STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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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 Complaint #: NJ 155924, NJ 157605, NJ 159503, NJ 159668, NJ 160417, NJ 161387, NJ 162667, NJ 164793 Survey Date: 10/19/2023 Census: 195 Sample: 35+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		11/27/23

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

Electronically Signed | 11/08/2023

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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to treat each resident with respect and dignity in a manner that promoted his/her quality of life for a.) a resident whose preference was to attend [redacted] services and was not provided their breakfast tray in a timely manner for 1 of 35 residents (Resident #108) and b.) a resident whose preference was to get out of bed was not honored 1 of 35 residents, (Resident #55) reviewed for Resident Rights.	F 550	Plan of Correction F 550 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #108 tray for breakfast placed on earlier delivery cart (Cart #1) • List of residents who prefer to attend church services provided by Activity	

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F 550	Continued From page 2 This deficient practice was evidenced by the following: 1. On 10/4/23 at 12:34 PM, during the lunch meal observation on the second floor day room, Resident #108 stated that they didn't receive their breakfast tray until 9:30 AM yesterday morning, which made them late for NJ Ex.Order 26. Resident #108 stated that they were NJ Exec Order 26.4b1 [redacted]. A review of the resident's Admission Record revealed that the resident had diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident #108's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ ex order 26.4b reflected the resident has a Brief Interview for Mental Status (BIMS) of NJ ex o out of 15 indicating Resident #108 NJ ex order 26.4b1 [redacted] On 10/5/23 at 12:10 PM, during the lunch meal observation, Resident #108 told the surveyor that they did not have breakfast this morning because it wasn't delivered until 9:30 AM, and the resident didn't want to be late for NJ Exec Order again. On 10/10/23 at 9:51 AM, the surveyor observed Resident #108 in their room waiting for breakfast. At that time, the activity coordinator announced that they were there to transport Resident #108 to NJ Exec Order 2. Resident #108 stated that they were hungry but didn't want to hold up the transporter	F 550	Department and given to Director of Food Services and Nursing Administration • Resident #55 NJ ex order 26.4b1 [redacted] • Resident #55 NJ ex order 26.4b1 [redacted] • Resident #55 NJ ex order 26.4b1 [redacted] ID Other Residents: • All residents within the facility Systemic Change: • "Mass List" will be provided by the Activity Director on a monthly basis to the Director of Food Services and Nursing Administration • Residents who attend Mass on a regular or scheduled basis will be offered meal delivery on an "early breakfast cart" • Preferred "Out of Bed" schedule will be placed on resident Care Plan • In-service on "Resident Rights" will be conducted to all departments by Social Services Director • In-service on "Residents Attending Mass" will be conducted to the following departments: Dietary, Activities, Nursing by Activities Director • In-service on "Care Planning Out of Bed Schedule" will be conducted to the Nursing Department by Nurse Educator Monitoring: • Audit - "Tray Distribution for Resident Attending Mass" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then	

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F 550	Continued From page 3 and did not want to be late for [NJ Exec Order 2] so the resident left for [NJ Exec Order] without having eaten breakfast. On 10/11/23 at 9:15 AM, the surveyor observed Resident #108 in their room waiting for breakfast to be delivered. The resident stated that they were so hungry yesterday that the resident ate every last bite of their lunch. On 10/11/23 at 9:25 AM, the surveyor observed Certified Nursing Assistant (CNA) #9 deliver the breakfast tray to Resident #108. The resident told CNA #9 and the surveyor that they would like their breakfast earlier so that they could attend [NJ Exec Order 2] services which began at 10:00 AM and that the transporters arrived between 9:30 AM and 9:50 AM. On 10/11/23 at 9:38 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that she expected all residents to have their breakfast trays delivered by 9:00 AM. The surveyor asked the LPN/UM #2 if she had a list of residents who attended [NJ Exec Order 2] services or any other morning activities to ensure these residents received their trays with enough time to eat before attending the activities. LPN/UM #2 replied, "no." LPN/UM #2 further stated that she should have had a system in place so that residents who leave for [NJ Exec Order 2] at 9:30 AM receive their trays first. On 10/11/23 at 11:37 AM, the surveyor interviewed the Food Service Director (FSD) who stated that all residents should have their breakfast trays by 9:00 AM, and further stated that he was not provided with a list of any residents who attended morning [NJ Exec Order] services/	F 550	(3) quarterly x' 1 quarter by Nursing Administration • Audit – "Care Plan Out of Bed Schedule" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 550	Continued From page 4	F 550		

activities or medical appointments nor was he aware of any residents who require early breakfast trays.

On 10/18/23 at 12:16 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing and Regional Clinical Nurse to discuss the above observations and concerns.

2. On 10/03/23 at 11:50 AM, the surveyor observed Resident #55 in bed watching TV. The resident stated they did not get out of bed that day.

A review of the Admission Record indicated the resident had the following diagnoses NJ ex order 26.4b1 [redacted]

A review of Resident #55 Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 revealed resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated Resident #55 [redacted].

A review of the Resident #55's NJ ex order 26.4b1 dated NJ ex order 26.4b1 reflected the NJ ex order 26.4b1 [redacted]

A review of the October NJ ex order 26.4b1 [redacted] reflected an NJ ex order 26.4b1 [redacted]. The TAR had been signed by the nurse from NJ ex order 26.4b1

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A review of the Activities Consult/Recommendation dated NJ ex order 26.4b1 NJ ex order 26.4b1 reflected that Resident #55's preference as to attend activities including activities held in the day room.

On 10/04/23 at 11:26 AM, the surveyor observed Resident#55 in bed watching TV who stated, "they did not get me out of bed today."

On 10/05/23 at 11:50 AM, the surveyor observed Resident #55 in bed watching TV who stated, "I did not get out of bed today."

On 10/13/23 at 10:09 AM, the surveyor observed Resident #55 in bed watching TV. Resident #55 stated that they used to get NJ Exec Order 26.4b1 and brought to the dayroom for bingo activities. Resident #55 stated it NJ Exec Order 26.4b1 since they had gotten out of bed.

On 10/13/23 10:24 AM, the surveyor interviewed the resident's routine Registered Nurse (RN#3) who stated Resident #55 got out of bed NJ Exec Order 26.4 ago but varied at times according to the resident's mood.

On 10/13/23 10:30 AM, the surveyor interviewed Unit Manager/Licensed Practical Nurse (UM/LPN #2) who stated that the resident did not like to get out of bed. UM/LPN #2 further explained that Resident #55 would be NJ Exec Order 26.4b1, but once in the chair would want to go back to bed right away. UM/LPN #2 stated the resident refused to get out of bed and that the physician and family were aware. UM/LPN #2 stated Resident #55's refusal was documented in progress notes and being signed in the Treatment Administration Record (TAR).

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F 550	Continued From page 6 The surveyor reviewed the TARs for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 which did not indicate that the resident refused to get out of bed. The surveyor reviewd Resident # 55's progress notes from NJ Exec Order 26.4b1 . There was no documentation that indicated that the resident refused to get out of bed. On 10/13/23 at 10:38 AM, the surveyor interviewed the resident's regular Certified Nursing Assistant (CNA#6). CNA #6 stated Resident #55 NJ ex order 26.4b1 CNA #6 further stated if the resident refused to get out of bed, they would notify the unit manager and the nurse. On 10/13/23 at 11:00 AM, after surveyor inquiry, the surveyor observed the resident in a NJ ex order 26.4b1 being transported out of their room and to the hallway by 2 CNAs and in the presence of the UM. The resident's NJ ex order 26.4b1 The resident told the surveyor NJ Exec Order 26.4 A review of the facility's "Resident Rights" policy and procedure, revised 12/31/22 reflected, "employees and staff will treat all residents with kindness, dignity, and respect the rights of each resident ...Resident Rights to independent choices are outlined and explained...residents are entitled to fully exercise their rights and privileges possible. " NJAC 8:39-4.1 (a) (12)(21)(24)(28)	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		11/27/23

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F 558	Continued From page 7 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Complaint # NJ 159668 Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to maintain the call bell within reach for two of thirty-five residents (Resident #19) and (Resident #82) reviewed for accommodation of needs and was evidenced by the following: 1. A review of Resident #19's Admission Record reflected that the resident was admitted to the facility with diagnoses which included, but were [redacted]. A review of Resident #19's Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated Resident #19 [redacted] On 10/11/23 at 9:01 AM, the surveyor observed Resident #19 seated in a wheelchair by the left side of the bed with the call bell wrapped around the upper right side rail. On 10/11/23 at 10:26 AM, the surveyor observed Resident #19 in their wheelchair with the call bell	F 558	Plan of Correction F558 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #19 – call bell repositioned within reach of resident • CNA #8 – 1:1 in-service on importance of having the call bell within reach of the resident • Resident #82 – call bell repositioned within reach of resident • CNA #7 – 1:1 in-service on importance of having the call bell within reach of the resident • Care plan for resident #19 and #82 updated to reflect preferences of resident • Facility wide rounds of Maintenance Department to ensure clips are located on call bell cord ID Other Residents: • Any resident within the facility Systemic Change: • In-service on “Call Bell Placement” will be conducted to the Nursing Department by the Nurse Educator	

