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 07/21/2023

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey Census: 53 Sample Size: 24 + 3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. Compalint # NJ 161082, NJ 162368, NJ 162805, NJ 163475	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		8/2/23

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

Electronically Signed | 08/05/2023

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

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote a home-like dining atmosphere for 1 of 1 facility dining rooms. This deficient practice was evidenced by the following: 1. On 07/13/2023 at 12:21 PM, the surveyor observed the lunch meal in the facility main dining room. The surveyor observed 30 residents present at the lunch meal. All 30 residents received their meal on a tray. 2. On 07/14/2023 at 11:55 AM, the surveyor observed the lunch meal in the facility main dining	F 584	F584 The following corrective actions have been implemented: F584 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) Residents identified All residents in Dining Room (DR) for meals 1. How the corrective action will be	

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F 584	Continued From page 2 room. 25 residents were observed in the dining room. 25 residents received their lunch meal served on a tray. 3. On 07/17/2023 at 12:25 PM, the surveyor observed the lunch meal in the main dining room. There were 29 resident's present in the main dining room for the lunch meal. 29 of 29 resident's received their lunch meal on a tray. 4. On 07/18/2023 at 12:05 PM, the surveyor observed the lunch meal in the main dining room. 28 residents were present at 7 tables in the dining room. 28 residents received the lunch meal on a tray. 5. On 07/19/2023 at 12:25 PM, the surveyor observed the lunch meal in the MDR. There were 25 residents present in the dining room at the lunch meal. 25 residents were observed to receive the lunch meal on at tray. On 07/20/2023 at 01:58 PM, the surveyor conducted an interview with the facility Licensed Nursing Home Administrator (LNHA) and the facility Director of Nursing (DON). The surveyor pointed out the facility dining practice of serving residents meals on plastic trays. The facility LNHA stated that the facility had previously not used trays to serve meals in the main dining room prior to COVID. However, once communal dining was restarted the facility had been serving meals on trays. The LNHA agreed that residents should not be served on trays as it did not create a "home-like environment." The facility did not provide a policy for home-like environment during meals.	F 584	accomplished for those residents found to have been affected by the deficient practice. Nursing supervisor and team nurse observed staff removing items from ALL resident trays at mealtime in the DR. Nursing, Therapy and Activity staff were in-serviced on taking everything off of resident trays in the DR and placing them on the table. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who eat in the DR 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, therapy and activity staff were in-serviced on removing everything off of all resident trays during meals and placing all items on the table in the DR. A policy & procedure for home-like environment during meals was created and implemented.	

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F 584	Continued From page 3 NJAC 8:39.4(a)(12)	F 584	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Nursing supervisor and/or team nurse will observe all meals being served in the DR daily to ensure everything is removed from trays and placed on tables to create a homelike environment. Monthly audits will be performed by staff education. Results will be reported monthly to the Director of Nursing(DON) and the 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.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		8/2/23

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F 684	Continued From page 4 This REQUIREMENT is not met as evidenced by: C/O # NJ 161082 Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to follow a physician order and care plan for the use of an *Ex Order 26. 4B1* [redacted] for 1 of 24 sampled residents, Resident #41. This deficient practice was evidenced by the following: During the initial tour of the facility on 07/13/2023 at 10:25 AM, Resident #41 said he/she had a *Ex Order 26. 4B1* and also [redacted] and *Ex Order 26. 4B1*. The Resident was out of bed sitting in a wheelchair. According to the Admission Record, Resident #41 was admitted to the facility with diagnoses including but not limited to: *Ex Order 26. 4B1* [redacted] According to the Minimum Data Set dated [redacted], an assessment tool used to facilitate care, revealed a *Ex Order 26. 4B1* [redacted] of [redacted]/15 indicating *Ex Order 26. 4B1* [redacted]. Section G indicated the resident required [redacted] staff assistance for bed mobility and transfers. A review of the Order Recap Report dated 01/01/2023-01/31/2023 revealed a physician order with a order date of [redacted], for *Ex Order 26. 4B1* every shift for *Ex Order 26. 4B1* NJ Exec. Order 26:4.b.1 [redacted]	F 684	F684 The following corrective actions have ben implemented: F 684 Quality of Care CFR(s): 483.25 Residents identified Resident #41 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Beginning on 1/31/2023 through February 2023 all staff involved were in-serviced on following careplans, documentation and the use of an *Ex Order 26. 4B1*. New hires have also been in-serviced on careplans, documentation and the use of an *Ex Order 26. 4B1*. 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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F 684	Continued From page 5 A review of the Order Recap Review also revealed a physician order for *Ex Order 26. 4B1* [redacted] give 2 tablets by mouth three times a day related to unspecified *Ex Order 26. 4B1* [redacted], subsequent encounter for NJ Exec. Order 26:4.b.1 [redacted] Two tabs=*Ex Order 26. 4B1*. A review of the Treatment Administration Record (TAR) revealed that the *Ex Order 26. 4B1* was signed as having been in place when in bed on NJ Exec. Order 26:4.b.1 [redacted]. A review of the care plan revealed a Problem of ADL's: (Activities of Daily Living) NJ Exec. Order 26:4.b.1 [redacted] ... Readmitted with *Ex Order 26. 4B1*. Under the interventions included, the Resident has 2 *Ex Order 26. 4B1*. NJ Exec. Order 26:4.b.1 [redacted]. A review of the Progress Notes revealed the following: On *Ex Order 26. 4B1* [redacted] timed at 15:08 (3:08 PM) resident was readmitted to the facility and admission weight was taken with *Ex Order 26. 4B1* with bed *Ex Order 26. 4B1* [redacted] and both *Ex Order 26. 4B1* on NJ Exec. Order [redacted] On NJ Exec. Order 26:4.b.1 [redacted] timed at 07:40 AM revealed resident complained of *Ex Order 26. 4B1* NJ Exec. Ord[redacted] and medicated with prn (as needed) *Ex Order 26. 4B1* at 5am which was effective. On NJ Exec. Order 26:4.b.1 [redacted] timed at 11:36 (AM) revealed *Ex Order 2*[redacted] and NJ Exec. Order 26:4.b.1 *Ex Orde*[redacted]. NP (Nurse Practioner) aware. *Ex Order 26.* [redacted] of *Ex Orde*[redacted] ordered. On NJ Exec. Order 26:4.b.1 [redacted] timed at 18:30 (6:30 PM) revealed *Ex Order 26. 4B1* [redacted] done. *Ex Order 26. 4B1* [redacted]	F 684	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 in January/February 2023 on following careplans, documentation and use of an *Ex Order 26. 4B1* [redacted] for resident #41. All new hires were also in-serviced. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Since 1/31/2023 staff education has been performing monthly checks on residents to ensure careplans are being followed and documentation is correct. Staff education also checked to ensure abduction pillow was placed correctly. Team nurse on all shifts checked for placement of abduction pillow. Staff education will continue to perform monthly audits on 10% of residents to ensure careplans are being followed and documentation is correct. Audits will be reported monthly to the Director of Nursing(DON)and to the QAA committee. The DON will	

