limited to, NJ Exec Order 26.4b1 [redacted] A review of Resident #4's Electronic Medical Record (EMR) could not provide documentation that the resident received or declined the NJ Exec Order 26.4b1 . On 9/24/2024 at 12:26 PM, the facility provided Resident #4's computer generated immunization record that did not identify a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 date. The facility also provided Resident #4's "New Admission/ Readmission Chart Review for Infections" which indicated under NJ Exec Order 26.4b1 "Yes" but a "?" under "Date".	F 883	F883 The following corrective actions have been implemented: F883 Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) Residents identified Resident # 4 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Infection preventionist created a form to document whether a resident recieved or declined the NJ Exec Order 26.4b1 and/or NJ Exec Order 26.4b1 which will be completed by the Infection preventionist. Resident #4 signed the declination form. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315418	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	**99 EAST MAIN STREET MARLTON, NJ 08053**

(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 883	Continued From page 45 In addition the consent boxes were not checked and the "documented in electronic records were not checked. On 9/26/2024 at 10:08 AM, during an interview with Surveyor #1, the US FOIA (b)(6)) advised that Resident #4's family could not provide any documentation that they received the NJ Exec Order 26.4b1 The US F confirmed that it is facility policy to offer the NJ Exec Order 26.4b1 which was not offered and a declination was not signed. The US F also acknowledged that it was their responsibility to ensure that their policy is followed. On 9/12/2024 at 11:22 AM in the presence of the survey team, the US FOIA (b)(6) confirmed that there was no proof on NJ Exec Order 26.4b1 administration for Resident #4 and "moving forward we will put it in the chart". NJAC 8:39-19.4 (h) (i) 2. On 09/23/2024 at 8:38 AM, during the initial tour of the facility, the surveyor observed Resident #32 dressed sitting in bed reading a paper. A review of Resident #32's Admission Record revealed that the resident was admitted to the facility with diagnosis which included, but were not limited to, NJ Exec Order 26.4b1	F 883	place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were in-serviced by the Infection preventionist on the new form for documentation of both the influenza vaccine and pneumococcal immunization and the need for the form to be completed and kept up to date. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Infection preventionist performed audits on all residents charts for immunization form completion. Infection preventionist will do monthly audits on all admissions to check immunization forms to ensure documentation of influenza and pneumococcal vaccines were administered or declined. This will be ongoing. Audit results will be reported by the Infection Preventionist monthly to the DON and the QAA committee. The DON will review audits monthly for three months and then quarterly. The QAA committee meets quarterly. The QAA committee will review audits quarterly. This will be ongoing. The DON/QAA committee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315418	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	**99 EAST MAIN STREET MARLTON, NJ 08053**

(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 883	Continued From page 46 and NJ Exec Order 26.4b1 A review of Resident #32's Electronic Medical Record (EMR) could not provide documentation that the resident received or declined the NJ Exec Order 26.4b1 . On 09/24/2024 at 09:33 AM, the facility provided Resident #32's "New Admission/ Readmission Chart Review for Infections" which indicated under NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 "NO". In addition, the consent boxes were not checked and the "documented in electronic records were not checked. During an interview on 09/25/2024 at 09:45 AM with Surveyor #2, the US FOIA (b)(6) said that Resident #32 refuses all NJ Exec Order 26.4b1 When asked if there was a declination form that the resident signed, the US F stated, "No we don't have a form if they decline" When asked how refusals are documented the US F replied, "there is no documentations on refusals, I am not sure why." During an interview on 09/25/2024 at 01:12 PM with Surveyor #2, The US FOIA (b)(6)) stated, "we don't document that at this time, I think the US F sometimes writes it on the admission check off sheet if they refuse" when asked where refusals of NJ Exec Order 26.4b1 were documented. When asked if refusals should be documented the US FOIA (b) stated, "yes, from here on out they will be." A review of the facility provided "Immunization of Residents" Policy, with a Version date of April 15, 2015, revealed under the title " Procedure" that, "2. All new residents (Health Care Center and	F 883	determine when the problem is resolved or if more training is required. Resident # 32 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Infection preventionist created a form to document whether a resident recieved or declined the NJ Exec Order 26.4b1 which will be completed by the Infection preventionist. Resident #32 signed the declination form. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were in-serviced by the Infection preventionist on the new form for documentation of both the influenza vaccine and pneumococcal immunization and the need for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315418	A. BUILDING _____ B. WING _____	C 09/27/2024