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F 558	Continued From page 8 wrapped around the upper right side rail. On 10/11/23 at 11:55 AM, the surveyor and Nursing Assistant (NA) observed Resident #19 lying in bed. The surveyor observed the call bell wrapped around the upper right side rail. The NA stated that she had assisted Resident #19 into the wheelchair "sometime" before 9:00 AM. At that time, the NA told Resident #19 it was lunch time, assisted Resident #19 back into their wheelchair, and left the resident's room with the call bell still wrapped around the upper right side rail. On 10/11/23 at 11:59 AM, the surveyor asked the NA to enter Resident #19's room and the surveyor showed the NA the call bell wrapped around the upper right side rail not within Resident #19's reach. The NA stated that she should have put the call bell within the resident's reach first thing that morning when she assisted Resident #19 into their wheelchair but she "forgot, it wasn't intentional." On 10/11/23 at 12:02 PM, the surveyor interviewed LPN/UM #2 in the presence of the NA. The LPN/UM #2 stated that the NA received an in-service on keeping call bells within residents' reach, beds in the lowest position, and providing freshwater every shift. The NA acknowledged that she had received that information during orientation. On 10/12/23 at 9:26 AM, the surveyor observed Resident #19 seated in chair of the left side of the bed, eating breakfast meal with the call bell wrapped around the right upper side rail. On 10/12/23 at 9:49 AM, the surveyor interviewed	F 558	• Rounding by nursing staff at start and end of each shift to ensure call bell locations are within reach; and when necessary Monitoring: • Audit - “Call Bell Placement” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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CNA #8 who stated that she provided morning care to Resident #19 and assisted her/him to the chair before 8:00 AM that morning.

On 10/12/23 at 9:50 AM, the surveyor showed LPN/UM #2 and CNA #8 Resident #19's call bell which was wrapped around the right upper side rail. The LPN/UM #2 stated that CNA #8 had not been present for the speech she gave to all the CNAs reminding them that all call bells should be kept within residents' reach when in or out of bed but acknowledged CNA #8 should have already known this. CNA #8 acknowledged the call bell should be kept within the resident's reach.

2. On 10/3/23 at 11:42 AM, the surveyor observed Resident # 82 seated in a wheelchair positioned on the right side of the bed, with the call bell on the left side of the bed not within Resident #82's reach.

A review of Resident #82's Admission Record reflected that the resident was admitted to the facility with diagnoses which included, but were NJ ex order 26.4b1 [redacted]

A review of Resident #82's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated Resident #82 NJ ex order 26.4b1 [redacted].

On 10/16/23 at 9:07 AM, the surveyor observed Resident #82 in bed with the call bell hanging down of the left side of the bed towards the floor.

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The surveyor asked the resident how they contacted staff for assistance. Resident #82 replied, "I push the button on the call bell when I can reach it". Resident #82 further stated that when the resident couldn't reach it, their roommate would use their call bell to call for them. The surveyor asked Resident #82 how often they were unable to reach the call bell. Resident #82 replied that they were not sure but stated that the roommate helped " a lot."

On 10/16/23 at 9:14 AM, the surveyor interviewed the resident's [NJ Exec O] and [NJ Exec Order 26.4] roommate who stated that Resident #82 asked the resident to call nursing staff at least two times a day.

On 10/16/23 at 10:22 AM, the surveyor observed Resident #82 seated in their wheelchair with their call bell within reach. Resident #82 stated with a [NJ Exec Order 26.4b1]

On 10/16/23 at 10:38 AM, the surveyor interviewed CNA #7 who stated that she had recently answered the call light for Resident #82's roommate. When CNA #7 answered the call light, the roommate stated that it was actually Resident #82 that needed assistance. Resident #82 told CNA #7 that they were unable to find their call bell. CNA #7 stated she picked Resident #82's call bell up off the floor and handed it to the resident. CNA #7 further stated that she had not had a chance to make rounds that morning, so she was not sure how long Resident #82's call bell was on the floor.

On 10/16/23 at 10:45 AM, the surveyor interviewed LPN/UM #2 who stated that her expectation was that the unit Nurses and CNAs

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F 558	Continued From page 11 made rounds every morning making sure all residents are okay, call bells are within reach and the beds are in the lowest positions. On 10/16/23 at 10:53 AM, the surveyor interviewed RN #1 who stated that she did not make morning rounds so she had not been aware that Resident #82's call bell was on the floor. RN #1 further stated that she had not gone into Resident #82's room until after breakfast but should have made rounds to ensure the resident was okay and that the call bell was within reach. On 10/18/23 at 12:16 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing and Regional Registered Nurse to discuss the above concerns. Review of the facility's policy and procedure titled "Call Bell Response", revised on 12/2021, reflected ... staff is to ensure that the call bell is within reach for ease of use. NJAC 8:39- 31.8 (c) (9)	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		11/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 12 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to inform, and provide written information to all adult residents concerning the right to formulate an advance directive. This deficient practice was identified for 1 of 35 residents reviewed (Resident #19) and was evidenced by the following:	F 578	F578 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #19 – Advanced Directives reviewed with POA • Documentation of conversation recorded in progress notes	

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F 578	Continued From page 13 1. On 10/11/23 at 9:01 AM, the surveyor observed Resident #19 seated in a wheelchair next to the left side of the bed. The resident greeted the surveyor with a smile. On 10/11/23 at 11:55 AM, the surveyor and Nursing Assistant (NA) observed Resident #19 lying in bed with their eyes closed. On 10/12/23 at 9:26 AM, the surveyor observed Resident #19 seated in a chair eating breakfast. A review of the resident's Admission Record reflected that the resident was admitted to the facility with diagnoses which included NJ ex order 26.4b1 [redacted] A review of Resident #19's Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4 , indicated Resident #19 NJ ex order 26.4b1 [redacted] On 10/11/23 at 12:33 PM, the surveyor interviewed the Director of Social Services who stated that the facility's policy was to discuss Advance Directives on admission and then quarterly but "for some reason" Advance Directives were not discussed for Resident #19. On 10/12/23 at 10:50 AM, the surveyor interviewed the Social Worker who stated that after the surveyors inquiry the Social Worker sent an email to Resident #19's family with information regarding Advance Directives. On 10/18/23 at 12:16 PM, the survey team met	F 578	ID Other Residents: • Any resident within the facility Systemic Change: • In-service on “Advanced Directives” will be conducted to the Social Services Department by the Nurse Educator • Advanced Directives will be reviewed at time of admission and quarterly Monitoring: • Audit - “Advanced Directives” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 578	Continued From page 14 with the Administrator, Director of Nursing and Regional Clinical Nurse to discuss the above observations and concerns. No further information was provided. A review of the facility's policy and procedure titled "Advanced Directives", revised 11/2020 reflected ... on admission the facility will determine whether the resident has an advance directive, and if not, determine whether the resident wishes to formulate an advance directive. ...If an adult individual is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility will give advance directive information to the individual's resident representative. NJAC 8:39 - 4.1 (a); 9.6(a) (e)	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		11/27/23

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F 609	Continued From page 15 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, medical record review (MR), and other pertinent facility documentation, it was determined that the facility failed to report an NJ Exec Order 26.4b1 to the New Jersey Department of Health (NJDOH) for 1 of 2 residents reviewed for accidents and incidents (Resident # 57). This deficient practice was evidenced by the following: On 10/3/23 at 11:42 AM, the resident was observed sleeping in bed with face partially covered by blanket. Resident #57 did not acknowledge surveyor's presence. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted with diagnosis which included NJ ex order 26.4b1 [redacted] A review of Resident #57's Quarterly Minimum Data Set (MDS), an assessment tool, dated	F 609	Plan of Correction F609 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #57 – incident report reviewed and reinvestigated ID Other Residents: • Any resident within the facility with an injury of unknown origin Systemic Change: • Injuries of unknown origin will be reported to Shift Supervisor or Unit Manager immediately for an immediate investigation to determine if reportable. • If noted to be reportable, DON/ADON/Administrator will be notified • In-service – “Reportable Events” to the Nursing Department by Nursing Administration • In-service – “Thorough Investigation”	