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F 684	Continued From page 6 Ex Order 26. 4B1 of Ex Order 26. 4B1. NP aware. Ex Order 26 faxed to MD . Will send to Ex Order per Ex Order. Ex Order 26. arrived at 4:45pm for transport. On Ex Order 26. 4B1 timed at 22:36 (10:36 PM) Resident admitted to hospital dx (diagnosis): Ex Order 26. 4B1 A review of the facility reportable event dated NJ Exec. Order 26:4.b.1 revealed the Resident had NJ Exec. Order 26:4.b.1. Resident found that morning without the Ex Order 26. 4B1 place between his/her Ex Order 2. The Resident was complaining of Ex Order 26. 4B1. An Ex Order 26. was done and showed Ex Order 26. 4B1 with Ex Order 26. 4B1. Resident sent to Ex Order for evaluation. Under 2. prior to event was care plan developed that addressed this issue and were planned interventions in place when the event occurred. Yes care plan in place indicating that resident is to have Ex Order 26. 4B1 in place when not in bed. A review of the facility Post Investigation/Conclusion signed and dated by the Director of Nursing (DON) dated NJ Exec. Order 26 revealed the following: daughter reported to nursing that she entered the resident's room and found her parent in bed with Ex Order 26. 4B1 over the right side of the bed and his/her Ex Order 26. 4B1 next to it. The resident c/o NJ Exec. Orde Ex Order 26. 4 was done and showed Ex Order 26. 4B1 with Ex Order 26. 4B1. Was admitted and had NJ Exec. Order 26:4.b.1 in the hospital under Ex Order 26. 4B1 on NJ Exec. Order 26:4 Spoke with 7am-3pm Certified Nursing Assistant (CNA) who stated that she entered residents room at 8am on NJ Exec. Order 26:4.1 with residents breakfast ray. At this time resident was in bed and both	F 684	review monthly. The QAA committee meets quarterly. The DON/QAA committee will determine when the problem is resolved or if more training is required.	

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F 684	Continued From page 7	F 684		

his/her [redacted] were in the middle of the bed. When asked about the *Ex Order 26. 4B1* the CNA said that she didn't check for it. [redacted] was reeducated about reading the residents care plan and following it.

Interview with NA 3PM-11PM shift on [redacted] (clarified with DON [redacted]) who said he didn't know the resident needed it. NA was counseled and reeducated on reading care plan on resident's door.

Interview with CNA who had the resident on 11PM-7AM shift [redacted] CNA stated she thought the *Ex Order 26. 4B1* was not being used anymore because it was not on the resident when she came on and the nurse who assisted her with positioning the resident never said anything about the pillow. CNA was reeducated on reading the residents care plan on the closet door and following it.

Interview with RN (Registered Nurse) who worked 7PM-7AM [redacted]. RN stated he did not check for the NJ Exec. Order 26:4.b.1 to be in place. RN documented it was in place. He stated he completely forgot. RN was disciplined and will be meeting with staff education nurse regarding documentation.

In conclusion, resident's care plan did state that the resident was to have *Ex Order 26. 4B1* on while in bed. Orders were in place. The nurse did not follow the care plan and the 3 CNA's did not follow the care plan which was on residents closet door in the room.
All nursing staff are being reeducated on *Ex Order 26. 4B1* and following care plans.

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F 684	Continued From page 8 During an interview with the surveyor on 07/19/2023 at 11:23 AM, the DON said Resident #41 did not have the Ex Order 26. 4B1 in place. The Ex Order 26. 4B1 walked in the room and the Ex Order 26. 4B1 was not in place and I started an investigation. The Resident c/o (complained of) NJ Exec. Ord and did the Ex Order 26. right then. The Resident had thrown his/her Ex Order 26. 4B1 over the side of bed and Ex Order 26. 4B1 was on the bed next to the Ex Order 26. 4B1 and I could tell by looking at it that the Ex Orde was Ex Order 26. 4B1. The resident was sent to the hospital. I determined that the nurse signed that the Ex Order 26. 4B1 was in place and it wasn't. One aide said they thought if the nurse didn't have the Ex Order 26. 4B1 in place, it was discontinued. The DON also said she determined staff needed a lot of in-services. The care plan did say the Ex Order 26. 4B1 was to be in place. The DON said they in-serviced all staff and Ex Order 26. 4B1 was involved. The Resident's room had pictures of how the staff was supposed to have pillows placed in the chair and in the bed. Ex Order 26. 4B1 assisted with all shift in-services as well. Ex Order 26. 4B1 thought the Ex Order to keep Ex Order 26. 4B1 may have played a part as it was very heavy. The DON confirmed the care plan wasn't followed. The DON said the Resident is very NJ Exec. Ord and I can't say that not using the Ex Order 26. 4B1 caused the Ex Order 26. 4B1. A review of a facility policy titled " Resident Assessment and Care Planning with revised date of NJ Exec. Order 26:4.b.1 revealed under the Policy section ..., the care plan is developed or updated in order to meet the residents need. NJAC 8:39-27.1(a)	F 684		

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F 692	Continued From page 9	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. 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 follow their own facility policy for [NJ Exec. Order 26:4.b.] for 1 of 3 residents (Resident #28) reviewed for [NJ Exec. Order 26:4.b.]. This deficient practice was evidenced by the following: On 07/13/2023 at 10:29 AM, the surveyor observed Resident#28 at an activity group. Resident #28 had a [Ex Order 26. 4B1] around their [Ex Order 26] and appeared [Ex Order 26. 4B1]. According to the face sheet, Resident #28 was	F 692	F692 The following corrective actions have been implemented: F692 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) Residents identified Resident #28 1. How the corrective action will be accomplished for those residents	8/2/23

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F 692	Continued From page 10 admitted to the facility with the following but not limited to diagnoses: *Ex Order 26. 4B1* [redacted]. According to the NJ Exec. Order 26:4.b.1, quarterly Minimum Data Set, an assessment tool, Resident #28 had a *Ex Order 26. 4B1* score of [redacted]/15, indicating *Ex Order 26. 4B1* [redacted]. Section G revealed Resident #28 required Ex Order 26. 4B1 [redacted] and Section K revealed that Resident #28 had Ex Order 26. 4B1 and was not on a *Ex Order 26. 4B1* [redacted]. A review of the Order Summary Sheet dated NJ Exec. Ord [redacted], revealed Resident #28 had the following physician orders: '*Ex Order 26. 4B1* [redacted] every evening shift every 4 weeks on Thursday. NJ Exec. Order 26:4.b.1 *Ex Order 26. 4B1* (*Ex Order 26. 4B1*) if applicable. NJ Exec. Order 26:4.b.1 [redacted] If +/- Ex Order 26. 4 OBTAIN NJ Exec. Order 26:4.b.1 ..(hours) IF NJ Exec. Order 26:4.b.1 +/- Ex Order 26. 4, NOTIFY NJ Exec. O [redacted] A review of the Medication Administration Record dated NJ Exec. Order 26:4.b.1 revealed that Resident #28 had a *Ex Order 26. 4B1* completed on NJ Exec. Order 26:4.b.1 and Resident #28 was measured at *Ex Order 26. 4B1*.. A review of the comprehensive care plan for Resident #28 revealed a care plan for NJ Exec. Order 26:4.b. Review of the care plan revealed under Interventions/Tasks '*Ex Order 26. 4B1* [redacted]" The care plan was	F 692	found to have been affected by the deficient practice. Nursing supervisor observed the CNAs involved weigh resident #28 and document. Policy was reviewed with CNAs. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who are weighed 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 on the policy and procedure for weighing and reweighing residents. Lifts with scales were purchased and have been delivered to ensure consistency. All staff were in-serviced on the use of the new lifts and the scales on the new lifts. 4. How the facility will monitor	