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WILEY MISSION	**99 EAST MAIN STREET MARLTON, NJ 08053**

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F 883	Continued From page 47 Residential Health Care) must be assessed for influenza and pneumococcal vaccine upon admission: 3. Because long-term care residents are prone to developing serious complications when they contact the flu, all residents receive a flu vaccination during the fall of each year, unless otherwise ordered by the residents attending physician or the resident refuses: 5. The original consents are filed in the resident's medical record." NJAC 8:39-19.4 (h) (i)	F 883	the form to be completed and kept up to date. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Infection preventionist performed audits on all residents charts for immunization form completion. Infection preventionist will do monthly audits on all admissions to check immunization forms to ensure documentation of influenza and pneumococcal vaccines were administered or declined. This will be ongoing. Audit results will be reported by the Infection Preventionist monthly to the DON and the QAA committee. The DON will review audits monthly for three months and then quarterly. The QAA committee meets quarterly. The QAA committee will review audits quarterly. This will be ongoing. The DON/QAA committee will determine when the problem is resolved or if more training is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030307	A. BUILDING: _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	99 EAST MAIN STREET MARLTON, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey from 05/12/2024 to 05/18/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts and for the 2 weeks of staffing prior to survey from 09/08/2024 to 09/21/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: This deficient practice was evidenced by the following: Reference: New Jersey Department of Health	S 560	S560 The following corrective actions have been implemented: S560 Mandatory Access to Care 8:39-5.1(a) 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON and/or staffing coordinator will review the schedule weekly to ensure the required minimum direct care staff to resident ratios	10/22/24

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

Electronically Signed | 10/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030307	A. BUILDING: _____ B. WING _____	C 09/27/2024

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S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA staffing for residents on 3 of 7 day shifts from 05/12/2024 to 05/18/2024 on the following dates: -05/15/24 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -05/17/24 had 4 CNAs for 52 residents on the day shift, required at least 6 CNAs. -05/18/24 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs. The facility was deficient in CNA staffing for residents on 4 of 14 day shifts from 09/08/2024 to 09/21/2024 as follows:	S 560	are maintained. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice if direct care staff to resident ratios are not maintained. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All Charge Nurses and unit secretaries were inserviced on protocol with call outs including notifying all staff through OnShift of shift availability with call outs. Incentive bonuses will continue to be offered to CNA's for picking up extra shifts. Wiley will continue to use our own CNA pool as well as agency staff to supplement our staffing needs. Wiley will continue to partner with a local CNA program to hire student nursing assistants and will continue to train them during the semester. 4. How the facility will monitor its	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030307	A. BUILDING: _____ B. WING _____	C 09/27/2024

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S 560	Continued From page 2 -09/13/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -09/16/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -09/17/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -09/19/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 09/27/24 at 09:48 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that she performed the staffing for the facility nursing staff. The DON stated that she determined staffing levels to meet the resident's needs ahead of time and through education and competencies assured that all staff were aware of how to take care of the resident. She stated that according to the facility assessment that staffing was determined according to resident acuity and census. She stated that the facility had decreased their resident census to accommodate the staffing needs of the facility. She stated that if there was an anticipated staffing shortage that she would put more staff on the schedule then anticipated. She added that incentives and bonuses were offered to try and maintain longevity. The facility policy titled; "Nursing Department Staffing" dated 08/01/2024 indicated that it was the policy of the facility to provide adequate staffing to ensure high quality of care for all residents. The policy indicate that the DON would review schedule weekly or more often if needed to ensure the required minimum direct care staff to resident ratios were maintained. Facility would review the person-centered staffing plan in conjunction with the facility assessment review.	S 560	corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON will review and/or staffing coordinator the CNA schedule weekly and 24 hours prior to the assigned day to ensure the required minimum direct care staff to resident ratios are maintained. The DON will report staffing compliance to the QAA committee monthly for three months and then quarterly. QAA committee will review DON reports quarterly. QAA committee will meet quarterly and more frequently if needed to review and discuss compliance with staffing. This will be ongoing.	