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F 609	Continued From page 16 NJ ex order 26.4b, revealed that the resident had a Brief Interview for Mental Status (BIMS) of score of NJ out of 15, which demonstrated NJ ex order 26.4b1 [redacted] A review of the care plans for Resident #57 identified that the resident had NJ ex order 26.4b1 [redacted] A review of Resident #57's Incident Report (IR) dated NJ ex order 26.4b1 at 2:09 PM, revealed that the Licensed Practical Nurse (LPN) was notified by the Nurse Practitioner (NP) NJ ex order 26.4b1 [redacted] he LPN assessed the resident and NJ ex order 26.4b1 [redacted]. Additional review of the IR revealed, under "Incident Description" NJ ex order 26.4b1 [redacted]. Attached to the IR was an undated typed summary included "On NJ ex order 26.4b1 at 2:04 PM observed resident NJ ex order 26.4b1 [redacted]. Resident NJ Exec Order [redacted]. Statements obtained. Monitor until resolution. Intervention: Monitor until resolution. Call MD if needed. Family/MD notified." No statements were provided as part of the IR investigation. During an interview with the surveyors on 10/6/23 at 12:28 PM, the Director of Nursing (DON) advised that the Department of Health was to be notified if there was NJ Exec Order 26.4b1 to the resident and the cause was not able to be determined. The DON stated that the Department	F 609	to the Nursing Department by Nursing Administration Monitoring: • Audit - "Injuries Investigation" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 609	Continued From page 17	F 609		

of Health was to be notified within 2 hours. The DON acknowledged that the NJ ex order 26.4b1 "as evidenced by BIMS [redacted]. The DON further explained that the resident had a [redacted] on NJ ex order 26.4b1 and the "NJ ex order 26.4b1 The DON added that this should have been a reportable because it was not NJ Exec Order 26.4b1 .

During an interview with the surveyor on 10/13/23 at 1:49 PM, the Administrator stated that the [redacted] was not reported to the NJDOH because the facility did not feel NJ Exec Order 26.4b1

A review of the facility's "Abuse and Neglect" Policy and Procedure, with an effective date of 1/15/2020, documented that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made.[...] to the Administrator of the facility, the Department of Health [...]

A review of the facility's policy titled, "Investigation and Reporting", with an effective date of 4/2017 and revised date of 6/2021, documented under the Role of the Investigator: 1. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident [...] g. Interview staff members (on all shifts) who have had contact with the resident during the period of

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F 609	Continued From page 18 the alleged incident [...] j. Review all events leading up to the alleged incident. NJAC 8:39-4.1(a)(5)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and other pertinent facility documentation, it was determined that the facility failed to timely and thoroughly investigate an NJ Exec Order 26.4b1 for 1 of 2 residents reviewed for accidents and incidents (Resident # 57). This deficient practice was evidenced by the following: On 10/3/23 at 11:42 AM, the resident was	F 610	Plan of Correction F610 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #57 – incident report reviewed and reinvestigated ID Other Residents:	11/27/23

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F 610	Continued From page 19 observed sleeping in bed with face partially covered by blanket. Resident #57 did not acknowledge surveyor's presence. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted with diagnosis which NJ ex order 26.4b1 [redacted] A review of Resident #57's Quarterly Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) of score of NJ out of 15 NJ ex order 26.4b1 [redacted] A review of the care plans for Resident #57 identified that the resident NJ ex order 26.4b1 [redacted] A review of Resident #57's Incident Report (IR) dated NJ ex order 26.4b1 [redacted] at 2:09 PM, revealed that the Licensed Practical Nurse (LPN) was notified by the Nurse Practitioner (NP) that the NJ ex order 26.4b1 [redacted]. The LPN assessed the resident and NJ ex order 26.4b1 [redacted]. Additional review of the IR revealed, under "Incident Description" that the resident NJ ex order 26 [redacted]. Attached to the IR was an undated typed summary included "On NJ ex order 26.4b1 [redacted] at 2:04 PM observed NJ ex order 26.4b1 [redacted]	F 610	• Any resident within the facility with an injury of unknown origin Systemic Change: • Injuries of unknown origin will be reported to Shift Supervisor or Unit Manager immediately for an immediate investigation to determine if reportable. • If noted to be reportable, DON/ADON/Administrator will be notified • In-service – "Reportable Events" to the Nursing Department by Nursing Administration • In-service – "Thorough Investigation" to the Nursing Department by Nursing Administration Monitoring: • Audit - "Injuries Investigation" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 610	Continued From page 20	F 610		

NJ ex order 26.4b1 . NJ ex order 26.4b1 Statements obtained. Monitor until resolution. Intervention: Monitor until resolution. Call MD if needed. Family/MD notified." No statements were provided as part of the IR investigation.

During an interview with the surveyors on 10/6/23 at 12:28 PM, the Director of Nursing (DON) advised that the Department of Health was to be notified if there was any NJ Exec Order 26.4b1 to the resident and the cause was not able to be determined. The DON stated that the Department of Health was to be notified within 2 hours and a follow-up with conclusion, including "everything we did in the investigation" was to be provided within 24 hours. When inquired about what was included with an investigation for discovery of a NJ Exec Order 26.4b1 the DON stated that an investigation will go back 24 hours prior to the discovery along with written statements, progress notes, etc. The surveyor reviewed the IR dated NJ ex order 26.4 with the DON who responded, "this is not even close to a full investigation." The DON acknowledged that the resident was not able to explain that happened "as evidenced by BIMS NJ ex order . The DON further explained that the resident NJ ex order 26.4b1 and the NJ ex order 26.4b1

On 10/18/23 at 8:15 AM, the surveyor was provided with an additional copy of the IR for NJ ex order 26.4 . Review of the IR included undated statements from staff, and an undated, unsigned summary that was indicated as "revised." Review of the statements revealed that all the statements were not dated with "Today's Date." In addition, the "revised" NJ Exec Order 2 investigation did not contain

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F 610	Continued From page 21 an author and was also undated. The LPN statement revealed, NJ Exec Order 26.4b1 [redacted]. The conclusion documented, NJ Exec Order 26.4b1 [redacted]" During an interview with the surveyor on 10/18/23 at 10:25 AM, the Administrator stated the investigation for [redacted] was not complete, and that she had staff complete statements on NJ ex order 26.4b1 [redacted] and she had completed the revision of the summary on NJ ex order 26.4b1 [redacted] A review of the facility's policy titled, "Investigation and Reporting", with an effective date of 4/2017 and revised date of 6/2021, documented under the Role of the Investigator: 1. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident [...] g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident [...] j. Review all events leading up to the alleged incident. NJAC 8:39-4.1(a)(5)	F 610		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F 640		11/27/23

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F 640	Continued From page 22 §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		

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F 640	Continued From page 23 (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care for 2 of 35 residents (Resident's #115 and #119) reviewed for resident assessment. This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #115 NJ ex order 26.4b1 [redacted] A review of Resident #115's progress note revealed that the resident NJ ex order 26.4b1 [redacted] A review of Resident #115's MDS records revealed that there was no entry MDS completed when the resident was readmitted back to the facility. 2. According to the Admission Record, Resident #119 had diagnoses which included but were not	F 640	Plan of Correction F640 Level B Completion Date: 11/27/2023 Corrective Action: • Resident #115 – Entry MDS completed and transmitted • Resident #249 – Discharge MDS completed and transmitted ID Other Residents: • Resident who require an MDS to be completed Systemic Change: • In-service on “Proper MDS Completion” will be conducted to the Nursing Department and MDS Coordinators by Nursing Administration Monitoring: • Audit will be completed on residents admitted at the end of each month for Entry MDS monthly x’s 3months by Nursing Administration	

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	315060	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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F 640	Continued From page 24 limited to; NJ ex order 26.4b1 . A review of Resident #119's progress notes dated NJ ex order 26.4b1 at 6:28 PM revealed that the resident was admitted to the hospital. A review of Resident #119's MDS records revealed that there was discharge MDS completed and was that the discharge assessment was [redacted] days overdue. During an interview with the surveyor on10/11/23 at 11:42 AM, the MDS Coordinator stated that one of his responsibilities was to ensure the MDS was completed, and the computer software would let him know if an MDS was missing. The MDS Coordinator added that he would base the coding of the MDS by reviewing nursing evaluations, progress notes and going to the nursing units and asking questions. At that time, the surveyor asked the MDS Coordinator to review Resident #119, and Resident #115. The MDS Coordinator confirmed that Resident #119 was missing a discharge assessment and Resident #119 was missing an entry. During an interview with the surveyor on 10/11/23 at 12:53 PM the MDS coordinator stated that the missing assessments were "human error" and should be corrected. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Asessment Intstrument (RAI) 3.0 user's manual dated October revealed on pages 2-17, 2-18, that discharge assessment-return anticipated, and discharge return-not anticipated must be completed no later than the discharge date + 14 calendar days with the transmission	F 640	• Audit will be completed on residents discharged at the end of each month for Discharge MDS monthly x's 3 months by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 640	Continued From page 25 date no later than MDS completion date +14 days. Entry tracking record must be completed no later than the entry date +7 day and transmitted no later than entry date +14 calendar days. A review of the MDS Coordinator job description revised 5/13, included that the MDS Coordinator's job responsibilities were to ensure that the MDS was completed in a timely and accurate manner, and was responsible for timely submission to the appropriate regulatory agencies. A review of a facility policy with subject "MDS Completion and Submission" revised on 8/2020 included that the facility would conduct and submit resident assessments in accordance with current federal and state submission timeframes. Timeframe for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. A review of a facility policy with subject "Transmission of MDS" revised 10/2022 included that all MDS assessments and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data. NJAC 8:39-11.1	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		11/27/23