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F 692	Continued From page 11 undated. On 7/18/2023 at 9:16 AM, the surveyor reviewed the Ex Order 26. 4B1 for Resident #28. Included in the Ex Order was the weight record for Resident #28. The weight record revealed that Resident #28 had a documented weight of Ex Order 26. 4 on NJ Exec. Order 26:4.b.1 measured via Ex Order 26. 4B1. On NJ Exec. Order 26:4.b.1 Resident #28 had a weight of Ex Order .1#, indicating a Ex Order 26. 4B1. The weight on NJ Exec. Order 26:4.b.1 was measured via shower chair and not the Ex Order 26. 4B1 that Resident#28 was measured by on NJ Exec. Order 26:4.b.1. On NJ Exec. Order 26:4.b.1 Resident #28 had a weight of Ex Order 26. 4, no scale was indicated for this weight. On NJ Exec. Order 26:4.b.1 Resident #28 had a weight of Ex Order 26. 4 measured via shower chair. This represented a weight NJ Exec. Order 26:4 of Ex Order 26 pounds over a seven-day period. According to the physician order for weights Resident #28 should have been NJ Exec. Order 26:4.b.1 because they had a weight NJ Exec. Order 26:4.b.1 +/- Ex Order 26. 4B1. The next weight for Resident #28 was completed on NJ Exec. Order 26:4.b.1, 9 days after the weight NJ Exec. Order 26:4. of +/- Ex occurred. On 07/21/2023 at 09:39 AM, the facility Director of Nursing told the surveyor, "Staff has been in-serviced on our weight policy and we have ordered 2 new lift scales and we are not going to use the wheelchair and shower scales anymore." The surveyor reviewed the facility policy titled WEIGHT POLICY, revised 11/22/11 and effective date: "Nov 2011." The following was revealed under the heading PROCEDURE: 1. Upon admission, all Healthcare Residents will be weighed weekly for 4 weeks. All Healthcare Center residents will be weighed the first week of	F 692	its corrective actions to ensure that the deficient practice is being corrected and will not recur. On a monthly basis staff education will audit 10% of residents who are weighed to ensure weights and reweights are being performed according to policy. Audits will be reported monthly to the Director of Nursing (DON) and to the QAA committee. The DON will review monthly. The QAA committee meets quarterly. The QAA committee/DON will determine when the problem is resolved or if additional training is needed.	

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	315418	A. BUILDING _____ B. WING _____	C 07/21/2023

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F 692	Continued From page 12 each month on their bath day. All residents must be weighed on the same shift, on their bath day, using the same scale. The team leaders and supervisors are responsible for reviewing previous and current weight for all residents weekly. Trends and changes are to be documented and followed according to this policy. All weights must be recorded in the supervisor's book and in the IMAR. 2. If a weight change of +/- five (5) pounds from the previous weight occurs, the resident will be re-weighed in 48 hours. The supervisor will meet with the dietician weekly to evaluate the need for weekly weights and other interventions. N.J.A.C. 8:39-27.1(a)	F 692		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation it was determined that the facility failed to ensure that a resident received care and services for the provision of parenteral fluids (intravenous) consistent with professional standards of practice, specifically by failing to label and date, as appropriate, infusion fluids and lines for 1 of 1 resident (Resident #21) identified for *Ex Order 26. 4B1* .	F 694	F694 The following corrective actions have been implemented: F694 Parenteral/IV Fluids CFR(s): 483.25(h) Residents identified Resident #21	8/2/23

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F 694	Continued From page 13 This deficient practice was evidenced by the following: On 7/13/2023 at 10:21 AM, during the initial tour of the facility, the surveyor observed an Ex Order 26. 4B1 of Ex Order 26. 4B1 hanging from a pole in Resident #21's room. The bag had no label identifying the resident, dose, or order, and the Ex Order 26. 4B had no date on it showing when it was initiated. At that time, the Ex Order 26 was not connected to the resident. On 7/18/2023 at 9:06 AM, the surveyor observed Resident #21 in bed. At that time, the surveyor observed the bag of Ex Order 26 hanging from a pole, connected to Resident #21 via Ex Order 26. 4B1 located on his/her NJ Exec. Order 26:4.b.1. The bag of Ex Order 26 had no label on it. A review of Resident #21's quarterly Minimum Data Set (an assessment tool) dated NJ Exec. Order 26:4.b.1, revealed that he/she was receiving Ex Order 26. 4B1 while a resident in the facility. A review of Resident #21's physician's orders revealed an ordered for Ex Order 26. 4B1 to be Ex Order 26. 4B1 at Ex Ord at bedtime for Ex Order 26. 4B1 . A review of Resident #21's Care Plan with a revision date of NJ Exec. Order 26:4.b.1 revealed an intervention to give Ex Order 26. 4B1 as ordered, Ex Order 26. 4 of Ex Order 26. 4B1 per hour during hours of sleep.	F 694	1. How the corrective action will be accomplished for those residents found to be affected by the deficient practice. Ex Order 26. 4B1 of Ex Order 26. 4B1 , and Ex Order 26. 4B were discarded for resident #21. Staff education in-serviced the nurses involved on labeling and dating Ex Order 26. 4B1 . 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving IV fluids 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 on the policy and procedure for labeling IV fluid bags and IV tubing. IV policy was updated to include labeling of IV fluids/tubing. 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 694	Continued From page 14 On 7/19/2023 at 12:32 PM, during an interview with the surveyor, the Registered Nurse #1 stated that IV bags should be labeled when used. On 7/20/2023 at 1:35 PM, during an interview with the surveyor, the Director of Nursing stated, "In a semi-private room, it (IV Bag) should be labeled and the tubing dated." She further said that the label on the bag should contain the name of the resident and dosing. The facility was unable to provide a policy referencing the labeling of IV fluids. NJAC 8:39-25.2 (c) 5	F 694	On a monthly basis staff education will audit all residents receiving IV fluids to ensure IV bags/tubing are being labeled according to policy. Audits will be reported monthly to the director of nursing(DON) and to the QAA committee. The DON will review monthly. The QAA committee meets quarterly. The DON/QAA committee will determine if the problem is resolved or if additional training is needed.	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to provide necessary *Ex Order 26. 4B1* consistent with professional standards of practice specifically by leaving a *Ex Order 26. 4B1* mask exposed on top of a nightstand when not in use, failing to date *Ex Order 26. 4B1*,	F 695	F695 The following corrective actions have been implemented: F695 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	8/2/23