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
315418 Y1	A. Building B. Wing Y2	11/4/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	99 EAST MAIN STREET MARLTON, NJ 08053

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 F0604	Correction	ID Prefix F0610	Correction	ID Prefix F0641	Correction
Reg. # 483.10(e)(1), 483.12(a)(2)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	10/22/2024	LSC	10/22/2024	LSC	10/22/2024
ID Prefix F0656	Correction	ID Prefix F0658	Correction	ID Prefix F0690	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	10/22/2024	LSC	10/22/2024	LSC	10/22/2024
ID Prefix F0810	Correction	ID Prefix F0812	Correction	ID Prefix F0883	Correction
Reg. # 483.60(g)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	10/22/2024	LSC	10/22/2024	LSC	10/22/2024
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?
9/27/2024	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315418 Y1	A. Building B. Wing Y2	11/4/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	99 EAST MAIN STREET MARLTON, NJ 08053

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 F0604	Correction	ID Prefix F0610	Correction	ID Prefix F0641	Correction
Reg. # 483.10(e)(1), 483.12(a)(2)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	10/22/2024	LSC	10/22/2024	LSC	10/22/2024
ID Prefix F0656	Correction	ID Prefix F0658	Correction	ID Prefix F0690	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	10/22/2024	LSC	10/22/2024	LSC	10/22/2024
ID Prefix F0810	Correction	ID Prefix F0812	Correction	ID Prefix F0883	Correction
Reg. # 483.60(g)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	10/22/2024	LSC	10/22/2024	LSC	10/22/2024
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?
9/27/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030307 Y1	A. Building B. Wing Y2	11/4/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	99 EAST MAIN STREET MARLTON, NJ 08053

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 10/22/2024	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	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 9/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: 07W512

STATE FORM: REVISIT REPORT (11/06)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
030307		11/4/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	99 EAST MAIN STREET MARLTON, NJ 08053

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 10/22/2024	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	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 9/27/2024	☐ 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
	315418	A. BUILDING **01** B. WING _____	**09/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	**99 EAST MAIN STREET** **MARLTON, NJ 08053**

(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 Wiley Mission was 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 on 9/24/24, 9/25/24, and 9/26/24, Wiley Mission 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 Occupancies. Wiley Mission is a two (2) story, Type II (222) unprotected construction that was built in the 60's. The health care building is divided into 6 smoke zones. The facility has two (2) exterior 350 KW diesel generators that provide power to approximately 80% of the building as per the Plant Operations Director. The healthcare facility is attached to 2 residental unit identified as Aldersgate and Hackett, both with 2-hour seperation from the healthcare building. *currently the D-wing (subacute) is unoccupied. The healthcare facility is licensed for 86 long term care beds and is currently occupying 50.	K 000		

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

Electronically Signed | 10/18/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315418	A. BUILDING **01** B. WING _____	**09/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	**99 EAST MAIN STREET** **MARLTON, NJ 08053**

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K 291 SS=E	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 and interview on 9/25/24, in the presence of the US FOIA (b)(6) it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 3 transfer switches in the healthcare facility and was evidenced by the following: Observations on 9/25/24 at 1:07 PM in the presence of the US FOIA (b)(revealed in the lower level generator room where the (3) generator transfer switches were located, that the room was equipped with two (2) battery back-up emergency lighting fixtures. One of two fixtures did not function when the US FOIA (b) activated the test button. The fixture that would not illuminate provided emergency lighting to 1 of the transfer switches. In an interview at the time of observation, the US FOIA (b) confirmed the above observations. The US FOIA (b) indicated he could not provide a monthly and annual 90 minute functional testing log. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 9/26/24 at 12:45 PM.	K 291	K291 □ Emergency Lighting 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The emergency lighting battery next to the transfer switch in lower level of health care center was replaced and tested. Along with our quarterly fire inspection facility will institute 90 minute annual testing for all emergency lighting. Proof of battery replacement attached. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure	10/22/24

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K 291	Continued From page 2 NJAC 8:39-31.2(e)	K 291	that the deficient practice would not recur: Facility established a policy and procedure for testing emergency lighting on an annual basis. Maintenance staff were in-serviced by Dir. of Plant Services. The in-service was completed on October 1, 2024. Monitoring will occur with quarterly inspection and fire departments quarterly inspection. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The quarterly inspections and annual testing will be shared with the QAPI team on a quarterly basis for one year.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		10/22/24

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K 324	Continued From page 3 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/26/24 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to provide the required instructional signage above the Class K portable fire extinguisher to ensure all portable fire extinguishers were ready for use in accordance with the requirements of NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition, Section 5.5.5.3(a). This deficient practice had the potential to affect 20 residents in the facility and was evidenced by the following: An observation at 11:28 AM during the kitchen tour, revealed two (2) K-type fire extinguishers that did not have the required instructional placard indicating: "Warning in case of appliance fire, use this extinguisher only after fixed suppression system has been activated."	K 324	K324 Cooking Facilities 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility purchased the proper signage and installed. Please see uploaded photo. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice.	