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F 641	Continued From page 26 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care for 2 of 35 residents, (Resident's #79 and #249) reviewed resident assessment. This deficient practice was evidenced by the following: 1.A review of Resident #79's Admission Record reflected that the resident had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of Resident #79's progress notes written by a NJ Exec Order care Nurse Practioner on NJ Exec Order 26.4b1 at 12:38 PM revealed that the resident was seen for a NJ Exec Order 26.4b1 that was identified as NJ Exec Order 26.4b1 [redacted] A review of Resident #79's Quarterly MDS dated NJ Exec Order 2 revealed that on NJ Exec Order 26.4b1 [redacted], NJ Exec Orde was not checked as coded. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Asessment Intstrument (RAI) 3.0 user's manual dated October 2019, section M1040 includes the following: "Steps for Assessment 1. Review the medical record, including skin care	F 641	Plan of Correction F641 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #79 – MDS updated to reflect NJ Exec Orde in NJ Exec Order 26.4 • Resident #249 – MDS updated to remove NJ Exec Order 26.4 NJ ex order 26.4b1 [redacted] ID Other Residents: • Resident who require an MDS to be completed Systemic Change: • In-service on “Proper MDS Completion” will be conducted to MDS Coordinators by Nursing Administration Monitoring: • Audit - “Proper MDS Completion” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 641	Continued From page 27	F 641		

flow sheets or other skin tracking forms. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present..Coding Instructions Check all that apply in the last 7 days."

2. A review of Resident #249's Admission Record reflected that the resident was admitted with diagnoses which included but were not limited to; NJ ex order 26.4b1 .

A review of resident #249's NJ ex order 26.4b1 at 11:44 AM indicated that the resident NJ ex order 26.4b1

A review of Resident of Resident #249's discharge MDS dated NJ ex order 26.4b1, revealed that on NJ Exec Order 26.4b1 (determination of NJ ex order 26.4b1

According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Asessment Intstrument (RAI) 3.0 user's manual dated October 2019, Section M0300 included the following: "Coding Instructions for M0300C M0300C1. Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.Enter 0 if no Stage 3 pressure ulcers are present and skip to M0300D, Stage 4. M0300C2. Enter the number of these Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND-for residents who are reentering the facility

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F 641	Continued From page 28	F 641		

after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital). Enter 0 if no Stage 3 pressure ulcers were first noted at the time of admission/entry."

During an interview with the surveyor on 10/11/23 at 11:42 AM, the MDS Coordinator stated that one of his responsibilities was to ensure the MDS was completed, and the computer software would let him know if an MDS was missing. The MDS Coordinator added that he would base the coding of the MDS by reviewing nursing evaluations, progress notes and going to the nursing units and asking questions. At that time, the surveyor asked the MDS Coordinator to review Resident #79 and Resident #249. The MDS Coordinator confirmed that Resident #79's quarterly MDS dated [redacted] was not coded correctly indicating that the resident had [redacted] and would need to complete a modification. The MDS Coordinator reviewed Resident #249's discharge MDS which indicated that the resident [redacted] then the MDS was not correct. The MDS Coordinator stated that he was not sure if miscoding affected anything but may affect billing. The MDS Coordinator added that the MDS Coordinator's signature on the MDS ensured that the MDS was accurate.

During an interview with the surveyor on 10/11/23 at 12:53 PM, the MDS Coordinator stated that Resident #79 and Resident #249's assessments were incorrectly coded by "human error" and should be corrected.

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F 641	Continued From page 29 A review of the MDS Coordinator job description revised 5/13, included that the MDS Coordinator's job responsibilities were to ensure that the MDS was completed in a timely and accurate manner, and was responsible for timely submission to the appropriate regulatory agencies. A review of a facility policy with subject "MDS Completion and Submission" revised on 8/2020 included that the facility would conduct and submit resident assessments in accordance with current federal and state submission timeframes. Timeframe for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. NJAC 8:39-11.1	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		11/27/23

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F 656	Continued From page 30 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan consistent with the resident's preferred [redacted]. This deficient practice was identified for 1 of 35 residents (Resident #146) reviewed for care plans and was evidenced by the following: On 10/3/2023 at 12:03 PM, the surveyor	F 656	Plan of Correction F656 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #146 – Care Plan, Meal Tag, Identification Band and Room Tag updated with "[redacted]"	

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F 656	Continued From page 31 interviewed the Licensed Practical Nurse Unit Manager(LPN/UM #3), who reported that Resident #146 had a NJ Exec Order 26.4b1. On 10/4/2023 at 12:14 PM, the surveyor observed the resident seated in a reclining chair at a table identified as "Table 2", which identified Resident #146 with their NJ Exec Order 26.4b1. On 10/10/23 at 11:26 AM, a surveyor overheard a staff member repeatedly calling Resident #146 by their NJ Exec Order 26.4b1. On 10/11/23 at 9:08 AM, the surveyor observed that the name tag outside Resident #146's room identified their NJ Exec Order 26.4b1. The surveyor reviewed the medical record for Resident #146: A review of the Admission Record face sheet (an admission summary) reflected that the resident NJ ex order 26.4b1 A review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ ex order 26.4b1, reflected a brief interview for mental status (BIMS) score of NJ out of 15, NJ ex order 26.4b1 A review of an Initial Social Services Note, dated NJ ex order 26.4b1, documented that Resident #146 NJ ex order 26.4b1 a BIMS was conducted and returned as NJ ex order 26 that established the NJ ex order 26.4b1	F 656	• CNA #2 – 1:1 in-service on "NJ Exec Order 26.4b [redacted]" ID Other Residents: • Any resident who wishes to be addressed by a Preferred Name Systemic Change: • In-service – "Addressing Residents by Preferred Name" to the Nursing Department by Nursing Administration • Resident "Preferred Names" will be displayed on resident door tags, meal ticket, table place card and care plan Monitoring: • Audit - "Preferred Name" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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A review of the individualized NJ ex order 26.4b1 [redacted] failed to include a focus area along with interventions that identified Resident #146's NJ ex order 26.4b1 [redacted]

On 10/11/23 at 9:33 AM, the surveyor interviewed Certified Nursing Assistant (CNA #2), who acknowledged that they were unaware of any nicknames or personal preferences for Resident #146. When asked if they were to receive this information when would the information be relayed CNA #2 responded, "in the AM meeting."

On 10/11/23 at 10:31 AM, the surveyor interviewed Social Worker #1 (SW #1) and Director of Social Services (DOSS), who acknowledged that as part of the LGBTQI+ training the facility is to honor resident preferences, including resident gender and identifiers. When asked to discuss Resident #146, the DOSS confirmed Resident's preferred NJ Exec Order 26.4b1 was established prior to their NJ ex order 26.4b1 DOSS also indicated that family also verified the resident's preferences. When asked to review Resident #146 care plan, the DOSS advised that the focus area stated their NJ Exec Order 26.4b1 [redacted]. The surveyor inquired if the resident's NJ Exec Order 26.4b1 was identified. The DOSS responded that the name should be an identifier of the NJ Exec Order 26.4b1 based on the "spelling". The surveyor questioned if the resident's specified preferences should care planned so all staff was made aware. The DOSS confirmed. When asked if the resident's NJ Exec Order 26.4b1 [redacted] should be identified at the room door and at the dining table the DOSS responded, "I'm not sure, that is a good question [...] It should be based on the resident's preference".