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F 695	Continued From page 15 and failing to appropriately store a Ex Order 26. 4B1 when not in use and failed to update the care plan for 4 of 5 residents (Resident #1, Resident #12, Resident #21, Resident #23) investigated for Ex Order 26. 4B1. The deficient practice was evidenced by the following: 1.) On 7/13/2023 at 10:09 AM during the initial tour of the facility, Surveyor #1 observed Resident #1 in his/her room. At that time, Resident #1 was wearing a Ex Order 26. 4B1 [redacted]. The tube did not reveal a date when it was replaced. On 7/14/2023 at 12:24 PM during the dining observation, Surveyor #1 observed Resident #1 seated at a table in the dining room. The [redacted] was connected to him/her. At that time, Surveyor #1 did not observe a date on the [redacted] indicating when it was replaced. Surveyor #1 also observed some of the Ex Order 26. 4B1 [redacted] in contact with the floor. A review of Resident #1's Physician Orders located in the Electronic Medical Record (EMR) revealed an order for Ex Order 26. 4B1 delivered at Ex Order 26. 4B1 per minute. The Physician Orders also revealed that Ex Order 26. 4B1, humidifiers, and masks Ex Order 26. 4B1 must be replaced every Friday 11-7 shift. A review of Resident #1's Diagnosis located in the EMR revealed a diagnosis of Ex Order 26. 4B1 [redacted]. A review of Resident #1's Care Plan with a	F 695	Residents identified Resident #1 1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Infection Preventionist (IP) met with staff involved and reviewed policy and procedure for handling/ labeling/storage of Ex Order 26. 4B1 and Ex Order 26. 4B1. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving oxygen (O2) 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 on the policy and procedure for handling/labeling/storing nasal cannulas and O2 tubing. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected	

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F 695	Continued From page 16 revision date of [NJ Exec. Order 26:4.b.1] located in the EMR revealed an intervention to administer [Ex Order 26. 4B] as ordered. On 7/19/2023 at 9:44 AM during an interview with Surveyor #1, the Infection Preventionist replied, "No." when asked by the surveyor if tubing from a nasal cannula should ever be on the floor. She stated, "Germs" when asked by the surveyor why it would be important to not have the nasal cannula in contact with the floor. On 7/20/2023 at 1:35 PM, during an interview with Surveyor #1, the Director of Nursing stated, "In a plastic bag. Usually, they put it on the bedside table in the top drawer next to the bed." when asked by the surveyor how should a nasal cannula be stored when not in use. Further, the DON confirmed that a nasal cannula should never be in contact with the floor. 2.) On 7/13/2023 at 10:20 AM during the initial tour of the building while in Resident #21's room, Surveyor #1 observed a [Ex Order 26. 4B] mask on the night stand next to the bed. The [Ex Order 26. 4B] mask was not in a bag or stored. On 7/18/2023 at 9:06 AM while in Resident #21's room, Surveyor #1 observed the [Ex Order 26. 4B] mask on the bedside table. The [Ex Order 26. 4B] mask was not in a bag or stored. At that time, during an interview with the surveyor, Resident #21 said he/she uses the [Ex Order 26. 4B] every night. A review of Resident #21's quarterly Minimum Data Set (MDS; an assessment tool) dated [NJ Exec. Order 26:4.b.1] revealed that he/she had a [Ex Order 26] score of [Ex Ord], indicating	F 695	and will not recur. On a monthly basis IP will perform an audit on all residents on O2 to ensure policy is being followed for handling/ labeling/storing of O2 tubing/nasal cannulas and humidifiers. On a monthly basis staff education and/or Quality Assurance and Performance Improvement (QAPI) nurse will perform an audit on all nursing careplans on residents receiving O2 to ensure the careplan has been updated with current O2 orders. Audits will be reported monthly to the Director of Nursing(DON) and to the QAA committee. The DON will review monthly. The QAA committee meets quarterly. The DON/QAA committee will determine when the problem is resolved or if additional training is required. Resident # 21 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. IP met with staff involved and reviewed the policy and procedure for handling/storage and	

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F 695	Continued From page 17 that he/she was Ex Order 26. 4B1. A review of Resident #21's Physician's Orders located in the Ex Order 26. 4B1 revealed an order for him/her to use the Ex Order 26. 4B at bedtime and to be removed in the morning. The Physician's Orders also revealed orders to clean the exterior of the Ex Order 26. 4B surface, Ex Order 26. 4B, and to change the blue, disposable, ultra-fine filter in the Ex Order 26. 4B. A review of Resident #21's diagnosis located in the EMR revealed a diagnosis of Ex Order 26. 4B1 . A review of Resident #21's Care Plan created on 3/21/2023 and located in the EMR revealed an intervention for Resident #21 to wear the Ex Order 26. 4B while sleeping. On 7/19/2023 at 12:31 PM, during an interview with Surveyor #1, Registered Nurse (RN) #1 stated that the CPAP should be stored in a bag in a drawer if possible. On 07/21/2023 at 1:35 PM during an interview with the surveyor, the Director of Nursing replied, "In a plastic bag. Usually, they put it on the bedside table in the top drawer next to the bed." when asked by the surveyor how a CPAP should be stored. 3.) During the initial tour of the Ex Order 26. 4B1 Unit on 07/13/2023 at 10:46 AM, Resident #12 was observed in bed with head of the bed elevated approximately 65 degrees. Resident #12 had Ex Order 26. 4B1 in use via Ex Order 26. 4B1 with humidification Ex Order 26. 4 in place on Ex Order 26. 4B1 per minute. The Ex Order 26. 4B was undated. Resident #12	F 695	cleaning of Ex Order 26. 4B mask and Ex Order 26. 4B. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents using a CPAP machine 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 on the policy procedure for handling/storage and cleaning CPAP mask and tubing. 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 IP will perform an audit on all residents using CPAP to ensure nursing staff are handling/storing and cleaning the CPAP mask and tubing according to policy. Audits will be reported monthly to the DON and to the QAA committee. The DON will review monthly. The QAA committee meets quarterly. The DON/QAA committee will determine	