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K 324	Continued From page 4 In an interview at the time of observation, the US FOIA (b) stated that he was unaware of this requirement. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 9/26/24 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 10	K 324	3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur: The Plant Service director in-serviced dining staff on October 21, 2024 on proper use of fire extinguishers. Dir. of Plant services will conduct annual education with dining department on fire extinguisher types and usage. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: A report on attendance of dining staff on education session and a report given to the QAPI committee. Annual education on proper use of fire extinguishers with dining staff will be submitted annually to the QAPI committee on a annual basis.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4.	K 531		10/22/24

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K 531	Continued From page 5 Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 9/24/24 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to conform with Firefighter's Service Requirements of ASME/ANSI A17.3 and NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. This included firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation for 1 of 1 devices. This deficient practice had the potential to affect 50 residents and was evidenced by the following: In an interview at 11:02 AM, the surveyor asked the US FOIA (b) [redacted] for the Phase I and Phase II firefighters monthly recall documentation for the healthcare #3 passenger elevator. The US FOIA [redacted] stated that currently the required monthly testing was not being performed.	K 531	K531 Elevators 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The contractor tested Phase 1 and Phase 2 on October 22, 2024. The contractor will perform bi-annual Phase 1 and Phase 2 tests. The contractor in-serviced maintenance staff on how to conduct Phase 1 and Phase 2 testing on October 22, 2024. Proof of testing attached.	

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K 531	Continued From page 6 The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 9/26/24 at 12:45 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur: Facility will keep monthly log report on the testing. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Log book report will be provided to the QAPI team on a quarterly basis. This will be completed for one year.	
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.	K 761		10/22/24

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K 761	Continued From page 7 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 on 9/24/24 and 9/25/24 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101: 2012 Edition, Section 7.2.1.15 and NFPA 80: 2010 Edition, Section 5.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: A document review at on 9/24/24, revealed there were no documented annual fire door inspections provided by the facility. In an interview on 9/25/24 at 09:30 AM, the US FOIA (b)(6) stated that the facility had no documented inspections of the fire doors in the previous year. The facility's US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 9/26/24 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	K761 Maintenance, Inspection & Testing - Doors 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Plant Operation Director who is NFPA certified checked all facility doors and found all were in compliance. This was completed October 21, 2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur:	

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K 761	Continued From page 8	K 761	Plant Services Director will on a monthly inspect all doors and log. Maintenance staff were in-serviced by Dir. of Plant Services with policy & procedure on how to report and identify doors in need of review by Dir. of Plant Services. On annual basis Dir. of Plant will measure gaps and check hardware and make any repairs needed to fire doors. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Monthly log and annual report will be given to the QAPI team on a quarterly basis for one 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	K 921		10/22/24

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K 921	Continued From page 9 or modification. Any system consisting of several electrical appliances demonstrates compliance 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 documentation review and interview on 9/24/24, in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) intervals were established with policies and protocols for Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1 and 10.3.5.4. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's maintenance records on 9/24/24, revealed there was no documentation regarding ITM for PCREE. In an interview on 9/24/2024 at 9:30 AM, the US FOIA (b	K 921	K921 Electrical Equipment - Testing and Maintenance 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Facility established a record of inspections of all PCREE equipment in accordance with our annual contractor that inspects all PCREE equipment in facility. Please see uploaded log. 2. How the facility will identify other	

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K 921	Continued From page 10 stated there was no ITM documentation for PCREE that included patient beds, air mattresses, oxygen concentrators, nebulizer and similar items that were used for patient care. The facility's US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 9/26/24 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur: Facility established a monthly log book and added a policy to add monthly inspection. In-servicing on testing and procedure was conducted by Dir. of Plant Services with all maintenance staff on October 19, 2024. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Monthly log report will be provided to the QAPI team on a quarterly basis for one 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
315418 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/4/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	99 EAST MAIN STREET MARLTON, NJ 08053

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 K0291	10/22/2024	LSC K0324	10/22/2024	LSC K0531	10/22/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0761	10/22/2024	LSC K0921	10/22/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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?
9/27/2024	☐ YES ☐ NO