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F 656	Continued From page 33 A review of the facility provided "LGBTQI+ Senior Bill of Rights", that was signed and dated by the DOSS, document identified that a violation of these rights would be "Repeatedly failing to use a resident's chosen name or pronouns despite being informed". A review of the document "LGBTQI+ Affirming Assessment Worksheet for Healthcare and Long-Term Care Environments", which was part of the LGBTQI+ Training Program, included...2. All forms seeking personal information about clients (from screening through discharge) include LGBTQI+ terminology. For example, [...] a. Chose name option if difference from their legal name [...] gender pronouns preferred: he/him/his; she/her/hers or they/them/theirs. A review the facility's "Care Plans", which effective date of 12/2015 and revised date of 6/2022, included [...] Care plans will include measurable objectives with interventions based on the resident's care needs and be individualized as able.	F 656		
F 658 SS=D	NJAC 8:39-11.2(e) thru (i); 27.1(a), (d) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # 159668	F 658	Plan of Correction	11/27/23

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F 658	Continued From page 34 Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to obtain a physician's order (PO) for a resident who was transferred to the hospital. This deficient practice was identified for 1 of 4 residents reviewed for hospitalization (Resident #249) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The surveyor reviewed the medical record for Resident #249.	F 658	F658 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #249 – unable to update Physician Order as resident was discharged • LPN #4 – 1:1 in-service provided on obtaining a Physician Order when sending a resident to the hospital ID Other Residents: • Any resident who is transferred to the hospital Systemic Change: • In-service – “Obtaining Physician Orders” to the Nursing Department by Nursing Administration • Physician orders will be obtained before transferring a resident to the hospital Monitoring: • Audit - “Physician Orders Upon Transfer” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 658	Continued From page 35	F 658		

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that NJ ex order 26.4b1 [redacted]

A review of the Significant Change in Status Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b1 [redacted] reflected a Brief Interview for Mental Status (BIMS) score of NJ ex [redacted] out of 15, which NJ ex order 26.4b1 [redacted]. The MDS also identified Resident #249 NJ ex order 26.4b1 [redacted]

A review of the Nursing Progress Notes included a note dated NJ ex order 26.4b1 [redacted] at 2:57 PM that indicated NJ ex order 26.4b1 [redacted]

A review of the Discontinued Physician Summary Report did not include an NJ ex order 26.4b1 [redacted]

During an interview with the surveyor on 10/6/23 at 9:02 AM, Licensed Practical Nurse Unit Manager (LPN/UM #3) reviewed the above referenced Nursing Progress Note and

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	315060	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 658	Continued From page 36	F 658		

Discontinued Physician Summary Report.
LPN/UM #3 stated that it was not documented if facility physicians were made aware of the resident's condition and did not observe orders in the Physician Summary Report to send the resident to the hospital. LPN/UM #3 further stated, NJ ex order 26.4b1 [redacted]

During an interview with the surveyor on 10/10/23 at 11:20 AM, the author of the Nursing Progress Note, Licensed Practical Nurse (LPN #4) stated that "considering the circumstances, I don't recall what was going on at the time [...] I'm not even sure if I endorsed it to the unit manager". When specifically asked if a PO should have been obtained to send the resident to the hospital LPN #4 stated, "I don't know".

During an interview with the surveyor on 10/12/23 at 11:01 AM, the Director of Nursing (DON) confirmed that a PO, along with a reason, was required for resident transport to the hospital.

During an interview with the surveyor on 10/13/23 at 11:30 AM, a Nurse Practitioner (NP #1) reported that there was an expectation that orders are to be received for any resident requiring transportation to the hospital. When asked who has the responsibility for entering the PO NP #1 stated, "the nurses will put in the orders."

During an interview with the surveyor on 10/13/23 at 1:49 PM, Licensed Nursing Home Administrator (LNHA) confirmed that there was no PO for the resident to be transported to the hospital.

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F 658	Continued From page 37 A review the facility's "Hospital Transfer Process" document dated 8/2017, included...An order should be obtained from the physician for the transfer. A review the facility's "Change in Resident Condition" policy, with an effective date 5/2018 and revised date of 2/2022, included "1. The nurse will notify the resident's physician when there has been a (an): a. accident or incident involving the resident; [...] d. significant change in the resident's physical/emotional/mental condition that impact their current pan of care; [...] e. need to alter the resident's medical treatment significantly; [...] g. need to transfer the resident to hospital/treatment center..." A review the facility's "Physician Orders-Obtaining/Transcribing" policy with an effective date 10/2018 and revised date 9/2020, included..."13. All orders will be identified as telephone, verbal, or prescriber written. Orders will be repeated and verified with physician or practitioner, and transcribed into record as quickly as practicable to when order has been received." A review the facility's "Job Description- LPN" document, with a revision date 5/13, included...Communicate change in resident status, test results and any other pertinent resident information to Physicians, Physicians Assistants, and Consultants in a timely and a professional manner. Document such communication in the Medical Record [...] Transcribe and implement physicians orders.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		11/27/23

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F 684	Continued From page 38 § 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. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review it was determined that the facility failed to a.) document and monitor a resident that had an NJ Exec Order 26.4b1 [redacted], and obtain physician orders for monitoring of a resident's NJ Exec Order 26 and b.) follow a physicians order for daily NJ Exec Order 26.4b1 changes. This deficient practice was identified for Resident #396, 1 of 1 NJ ex order 26.4b1 and Resident #398 1 of 3 NJ ex order 26.4b1 [redacted]: 1.On 10/03/23 at 10:35 AM, during the initial tour of the facility the surveyor observed Resident #396 in the bed. Resident #396 told the surveyor he/she NJ ex order 26.4b1 [redacted] A review of the Admission Record revealed the resident was recently admitted to the facility with NJ ex order 26.4b1 [redacted]	F 684	Plan of Correction F684 Level D Completion Date: 11/27/2023 Corrective Action: • Resident # 396 – NJ ex order 26.4b1 [redacted] • Resident #398 – NJ ex order 26.4b1 [redacted] • Resident #396 – NJ ex order 26.4b1 [redacted] • CNA #4 – 1:1 NJ ex order 26.4b1 [redacted] • Resident #398 – treatment orders reviewed • LPN #3 – 1:1 in-service on monitoring orders upon admission ID Other Residents: • Any resident who utilizes a life vest • Any resident who requires a treatment by a licensed nurse	

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F 684	Continued From page 39 NJ ex order 26.4b1 [redacted] A review of the admission Minimum Data Set, an assessment tool (MDS) dated NJ ex order 26.4b1 indicated Resident #396 had a Brief Interview of Mental Status of NJ ex [redacted] meaning the resident NJ ex [redacted]. On 10/05/23 at 09:51 AM, the surveyor reviewed physician progress notes that were completed on admission to the facility. The physician documented that the resident NJ ex order 26.4b1 [redacted] At the same time the surveyor reviewed all of the nursing progress notes and a NJ Exec Order 2[redacted] was not mentioned in the progress notes since Resident #396 physician admission note. On 10/05/23 at 09:57 AM, the surveyor reviewed the Admission Nursing Assessment which did not include the resident was wearing a NJ Exec Order 2[redacted]. On 10/05/23 at 10:02 AM, the surveyor reviewed Resident #39 NJ ex order 26.4b1 [redacted] On 10/05/23 at 10:30 AM, the residents care plan. The care plan was initiated on NJ ex order 26.4b1 and had a focus of NJ ex order 26.4 [redacted] The care plan did not include that the resident NJ ex order 26.4b1 [redacted] On 10/05/23 at 12:03 PM, the surveyor asked the Unit Manager/Licensed Practical Nurse (UM/LPN) if the resident had a NJ Exec Order 2[redacted] and the UM/LPN stated, NJ ex order 26.4b1 [redacted]." The	F 684	Systemic Change: • In-service on "Life Vest: Usage and Monitoring" will be conducted to the Nursing Department by Nursing Administration • In-service on "Treatment Procedures" will be conducted to the Nursing Department by Nursing Administration Monitoring: • Audit - "Life Vest" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Administration • Audit – "Treatment Procedures" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 684	Continued From page 40	F 684		

UM/LPN stated the resident came with the [NJ Exec Order 26.4b1]. The surveyor asked if something like a [NJ Exec Order 26.4b1] should be included on the care plan and the UM/LPN stated, "I believe it is." At that time the UM/LPN went into the Electronic Medical Record (EMR) to check the residents care plan and stated to the surveyor, "It isn't, but it definitely should be on the care plan". During the interview with the UM/LPN the Clinical Regional Nurse (CRN) was present who stated, "I don't even see a [NJ Exec Order 26.4b1] in the physician orders." The surveyor reviewed the physician orders and could not locate any orders pertaining to a [NJ Exec Order 26.4b1] or monitoring.

On 10/05/23 at 12:16 PM, the surveyor went to see Resident #396. The resident told the surveyor he/she [NJ ex order 26.4b1]. The surveyor asked who charges the vest and resident stated, [NJ Exec Order 26.4b1]

On 10/10/23 at 12:29 PM, the surveyor interviewed CNA #4 who was caring for Resident #396. The surveyor asked CNA #4 how she washed the resident with the [NJ Exec Order 26.4b1] and CNA #4 stated, "She was all done when I came in today, so I didn't have to." The surveyor asked if she knew the resident had a [NJ Exec Order 26.4b1] and if she received any education on the [NJ Exec Order 26.4b1] when she received her assignment in the morning, and CNA #4 stated, "No."

On 10/12/23 at 10:55 AM, Resident #396 was observed sitting on the side of bed fully clothed. The resident told the surveyor he/she was going home and was awaiting discharge instructions. The surveyor asked the resident if, during the stay at the facility did the staff check the [NJ Exec Order 26.4b1] and the resident replied, "Not at all, not once. I

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F 684	Continued From page 41	F 684		

did everything and when the alarm would go off, I would hit a button and the machine would tell me what to do."