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F 695	Continued From page 18 said he/she just started with Ex Order 26. 4B1 due to Ex Order 26 problem. On 07/14/2023 at 08:41 AM, Resident #12 was observed sitting up in bed Ex Order 26. 4B1 in use Ex per minute with humidifier in use. The Ex Order 26. 4B1 was undated. A review of the Admission Record revealed Resident #12 was admitted with diagnoses including but not limited to: Ex Order 26. 4B1 . A review of a significant change MDS dated NJ Exec. Order 26:4.b.1 revealed a Ex Order 26. 4 score of NJ Exec /15 indicating Ex Order 26. 4B1 . Section O indicated Resident #12 used Ex Order 26. 4B1 when a resident. A review of the Ex Order 26. 4B1 with active Orders as of NJ Exec. Order 26:4.b.1 3 revealed Ex Order 26. 4B1 every shift NJ Exec. Order 26:4.b.1 . DOCUMENT Ex Order 26. 4B1 . The Ex Order 26. also indicated 'Ex Order 26. 4B1 : CLEANING every night shift every Fri ALL Ex Order 26. 4B1 , HUMIDIFIERS AND MASKS Ex Order 26. 4B1 MUST BE REPLACED EVERY FRIDAY 11-7 SHIFT." During an interview with Surveyor #2 on 07/14/2023 at 11:53 AM, Licensed Practical Nurse (LPN #1) the assigned nurse revealed If on continuous oxygen the physician goes over orders and tells us if a resident needs oxygen to be continued. Yes, we still need physician order. LPN #1 went on to say tubing changes weekly every Friday 11-7 shift. tubing and humidifier bottle. usually have little piece of tape with nurses	F 695	when the problem is resolved or if additional training is required. Resident #12 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. IP met with staff involved and reviewed the policy and procedure for handling/labeling and storage of Ex Order 26. 4B1 and Ex Order 26. 4B1 . 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving O2 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 on the policy and procedure for handling/labeling and storing of nasal cannulas and O2 tubing. 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 695	Continued From page 19 initials who changed it and the date. On 07/14/2023 at 11:57 AM, LPN #1 accompanied Surveyor #2 to Resident #12's room and Surveyor #2 asked LPN #1 to show them the date on the [redacted]. LPN #1 said I actually don't see a date, tape is usually at the end by the [redacted]. Resident #12 was interviewed at that time and said the staff changes the [redacted] every Friday night on 11-7 shift. 4.) During the initial tour of the [redacted] Unit on 07/13/2023 at 10:12 AM, Resident # 23 was observed sitting in his/her wheelchair (w/c) in their room. Surveyor #2 observed an [redacted] on back of the w/c, turned off/not in use. The [redacted] was hanging over the [redacted] undated, uncovered and exposed. Resident #23 said he/she does not use [redacted] and doesn't become [redacted]. On 07/14/2023 at 08:38 AM, Resident #23 was observed by Surveyor #2, sitting in their w/c with the [redacted] on the back of the w/c. The tubing was hanging over the [redacted], undated, uncovered and exposed. A review of the Admission Record revealed Resident #23 was admitted to the facility with diagnoses including but not limited to: [redacted]. A review of a significant change MDS dated [redacted] revealed a [redacted] score of [redacted]/15 indicating [redacted]. Section	F 695	On a monthly basis the IP will perform an audit on all residents receiving O2 to ensure the policy and procedure is being followed for handling/labeling storing of O2 tubing/nasal cannulas and humidifiers. Audits will be reported monthly to the DON and to the QAA committee. The DON will review monthly. The QAA committee meets quarterly. The DON/QAA committee will determine when the problem is resolved or if additional training is required. Resident #23 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. IP met with staff involved and reviewed the policy and procedure for handling/labeling and storage of [redacted] and the removal of all [redacted] from a resident'sroom when [redacted] is discontinued. Staff Education met with staff involved and reviewed physician orders and careplans with [redacted] administration. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 695	Continued From page 20 [redacted] did not include documentation of Resident #23 using [redacted] while a resident. A review of the Order Summary Report dated [redacted] did not include a physician order for [redacted]. A review of the discontinued physician orders revealed [redacted] as needed for as needed for [redacted], [redacted] with a start date of [redacted] and discontinued date of [redacted] A review of Resident #23's care plan revealed a focus area of [redacted] use with an initiated date of [redacted] and revised on [redacted]. Under the Goal Resident #23 will have no signs and symptoms of poor [redacted] absorption through the review date. Interventions included: [redacted] As ordered. During an interview with Surveyor #2 on 07/14/2023 at 11:53 AM, LPN #1 said Yes, we need a physician order for [redacted]. On 07/14/2023 at 11:59 AM, Surveyor #2 accompanied by LPN #1 went to Resident #23's room. LPN #1 said Resident #23 is not on [redacted] any more. the LPN and surveyor observed [redacted] and LPN said no [redacted] not to be like that. She said if [redacted] is not in use fold up the [redacted] and put tape around the end when not in use. Surveyor clarified with LPN that the tape went around the [redacted] and she replied yes. I know sometimes the resident needs [redacted] due to [redacted] when walking with [redacted] During an interview with Surveyor #2 on 07/20/2023 at 02:02 PM, the DON confirmed that a resident needs a physician order for oxygen	F 695	All residents receiving O2 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 is being corrected and will not recur. All nursing staff were in-serviced on the policy and procedure for handling/labeling and storage of nasal cannulas, O2 tubing, humidifiers and the removal of all O2 equipment from a residents room when O2 is discontinued. All nursing staff were in-serviced on physician orders with O2 administration. 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 IP will perform an audit on all residents receiving O2 to ensure policy and procedure is being followed for the handling/labeling/storage of O2 tubing/nasal cannulas and humidifiers. On a monthly basis staff Ed and/or QAPI will perform an audit on the nursing careplans of all residents receiving O2 to ensure	

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

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F 695	Continued From page 21 use. The DON further explained that when oxygen therapy is discontinued, the concentrator or tank are removed from the room or wheelcahir, tubing is discarded and the concentrator is cleaned by housekeeping. Surveyor #2 questioned what is the process for updating care plans should a intervention be discontinued if no longer appropriate. The DON replied we discuss it at morning meeting and change it then. We then hang in the closet door. When Surveyor #2 asked why the [redacted] was discontinued from Resident #23's care plan, the DON replied the intervention should have been discontinued. A review of the facility policy titled, "Oxygen/Nebulizer Equipment" dated 2/25/2016 revealed under section, "2. Oxygen Tanks" to, "Replace humidifiers, masks, cannulas and oxygen tubing every 7 days by the 3-11 shift. Nurses initial and date tubing..." A review of a facility policy titled "Resident Assessment and Care Planning" with a revision date of 10/25/22 revealed under 11. The care plan is to be updated accordingly at the time of the MDS review and at any time changes occur in the residents status (i.e., goals are met, interventions are no longer appropropriate...).	F 695	the careplans have been updated with the current O2 orders. Audits will be reported monthly to the DON and to the QAA committee. The DON will review monthly. The QAA committee meets quarterly. The DON/QAA committee will determine when the problem is resolved or if additional training is required.	
F 812 SS=E	§ 8:39-27.1 (a) 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,	F 812		8/2/23

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F 812	Continued From page 22 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. §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 review of other facility documentation, 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 7/13/2023 from 9:00 to 9:42 AM, the surveyor, accompanied by the Food Service Director (FSD) and Assistant Food Service Director (AFSD), observed the following in the kitchen: 1. In the dry storage room on a middle shelf an opened bag of breadcrumbs was stored inside a plastic bin. The bin was labeled "Bread Crumbs" and had a date of "3/3". The AFSD stated they are good for about a week after opening. We get these regularly, but the date wasn't changed. We date the bag, but this bag isn't dated." The AFSD removed the bread crumbs to the trash. On the same shelf, a clear plastic scoop used to access bulk foods was lying on the wire shelf uncovered	F 812	F812 The following corrective actions have been implemented: F812 Food Procurement,Store/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. Food Service Director (FSD) and Assistant Director of Food Services (AFSD) in-serviced dining staff involved on the policy and procedure of dating/labeling/and storing food in the dry storage room.	

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F 812	Continued From page 23 and exposed to contamination. On the shelf directly above a stack of 3 Styrofoam bowls were not inverted and were not covered. The bowls were exposed to contamination. 2. In the cold prep area: on a metal shelf 4 stacks of cleaned and sanitized bowls were not inverted and were uncovered and exposed. The FSD stated, "They probably just put them back here." On 7/14/2023 at 12:13 PM, during the lunch meal in the main dining room the surveyors observed staff serve resident's pizza slices on the metal insert pellet with no plate on the pellet to 3 residents. One (1) resident had the pizza cut into pieces for him/her to eat. No plates were observed on the tray and staff placed the pizza slice directly onto the metal pellet insert that is utilized to keep food warm. The metal insert is not designed to be used as a surface to serve food to residents. On 7/20/2023 at 01:58 PM, the surveyors conducted an interview with the facility Licensed Nursing Home Administrator (LNHA) and the facility Director of Nursing (DON). The surveyors asked the LNHA and DON if it was appropriate to serve pizza to residents on the metal pellet insert. The DON agreed that staff should not have served pizza on 7/14/2023 at the lunch meal on the metal pellet insert. The DON stated they had some issues with plates and staff should have waited for plates and not served the pizza on the metal pellet inserts. On 7/17/2023 at 10:57 AM, the surveyor, accompanied by the Unit Secretary (US) and Registered Nurse (RN#2), observed the following on the health care unit pantry:	F 812	FSD and AFSD in-serviced dining staff involved on the storage of all bowls/plateware and all non-food items in the dry storage room. FSD/AFSD reviewed the storage of the plastic scoops used to access bulk foods with dining staff involved. FSD/AFSD reviewed healthcare unit refrigerator policy with dining staff involved. The dated bread crumbs 3/3 were discarded immediately. The bin the bread crumbs were in was re-labeled with the appropriate item and date. The plastic scooped that was found on the same shelf was cleaned. A holster was purchase and installed in the dry storage room. All bowls a plate ware that were not inverted were sanitized. All bowls and plateware were kept inverted. 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 812	Continued From page 24 1. The surveyor observed the following foods on the shelf of the freezer door: A frozen breakfast sandwich in a plastic wrapper, appeared to be a sausage, egg, and cheese on a muffin. The sandwich had no dates and was covered with ice. An opened bag contained (2) frozen Eggo waffles. The bag was opened, and the waffles were exposed. The waffles had no dates. A plastic Zip Loc style bag contained what appeared to be a whole wheat waffle. The waffle was covered with ice and the bag was dated "5/27." On interview RN#2 stated, "I think dietary is responsible for the maintenance of the pantry freezer and refrigerator. We will throw these in the trash." RN#2 and the US agreed that foods must be labeled and dated prior to storage in the freezer or refrigerator, according to facility policy. The surveyor reviewed the facility policy titled Dry Storage Areas, undated. The following was revealed under the Procedure heading: 7. Staff will maintain care of the storeroom according to the following directions: b. Canned and dry foods should be labeled with date of receipt so that they will be used within six months of delivery (or according to manufacturer's guidelines). The surveyor reviewed the facility policy titled Handling Clean Equipment and Utensils, undated. The following was observed under the Procedure heading: 2. Clean equipment and utensils will be stored in a clean, dry location in a way that protects them	F 812	deficient practice. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice would not recur. All dining staff were in-serviced on the policy and procedure of dating/labeling and storing food in the dry storage room. All dining staff were in-serviced on the storage of all bowls/plateware and all non-food items in the dry storage room. All dining staff were in-serviced on the storage of plastic scoops used to access bulk foods. A holster was purchased for the scoops in the dry storage room to prevent exposure and contamination. All dining staff were in-serviced on the policy for food in the healthcare pantry refrigerator. Dining and Activity staff were in-serviced on serving food brought in for pizza parties and were reminded to make sure we had plates available. Staff were also reminded to wear hairnets and gloves. 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 812	Continued From page 25 from splashes, dust, or other contamination. Stationary equipment will also be protected from contamination. The surveyor reviewed the facility provided policy titled Policy & Procedure Manual, undated. The following was revealed at 4.: a. Stored food is handled to prevent contamination and growth of pathogenic organisms. All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored. When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. Leftovers are used within 72 hours (or discarded). N.J.A.C. 8:39-17.2(g)	F 812	On a monthly basis FSD/AFSD will perform audits on dry food storage room to ensure all dishware is inverted and stored properly and that all food items are labeled/dated according to policy. All audits will be reported to the QAA committee that meets quarterly. The QAA committee will determine when the problem is resolved or if additional training is needed.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following: On 7/13/2023 from 9:00 to 9:42 AM, the surveyor	F 814	F814 The following corrective actions have been implemented. F814 Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) Residents Identified	8/2/23

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F 814	Continued From page 26 observed the facility designated garbage area: The area consisted of what the Food Service Director (FSD) described as (4) comingled dumpster's for recyclables and (2) additional dumpster's that were designated for the facility garbage. The (4) co-mingled dumpster's for recyclables were observed to have their lids closed and no garbage was on the ground surrounding the co-mingled dumpster's. The surveyor them observed the garbage dumpster's. The facility had (2) red garbage dumpster's. One out of 2 lids on one dumpster were opened and the bagged garbage was exposed. (2) doors to access the 2nd dumpster were elevated at the top of the dumpster. The doors opened and closed by sliding them in a back-and-forth motion. Both slider doors were opened exposing the bagged garbage contents. The FSD stated that "Dietary and housekeeping were responsible for maintaining the garbage area. The surveyor reviewed the facility policy titled Waste Disposal, undated. The following was revealed under the heading Procedure: 2. Prior to disposal all waste shall be in leak-proof, non-absorbent, fireproof containers that are kept covered when not in use. N.J.A.C. 8:39-19.3(c)	F 814	All residents 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All staff involved who use the garbage dumpster were in-serviced on closing all lids after using. Also staff were in-serviced on making sure slider doors were closed. All residents in the community have the potential to be affected by the deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All facility residents, staff and the community 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 housekeeping, maintenance, and security staff were in-serviced on making sure the garbage dumpster	

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F 814	Continued From page 27	F 814	lids and slider doors are closed after use. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. On a daily basis housekeeping, maintenance, security, and dining staff will monitor the facility designated garbage area to ensure all lids and slider doors are closed when not in use. The Dir. of Plant Services will submit all audits to the QAA committee on a quarterly basis. The QAA committee will determine when or if the problem is resolved or if additional training is needed.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		8/2/23