On 10/17/23 at 09:30 AM, the surveyor reviewed the policy titled, "Wearable Cardioverter Defibrillator", the policy had an effective date of 03/2020. Under the procedure section of the policy, it indicated the facility will verify the use of the defibrillator, the clinical team will monitor the use of the device routinely, and the residents wearing one will be placed close to the nursing station for monitoring when possible.

2. On 10/03/23 at 11:18 AM, during the initial tour of the facility the surveyor observed Resident #398 in the room. The surveyor observed that Resident #398 NJ ex order 26.4b1 During the interview the surveyor asked the resident how often the staff change the NJ Exec Order 26.4b1 and the resident said, "It should be changed every day, but they don't do it every day." Resident #398 then said, NJ ex order 26.4b1 " During the observation of the NJ ex order 26.4b1 the surveyor observed a date on the NJ Exec Order 26.4 of NJ ex order 26 with a staff member initials on the NJ Exec Order 26.4 .

A review of the Admission Record revealed that Resident #398 was recently admitted to the facility with medical diagnoses NJ ex order 26.4b1

A review of the Admission Minimum Data Set (MDS), an assessment tool date NJ ex order 26.4b1 which indicated the resident had a Brief Interview of Mental Status of NJ ex o meaning Resident #398 was

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NJ ex order 26.4b1.

On 10/03/23 at 11:24 AM, the surveyor interviewed a Licensed Practical Nurse (LPN #3) who was caring for the resident. LPN #3 along with the surveyor entered the room and the surveyor showed LPN #3 the date on the NJ Exec Order 26.4, LPN #3 said, "September 30th, but the NJ Exec Order 2 nurse is coming today." The surveyor asked LPN #3 that if it was a daily NJ Exec Order 26.4 what should the date on the NJ Exec Order 26.4 be and LPN#3 said, October second". The LPN #3 then told the surveyor, "there may have been some confusion because sometimes the NJ Exec Order nurse gets pulled to a medication cart when they are short staffed."

On 10/04/23 at 01:35 PM, the surveyor reviewed the physician orders which showed on NJ ex order 26.4b1 there was NJ ex order 26.4b1 It was an active order. Further review of the physician orders showed an order dated NJ ex order 26.4b1, NJ ex order 26.4b1 .

On 10/04/23 at 02:01 PM, the surveyor reviewed the Treatment Administration Record which showed that the nursing staff signed the NJ Exec Order care as completed on NJ ex order 26.4b1. The third was the day of the observation with the NJ Exec Order 26.4b1 dated NJ ex order 2.

On 10/04/23 at 02:11 PM, the surveyor further reviewed the MDS dated NJ ex order 26.4b1, section NJ Exec Order, which indicated that the resident had NJ ex order 26.4b1

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F 684	Continued From page 43 On 10/04/23 at 02:23 PM, the surveyor reviewed Resident #398 care plan that was initiated on [NJ ex order 26.4b1]. The focus of the care plan was actual [NJ ex order 26.4b1 NJ ex order 26.4b1] On 10/17/23 at 09:31 AM, the surveyor interviewed the Director of Nursing (DON) regarding residents with [NJ Exec Order 2] treatment orders. The DON told the surveyor that when a resident had a [NJ Exec Order], the nurse would look for the current treatment orders in place and transcribe the orders onto the Treatment Administration Record (TAR). The surveyor asked who was responsible to complete the [NJ Exec Order] care treatments and the DON responded, "Ninety-nine percent of the time the nurse on the cart (medication cart) who does the [NJ Exec Order] treatment. If there is an extra nurse on duty, we assign them to the [NJ Exec Order] cart." The DON told the surveyor the Charge Nurse was responsible to ensure that [NJ Exec Order] treatments were done, and the assigned nurse was also responsible to ensure the [NJ Exec Order 2] treatment was done, even if the facility had a [NJ Exec Order] nurse. The surveyor questioned the DON regarding the date of Resident #398's [NJ ex order 26.4b1] and she stated that "obviously the [NJ Exec Order] treatment was not done if not dated [NJ ex ord]." The DON stated that she knew that Resident #398's [NJ ex order 26.4b1] was not done, and that the resident even said it. The DON stated that the issue was identified upon surveyor inquiry. She stated that if the nurse documented the [NJ Exec Order] treatment was completed on the TAR and it was not done that was false documentation. The DON further stated that the	F 684		

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F 684	Continued From page 44 treatment would still need to have been done on [NJ ex order 26.4b] as the [NJ Exec Order] consultant would just assessed the [NJ Exec Order 2] and would not [NJ Exec Order 26] the [NJ Exec Order 2] On 10/18/23 at 11:22 AM, the surveyor reviewed the policy titled, "Physician Orders", the policy had a revision date of 07/2017. The policy read that the facility was to assure that medication/treatment orders are implemented accurately, timely, and in accordance with the State of New Jersey and Federal Government regulations. NJAC 8:39-27.1	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint # 159668 Based on record review, staff interviews, and facility policy review, the facility failed to ensure a	F 686	Plan of Correction F686 Level D	11/27/23

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F 686	Continued From page 45 newly identified area of NJ ex order 26.4b1 was assessed and treated in a timely manner for 1 of 3 residents (Resident #249) reviewed for NJ ex order 26.4b1 The surveyor reviewed the medical record for Resident #249. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included NJ ex order 26.4b1 A review of the Significant Change in Status Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b1, reflected a brief interview for mental status (BIMS) score of NJ ex out of 15, which demonstrated NJ ex order 26.4b1. The MDS also identified Resident #249 NJ ex order 26.4b1 A review of the NJ ex order 26.4b1 for Resident #249 identified a NJ ex order 26.4b1 and interventions that included, but not limited to: NJ ex order 26.4b1 The care plan also identified that the resident NJ ex order 26.4b1 NJ ex order 26.4b1 The care plan identified the Resident #249 NJ ex order 26.4b1	F 686	Completion Date: 11/27/2023 Corrective Action: • Resident #249 – unable to update treatment order as resident was discharged from facility • LPN #4 – provided 1:1 education on notification on expectations of documentation of change in resident condition and obtaining treatment orders from physician with timely implementation ID Other Residents: • Any resident who has a change in condition that results in notification to physician and intervention of treatment Systemic Change: • In-service on “Notification of Skin Alterations” will be conducted to the Nursing Department by Nursing Administration • In-service on “Obtaining Treatment Orders” will be conducted to the Nursing Department by Nurisng Administration Monitoring: • Audit - “Wound Notifications/Treatment Orders” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 686	Continued From page 46	F 686		

NJ ex order 26.4b1 with initiation date of NJ ex order 26.4b1 and interventions that included, but not limited to: NJ ex order 26.4b1

A review of the NJ ex order 26.4b1 with start date of NJ ex order 26.4b1 identified NJ ex order 26.4b1 and interventions included: NJ ex order 26.4b1

A review of the NJ Exec Order 26 Nursing Clinical Note, dated NJ ex order 26.4b1 and signed at 12:24 PM, detailed the following summary note: NJ ex order 26.4b1

A review of the facility NJ Exec Order 26.4b1 Assessment dated NJ ex order 26.4b1 at 7:00 AM, under the Section titled: NJ Exec Order 26.4b1, the boxes next to NJ ex order 26.4b1 " and NJ ex order 26.4b1 " was checked. Under the section titled Body Diagram, the following was entered: NJ ex order 26.4b1

A review of the facility Nursing Progress Notes included a note dated NJ ex order 26.4b1 at 10:00 AM, indicated: "Cart/floor nurse notified this RN that resident had NJ ex order 26.4b1

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F 686	Continued From page 47 NJ ex order 26.4b1 [redacted] "	F 686		

A review of the facility [redacted] Assessments dated [redacted] at 11:44 AM, revealed under location/Type, "NJ ex order 26.4b1 [redacted] nder the Section titled: Comments/Interventions, the following was entered: NJ ex order 26.4b1 [redacted].

A review of the facility Nursing Progress Notes included a note dated [redacted] at 12:15 PM, that indicated: NJ ex order 26.4b1 [redacted] "

A review of the facility Nursing Progress Notes included a note dated [redacted] at 3:14 PM, that indicated: "NJ ex order 26.4b1 [redacted] "

A review of the facility [redacted] Assessment dated [redacted] at 7:00 AM, under the Section titled: [redacted], the boxes next to [redacted] "

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was checked and under Other the following was entered: NJ ex order 26.4 NJ ex order 26.4b1 . Under the section titled Body Diagram, the following was entered: NJ ex order 26.4b1

A review of the facility NJ Exec Order 2 Assessment dated NJ ex order 26.4b1 at 11:35 AM, revealed under NJ Exec Order 2 location/Type, NJ ex order 26.4b1

A review of the Practitioner Note included an entry, dated NJ ex order 26.4b1 at 3:42 PM, that indicated: NJ ex order 26.4b1 .

A review of the Order Summary Report revealed the following orders:
NJ ex order 26.4b1

Consult NJ Exec Order 2 Nurse fo NJ ex order 26.4b1

Consult NJ Exec Order 2 Nurse for NJ ex order 26.4b1

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NJ ex order 26.4b1 .

NJ ex order 26.4b1

A review of NJ Exec Order 26.4b1 Treatment Administration Record (TAR) revealed the following:

Clear NJ Exec Order 26.4b1 with NJ Exec O, NJ ex order 26.4b1 at 1807 (5:07 PM);

NJ ex order 26.4b1 with a start date of NJ ex order 26.4b1 at 1522 (3:22 PM) and D/C Date of NJ ex order 26.4b1 at 1807 (5:07 PM).

The review of the TAR revealed that the start dates of the orders were three days after the NJ Exec Order assessment identified the order on NJ ex order 26.4b1. The month of NJ Exec Order 26.4b1 contain an "X", which indicated that the treatments were not administered.

During an interview with the surveyor on 10/6/23 at 9:02 AM, Licensed Practical Nurse Unit Manager (LPN/UM #3) reviewed the Nursing Progress Notes, Physician Orders, NJ Exec Order 26.4b1 Assessments, and NJ Exec Order 2 Assessments. LPN/UM #3 confirmed that there was no

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documentation of physician being contacted upon initial discovery of the [redacted]. When asked if there should have been a delay the LPN/UM #3 responded, "absolutely not [...] treatment should have been in place right away".

During an interview with the surveyor on 10/10/23 at 11:20 AM, the author of the Nursing Progress Note Licensed Practical Nurse (LPN #4) confirmed that nurses were responsible for any type of follow ups and the end of their shift. When inquired about the status of the physician notification for Resident #249's [redacted] LPN #4 responded, "I endorsed it to [unit manager] and it was up to them." LPN #4 concluded the interview and stated, "considering the circumstances, I don't recall what was going on at the time" and would not elaborate.

During an interview with the surveyor on 10/12/23 at 11:01 AM, the Director of Nursing (DON) advised that when a NJ Exec Order 26.4b1 is observed, the nurses are to notify the physician, family, and [redacted] care team and obtain a treatment order. The DON advised that the [redacted] care team can be contacted at any time. When asked what the expected timeframe for a [redacted] intervention the DON responded, "immediately [...] it can NJ Exec Order 26.4b1 [redacted].

During an interview with the surveyor on 10/12/23 at 1:37 PM, the Licensed Nursing Home Administrator (LNHA) acknowledged that the nurse "missed the treatment" and "no treatment was put into place." The LNHA further explained that the nurses staging of the [redacted] may not be accurate based on the measurement and the overall description of the [redacted]. The LNHA also

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F 686	Continued From page 51 acknowledged that the resident was [NJ Exec Order 26] and "[NJ Exec Order 26.4b1]." During an interview with another surveyor on 10/16/23 at 8:51AM, the LNHA provided written acknowledgement that there was a failure "to place treatment in place post finding of [NJ Exec Order]". A review the facility's "Change in Resident Condition" policy, with an effective date 5/2018 and revised date of 2/2022, included...1. The nurse will notify the resident's physician when there has been a (an): a. accident or incident involving the resident; [...] d. significant change in the resident's physical/emotional/mental condition that impact their current pan of care; [...] e. need to alter the resident's medical treatment significantly..." A review the facility's "Skin Management" policy, with an effective date 12/2018 and revised date of 10/2021, included under the title Monitoring, "1. The staff will examine the skin of a resident with ulcerations or alterations in skin routinely." A review the facility's undated "Skin Assessment" document included under the title policy: skin assessments will be completed by the nurse upon admission and weekly thereafter. The aides will also monitor skin integrity during routine care, and will notify the nurse should they find any changes in the resident's skin. The document further relayed, the assessment should note any signs of redness, rash, bruises, abrasions, lacerations or breakdown. If found by the nursing assistance, they shall report their findings to the nurse immediately. The nurse will then assess the resident, and if warranted, notify MD for appropriate interventions. Documentation of the	F 686		

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F 686	Continued From page 52 findings or lack thereof, will be documented in the resident's record. A review the facility's "Job Description- LPN" document, with an revision date 5/13, included...assess, monitor and evaluate the residents' physical and emotional status for significant changes on a continual basis and document such in the medical record [...] take temperature, pulse, blood pressure and other vital signs to detect deviations from normal and assess condition of residents. NJAC 8:39-27.1(e)	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer [redacted] according to the physician's order. This deficient practice was identified for 1 of 1 resident (Resident #137) reviewed for [redacted], and was evidenced by the following: On 10/03/23 at 10:41 AM, the surveyor observed	F 695	Plan of Correction F695 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #137 – [redacted] order verified • Resident #137 – [redacted] set to appropriate order level	11/27/23

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F 695	Continued From page 53 Resident #137 resting in bed watching television (TV). The resident was NJ ex order 26.4b1 [redacted] On 10/04/23 at 11:19 AM, the surveyor observed Resident #137 sitting in a wheelchair in their room watching TV. The resident was NJ ex order 26.4b1 [redacted] he resident informed the surveyor that they did not adjust the NJ Exec Order 2 setting themselves, and that the facility nursing staff check on it every now and then. On 10/11/23 at 9:20 AM, the surveyor observed the resident eating breakfast in bed with the NJ ex order 26.4b1 [redacted] On 10/13/23 at 9:05 AM, the surveyor observed the resident eating breakfast wit NJ ex order 26.4b1 [redacted] A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis which included but not limited to NJ ex order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b1, reflected a brief interview for mental status (BIMS) score of NJ ex out of 15, which indicated the resident NJ ex order 26.4b1	F 695	ID Other Residents: • Any resident who utilizes oxygen Systemic Change: • In-service on "Oxygen Therapy" will be conducted to the Nursing Department by Nursing Administration Monitoring: • Audit - "Oxygen Therapy" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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NJ ex order 26.4b1 A further review reflected the resident NJ ex order 26.4b1

A review of the resident's individualized resident-centered Care Plan included a focused care area indicating the resident's NJ ex order 26.4b1

A review of the resident's physician's orders (PO) included an active order started on NJ ex order 26.4b1 for NJ ex order 26.4b1 for NJ ex order 26.4b1 NJ ex order 26.4b1

On 10/13/23 at 9:12 AM, the surveyor interviewed Licensed Practical Nurse #2 (LPN #2) who stated that NJ Exec Order 26.4b1 should be set to deliver NJ Exec Order 2 to the residents per the physician's order, and that she checked the NJ Exec Order 26.4b1 s setting when rounding approximately every two hours.

On 10/13/23 at 10:25 AM, the surveyor asked the Registered Nurse/Unit Manager (RN/UM) to check Resident #137's NJ ex order 26.4b1 setting. The RN/UM accompanied by the surveyor went to the resident's room at which point the NJ ex order 26.4b1 and the NJ ex order 26.4b1 At that time, the RN/UM stated she should have caught that error during her rounds, and the nurse's assigned to the resident were responsible

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F 695	Continued From page 55 for ensuring the setting to be adjusted to the ordered setting. The RN/UM also confirmed that the setting should be to the level ordered even if it is ordered to be PRN. On 10/13/23 at 10:59 AM, the surveyor interviewed the Director of Nursing (DON) who stated that NJ Exec Order 26.4b1 settings should be checked by the nursing staff every shift to ensure the NJ Exec Order 2 is being administered to the residents as ordered. Review of the facility's "Oxygen Therapy" policy with a revision date of 12/2021 included: "verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration ... Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate ordered. Place appropriate oxygen device on the resident. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered." NJAC 8:39 - 27.1(a)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the	F 698	Plan of Correction	11/27/23