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F 880	Continued From page 28 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 29 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. 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 staff implemented appropriate sanitary practice for resident care equipment, specifically by staff retrieving a *Ex Order 26. 4B1* from the floor and placing it onto 1 of 5 residents (Resident #1) investigated for *Ex Order 26. 4B1* . The deficient practice was evidenced by the following: On 7/20/2023 at 10:51 AM, while inside Resident #1's room, the surveyor observed a *Ex Order 26. 4B1* [redacted] on the floor behind the *Ex Order 26. 4B1* [redacted]. Resident #1 was not in the room at this time. A review of Resident #1's Diagnosis located in the EMR revealed a diagnosis of *Ex Order 26. 4B1* [redacted].	F 880	F880 The following corrective actions have been implemented: F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) Residents identified Resident #1 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 *Ex Order 26. 4B1* and *Ex Orde* [redacted] were replaced and dated. Plastic bag was placed at bedside for storing *Ex Order 26. 4* [redacted] when not in use. *Ex Or* [redacted] in-serviced staff involved on the policy and procedure of handling *Ex Order 26. 4* [redacted]	

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F 880	Continued From page 30 A review of Resident #1's Physician Orders located in the Electronic Medical Record (EMR) revealed an order for [redacted] delivered at [redacted] per minute. The Physician Orders also revealed that *Ex Order 26. 4B1*, humidifiers, and masks *Ex Order 26. 4B1* must be replaced every Friday 11-7 shift. A review of Resident #1's Care Plan with a revision date of [redacted], located in the EMR revealed an intervention to administer [redacted] as ordered. On the same date at 11:02 AM, while in the hallway, the surveyor observed Certified Nurses Aide (CNA) #1 returning Resident #1 back to his/her room. From the hallway outside the room, the surveyor observed CNA #1 retrieve the [redacted] from the floor and place it back onto Resident #1 under his/her [redacted]. On the same date at 11:03 AM, during an interview with the surveyor, CNA #1 replied that he thinks the *Ex Order 26. 4B1* was on top of the *Ex Order 26. 4B1* but that he wasn't sure. He concluded his statement but saying, "Honestly, I probably should have got a new one or told the nurse." On the same date at 11:11 AM, during an interview with the surveyor, the Infection Preventionist replied, "No" when asked if a nasal cannula should be left on the floor attached to an oxygen concentrator. During the same interview, the Infection Preventionist replied, "No" when the surveyor asked if the nasal cannula should be put back onto the resident. She concluded the interview stating, "There should be a bag on the	F 880	[redacted] and disposing/replacing of contaminated *Ex Order 26. 4B1*. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents using nasal cannulas 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 on the policy and procedure of handling nasal cannulas and disposing/replacing of contaminated nasal cannulas. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. IP will perform monthly observations on staff applying nasal cannulas and review discarding/replacing contaminated nasal cannulas. Observations will be reported monthly to the Director of Nursing	

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F 880	Continued From page 31 side for that" when the surveyor asked how the nasal cannula should be stored. On 7/20/2023 at 1:35 PM, during an interview with the surveyor, the Director of Nursing replied, "Absolutely not." when asked by the surveyor should a nasal cannula left on the floor be placed back onto a resident. She also replied, "It (nasal cannula) should have been thrown out and replaced with a brand new one. A review of the facility policy titled, "Oxygen/Nebulizer Equipment" with an effective date of 2/25/2016 revealed under "Procedure" number 7 that, "All used humidifiers, tubing, masks, and cannulas must be discarded. The 3-11 team must document in the treatment record when humidifiers, tubing, masks, and cannulas are replaced. A sticker will be placed on all new tubing with the nurse's initials and date." § 8:39-19.4(a)	F 880	(DON) and to the QAA committee. The DON will review monthly. The QAA committee meets quarterly. The QAA committee/DON will determine when the problem is resolved or if additional training is needed.	

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #NJ161082 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the state of New Jersey for 1.) the weeks of 06/25/2023 through 07/08/2023; 2.) and the week of 01/29/2023 to 02/04/2023. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	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 be affected by the deficient practice. The Director of Nursing will review the schedule weekly to ensure the required minimum direct care staff to resident ratios are maintained. 2. How the facility will identify other	8/2/23

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

Electronically Signed | 08/05/23

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 07/21/2023

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 560	Continued From page 1 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 Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1.) As per the "Nurse Staffing Report" completed by the facility for the weeks from 06/25/2023 to 07/08/2023 for the 07/21/2023 Standard survey, the staffing-to-resident ratios did not meet the minimum requirement of one CNA to every eight residents during the day shift. The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -07/01/23 had 6 CNAs for 55 residents on the day shift, required 7 CNAs. -07/02/23 had 6 CNAs for 55 residents on the day shift, required 7 CNAs. -07/03/23 had 6 CNAs for 55 residents on the day shift, required 7 CNAs. -07/05/23 had 6 CNAs for 54 residents on the day shift, required 7 CNAs. -07/08/23 had 6 CNAs for 55 residents on the day shift, required 7 CNAs.	S 560	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. The Director of Nursing is to be notified when a CNA who calls out is unable to be replaced. Incentive bonuses will continue to be offered to CNAs for picking up extra shifts. Facility will continue to offer flexible hours to all CNAs. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing will review 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 Quality Assurance committee	

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S 560	Continued From page 2 2.) For the staffing from 01/29/2023 to 02/04/2023, the facility was deficient in CNA staffing for residents on 2 of 7 days as follows: -01/29/23 had 5 CNAs for 53 residents on the day shift, required 7 CNAs. -01/30/23 had 6 CNAs for 53 residents on the day shift, required 7 CNAs. During an interview with the Director of Nursing (DON)/ Staffing Coordinator (SC) on 07/19/23 at 12:39 PM, the DON stated that it was her responsibility to staff the facility. The DON stated that the facility was scheduling staff to meet and exceed the staffing requirements, however, call outs are inevitable. The Facility was unable to provide a policy for staffing.	S 560	will meet quarterly to review and discuss compliance for staffing.	

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	8/15/2023 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 F0584	Correction	ID Prefix F0684	Correction	ID Prefix F0692	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	08/02/2023	LSC	08/02/2023	LSC	08/02/2023
ID Prefix F0694	Correction	ID Prefix F0695	Correction	ID Prefix F0812	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	08/02/2023	LSC	08/02/2023	LSC	08/02/2023
ID Prefix F0814	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	08/02/2023	LSC	08/02/2023	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?
7/21/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030307 Y1	A. Building B. Wing Y2	8/15/2023 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 08/02/2023	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 7/21/2023	☐ 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 _____	**07/21/2023**

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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/14/2023 and 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 Un-Protected building that was built in January 1966. The facility is divided into 6 smoke zones.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/13/2023, in the presence of facility management, it was determined that the facility failed to ensure that an illuminated exit sign were in one (1) location to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the	K 293	K293 □ Emergency Exit Signage 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: A new exit sign was installed by an electrical contractor to install	8/2/23

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

Electronically Signed | 08/03/2023

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K 293	Continued From page 1 following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 07/13/2023 (day one of survey) during the survey entrance at approximately 8:44 AM, a request was made to the Administrator and Plant Services Director (PSD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with five (5) wings, West wing, North wing, East wing, E-Wing and D-Wing (currently shut down unit). Starting at approximately 9:08 AM on 07/13/2023, in the presence of the facility PSD, a tour of the building was conducted. During the building tour at approximately 11:20 AM, the surveyor followed the exit access route out of the D-Wing and through the double smoke doors (next to Resident room #1). This access route leads to a lobby area the of the facility. The surveyor observed a set of double fire doors to the left that leads to the Administration building.	K 293	the new emergency exit light. 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 continue to have quarterly inspections by local fire officials. Maintenance staff surveyed all areas of the facility to make certain exit signs were in the proper location and working. The affected area had a new exit sign installed. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: We will continue to have quarterly inspections by local fire officials. Maintenance staff will survey all exit signs on a monthly basis to ensure they are in working order and in the appropriate locations.	

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K 293	Continued From page 2 There was a second set of double fire doors to the right that would lead to the Residential section of the facility. With the activation of the buildings fire alarm system both sets of double fire rated doors would close into their frames. The surveyor observed no evidence of an illuminated exit sign to identify the exit access route to reach an exit discharge door. A review of an emergency evacuation diagram posted on the D-Wing corridor identified that you would pass through the double smoke doors as the primary and/ or secondary egress route out of D-Wing to reach an exit.. The PSD confirmed the findings at the time of observation. On 07/14/2023 during the survey exit at approximately 1:50 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard.	K 293	A report of their findings will be given to the QAPI team on a monthly basis.	
K 351 SS=D	NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101 Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state	K 351		8/2/23

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K 351	Continued From page 3 or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation on 07/13/2023, in the presence of Facility Management, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the Facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. This deficient practice was evidenced by the following: Reference #1: National Fire Protection Association (NFPA) 13 Standard for the Installation of Sprinkler Systems. Installation Requirements: -8.8.4.1.1 Unobstructed Construction. -8.8.4.1.1.1 Under unobstructed construction, the distance between the sprinkler deflector and the ceiling shall be a minimum on 1 inch (25.4 mm) and a maximum of 12 inches (305 mm) throughout the area of coverage of the sprinkler. On 07/13/2023 (day one of survey) during the survey entrance at approximately 8:44 AM, a request was made to the Administrator and Plant Services Director (PSD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.	K 351	K351 □ Sprinkler 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The provider contacted our vendor and they removed current sprinkler and modify sprinkler head to meet requirement as specified. 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	

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K 351	Continued From page 4 A review of the facility provided lay-out identified the facility is a two-story building with five (5) wings, West wing, North wing, East wing, E-Wing and D-Wing (currently shut down unit). Starting at approximately 9:08 AM on 07/13/2023, in the presence of the facility PSD, a tour of the building was conducted. During a tour of the building with the PSD at approximately 9:35 AM an inspection inside the Basement level Staff break room mechanical room was performed. The surveyor observed one (1) down pendant type fire sprinkler. These type of fire sprinkler heads are used in the application where there is a ceiling tile or wallboard type ceiling. At that time the surveyor used a construction tape measure to record the distance from the sprinkler to the decking above. The down pendant heads were two (2) feet down form the metal decking above. Code requires up-rite fire sprinkler heads to be with-in twelve (12) inches of a rooms ceiling. The PSD confirmed the findings at the time of observation. On 07/14/2023 during the survey exit at approximately 1:50 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	not recur: We will use local fire officials on a quarterly basis to ensure our facility meets or exceeds all fire codes. Maintenance staff will also do quarterly audits to ensure sprinkler heads are in the proper position. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The facilities sprinkler systems will be surveyed on quarterly basis by maintenance staff and a report given to the QAPI committee on a quarterly basis.	
K 521 SS=E	HVAC CFR(s): NFPA 101	K 521		8/2/23

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K 521	Continued From page 5 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation on 07/13/2023, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 5 of 14 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 07/13/2023 (day one of survey) during the survey entrance at approximately 8:44 AM, a request was made to the Administrator and Plant Services Director (PSD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with five (5) wings, West wing, North wing, East wing, E-Wing and D-Wing (currently shut down unit). There are a total of 85 Resident sleeping rooms and common areas in the facility.	K 521	K521- HVAC 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Our Maintenance staff inspected all of the exhaust systems in the facility for proper working order. Staff found two broken belts on two motors. The belts were replaced. Housekeeping and maintenance staff were in-serviced on how to check exhaust fans are working. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the	

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K 521	Continued From page 6 During the building tour on 07/13/2023 starting at approximately 9:08 AM, in the presence of the PSD a tour of the facility was conducted. Along the tour the surveyor inspected and tested fourteen (14) Resident bathroom exhaust systems. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 5 of 14 resident bathrooms in the following locations: 1. On 07/13/2023 at approximately 9:32 AM, inside Resident room #53 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the PSD that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. On 07/13/2023 at approximately 9:34 AM, inside Resident Unisex bathroom (near Resident room #53), when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. On 07/13/2023 at approximately 9:41 AM, inside Resident room #61 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation.	K 521	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: Housekeeping staff will test each room to ensure all exhaust fans are in working order on a weekly basis. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The maintenance staff will also audit twenty-five percent of room during facilities quarterly maintenance and inspection requirements. They will submit a report of their findings to the QAPI committee on a monthly basis.	

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K 521	Continued From page 7 4. On 07/13/2023 at approximately 9:47 AM, inside Resident room #50 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. On 07/13/2023 at approximately 9:50 AM, inside Resident Unisex bathroom (near Resident room #50), when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The PSD confirmed the findings at the time of observation. On 07/14/2023 during the survey exit at approximately 1:50 PM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		8/2/23

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 _____	**07/21/2023**

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
K 918	Continued From page 8 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 0713/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop stations for 2 of 2 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 07/13/2023 (day one of survey) during the survey entrance at approximately 8:44 AM, a request was made to the Administrator and Plant Services Director (PSD) to provide a copy of the	K 918	K918 □ Essential Electrical System 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The provider has electrical contractor scheduled to install a remote stop for both generators. The remote switch will be installed by August 11, 2023.	

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 _____	**07/21/2023**

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 918	Continued From page 9 facility lay-out which identifies the various rooms and smoke compartments in the facility and if the facility had an Emergency Generator. The PSD told the surveyor, yes we have two (2) Diesel Emergency Generators. . During the building tour on 07/13/2023 at approximately 11:14 AM, in the presence of the PSD an inspection outside of the building where the two (2) Emergency Generators is located was performed. The surveyor observed that the emergency stop buttons were located inside the metal housing and on the front control panel of both of the generators. At this time the surveyor asked the PSD, Do you have a remote emergency stop buttons for the two (2) generators. The PSD told the surveyor no we don't. The PSD confirmed the findings at the time of observation. On 07/14/2023 during the survey exit at approximately 1:50 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	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 maintenance staff will be in-serviced on how the remote device will be used. The remote device will be tested by maintenance staff on a quarterly basis. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: This will be monitored in the facilities quarterly maintenance and inspection requirements. A report on the findings will be be submitted to the QAPI committee on a quarterly basis.	

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	8/15/2023 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 K0293	08/02/2023	LSC K0351	08/02/2023	LSC K0521	08/02/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	08/02/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/21/2023	☐ YES ☐ NO