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F 698	Continued From page 56 facility failed to monitor and document the amount of [NJ Exec Or] administered on a resident on [NJ Exec Order 26.4b1]. This deficient practice was identified for 1 of 2 residents reviewed for [NJ Exec Order 2], Resident #171, and was evidenced by the following: On 10/04/23 at 12:09 PM, the surveyor observed Resident #171 in their room and observed an unmarked white cup with a lid on the overbed table. The resident stated the cup contained water and would drink the water "but not too much." The resident opened the cup and showed surveyor the contents of the cup. The resident further stated that they received [NJ ex order 26.4b1] The surveyor observed a picture of a water pitcher taped next to Resident #171's room number and name on the door. On 10/04/23 at 12:12 PM, the surveyor interviewed the Certified Nurses Aide (CNA #5) who stated the water pitcher on the resident's door meant the other resident in the room [NJ ex order 26.4] On 10/04/23 at 12:24 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #5) outside the resident's room, who stated Resident #171 [NJ ex order 26.4b1] PN #5 stated the resident was [NJ ex order 26.4b1] [NJ ex order 26.4b1] At that time, the LPN saw the white cup with water on the resident's overbed table. LPN #5 stated residents on [NJ Exec Order 26.4b1] were not supposed to have a water cup at their bedside and removed the cup.	F 698	F 698 Level E Completion Date: 11/27/2023 Corrective Action: • Resident #171 – water cup removed from bedside • Resident #171 educated on the purpose of [NJ Exec Order 26.4b1] and the risk vs benefits of following ID Other Residents: • Any resident who has an order for Fluid Restrictions Systemic Change: • In-service on “Fluid Restrictions” will be conducted to all departments by Nursing Administration • In-service on “Dietary Icons” will be conducted to all departments by Nursing Administration Monitoring: • Audit - “Fluid Restrictions” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Audit – “Dietary Icons” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 698	Continued From page 57 On 10/05/23 at 11:37 AM, the surveyor observed a white cup with dark liquid with ice in it on top of Resident #171's overbed table. On 10/10/23 at 7:54 AM, the surveyor observed a white cup half-filled with water on the resident's bedside table. According to the Admission Record, Resident #171 had diagnosis which included but were not [redacted]. A review of the resident's Annual Minimum Data Set (MDS) dated [redacted] revealed resident had a Brief Interview of Mental Status (BIMS) of [redacted] which indicated that the resident's [redacted]. A review of the resident's care plan initiated [redacted] revealed resident was on [redacted] which included; [redacted] A review of the resident's Physician's Orders (PO) dated [redacted] revealed an order for: [redacted] A review of the resident's Medication Administration Records (MAR) revealed the aforementioned PO with following dates that Resident #171's [redacted] July 2023 MAR from [redacted]	F 698		

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NJ ex order 26.4b1 MAR from NJ ex order 26.4b1
NJ ex order 26.4b1 MAR from NJ ex order 26.4b1
and
NJ ex order 26.4b1 MAR from NJ ex order 26.4b1

On 10/10/23 at 8:21 AM. the surveyor interviewed the Unit Manager LPN (UM/LPN #3) who stated Resident #171 was on NJ Exec Order 26.4b1 with a NJ Exec O [redacted]. She further stated nurses would give the resident NJ Exec Or in the amount scheduled for the shift and then would document the amount of NJ Exec O that was given in the resident's electronic Medication Administration Record (eMAR) at the end of their shift.

On 10/10/23 at 9:45 AM, the surveyor interviewed the Director of Nursing (DON). who stated residents who were on NJ Exec Order 26.4b1 must have an order from the physician. The DON further stated staff would know if residents were on NJ Exec O [redacted] because of the water pitcher picture next to a resident's name on the door. The DON stated only nurses would give NJ Exec Or to residents who have a NJ Exec Order 26.4b1 and that residents should not have water cups at their bedside. The DON stated nurses would document the amount of NJ Exec Or the resident had at the end of their shift in the eMAR. DON stated the nurses of resident #171 should have documented the amount of NJ Exec Or in the medication administration record.

A review of the facility's Policy & Procedure on Restricting/Encouraging Fluids General Policy Guidelines with revised date of 04/2021, "#4 stated to record fluid intake in milliliters (ml) in the eMAR, #8 when resident is placed on restricted fluids, remove the water pitcher and cup from the room, and #6 document the amount in mls of

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F 698	Continued From page 59 fluids consumed by the resident during the shift." NJAC 8:39-2.9	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		11/27/23

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by:
Complaint # NJ 155924

Based on observation, interview, and review of facility documents, it was determined that the facility failed to ensure: a.) the accurate documentation of the administration of controlled medication for one unsampled resident (unsampled Resident #4) identified upon inspection of 1 of 8 medication carts [NJ Exec Orde] cart #1), b.) the shift to shift controlled medication count record was completed for 1 of 8 medication carts, [NJ Exec Order 26.4b1] cart #2), c.) accurate documentation for the destruction of controlled medication for one unsampled resident (unsampled Resident #5) identified upon inspection of 1 of 8 medication carts [NJ Exec Orde] cart #2), and d.) medication was received timely from the provider pharmacy 1 of 35 residents (Resident #246) reviewed.

These deficient practices were evidenced by the following:

1. On 10/12/23 at 11:10 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #4) inspected the [NJ Exec Order 26.4b1] cart #1. The surveyor and LPN #4 reviewed the controlled medications located in the secured and locked controlled medications box. When the controlled medication inventory was compared to the corresponding patient-controlled substance record, a declining inventory sheet, the surveyor identified the following concerns:

Unsampled resident #4's [NJ ex order 26.4b1] a medication used for [NJ Exec O], did not match the declining inventory sheet quantity. [NJ ex order 26.4b1]

Plan of Correction

F755 Level D
Completion Date: 11/27/2023

Corrective Action:
- Resident #4 – medication and declining record sheet removed and placed for destruction
- LPN #4 – 1:1 in-service provided on [NJ Exec Order 26] count
- Resident #5 – medication and declining record sheet removed and placed for destruction
- Resident #246 – resident was discharged and adjustments were unable to be made

ID Other Residents:
- Any resident receiving a Controlled Substance

Systemic Change:
- In-service – "How to Complete a Narcotic Count" will be given to the Licensed Nursing Staff by Nursing Administration
- In-service – "Procedure for Signing Declining Record Sheet" will be given to the Licensed Nursing Staff by Nursing Administration
- In-service – Communication of Pharmacy Needs" will be given to the Licensed Nursing Staff by Nursing Administration
- Nursing staff will communicate during shift report and place pharmacy needs on

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F 755	Continued From page 61 and the declining inventory sheet indicated there should be NJ ex order 26.4b1. LPN #4 stated that the night supervisor and Registered Nurse #1 (RN #1) had counted the [redacted] at change of shift, that she was not present at that time. LPN #4 further stated she was not made aware there was a discrepancy in the controlled medication count prior to taking over the cart and acknowledged she should have done her own [redacted] count with the nurse before she had taken over the cart. LPN #4 stated two nurses, the outgoing and incoming nurse should count and then sign the [redacted] log to ensure accuracy. On 10/12/23 at 11:29 AM, the surveyor interviewed RN #1 in the presence of the [redacted] Licensed Practical Nurse Unit Manager (LPN/UM). RN #1 stated she had counted the [redacted] for [redacted] cart #1 with the night supervisor that morning and the night supervisor told her the evening nurse on [redacted] had not signed the declining inventory sheet when she had administered the [redacted] to unsampled resident #4. At that same time, the LPN/UM stated she had not been made aware there was a discrepancy identified. On 10/17/23 11:02 AM, the surveyor interviewed the Director of Nursing (DON) who stated she was aware of the discrepancy in the declining inventory sheet for unsampled resident #4. The DON further stated that two nurses must count and sign the [redacted] at the start and at the end of every shift. 2. On 10/12/23 at 11:29 AM, the surveyor, in the presence of Registered Nurse (RN#1), reviewed	F 755	the 24 hour nursing report Monitoring: • Audit - "Narcotic Declining Record" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 755	Continued From page 62 the NJ Exec Order 26.4b1 Record of NJ Exec Order 26.4b1 Drug Count, a shift-to-shift record accounting for the accuracy of each individual resident's controlled medication declining inventory sheet, for NJ Exec Order 26.4b1 medication cart #2 and observed the following blank areas: NJ Exec Order 26 11:00 PM, no signature or initials- Column 1 for incoming nurse. NJ Exec Order 26 7:00 AM, no signature or initials- Column 2 for outgoing nurse. NJ Exec Order 26 11:00 PM, no signature or initials- Column 1 for incoming nurse. NJ Exec Order 26 3:00 PM, no signature or initials- Column 1 for incoming nurse. NJ Exec Order 26 11:00 PM, no signature or initials- Column 1 for incoming nurse. NJ Exec Order 26.4b 7:00 AM, no signature or initials- Column 1 for incoming nurse. NJ Exec Order 26.4b 3:00 PM, no signature or initials- Column 2 for outgoing nurse. On 10/12/23 at 11:29 AM, the surveyor interviewed RN #1 regarding the discrepancies in the controlled medication count record. RN#1 stated the incoming nurses must count the controlled medications with the outgoing nurses and both nurses must sign the NJ Exec Order 26.4 log. 3. On 10/12/23 at 11:29 AM, the surveyor, in the presence of RN #1 reviewed the NJ ex order 26.4b1, a NJ ex order 26.4b1 declining inventory sheet, for unsampled Resident #5 which revealed on NJ ex order 26.4 at 9:00 AM, a NJ ex order 26.4b1 NJ ex order 26.4b1, a medication that had been documented as "wasted". There was no nurse signature to account for who had wasted the medication. RN #1 stated when wasting	F 755		

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F 755	Continued From page 63	F 755		

NJ Exec Order 26.4b1 medications there should be two nurses who witness the destruction and disposal of the medication and once finished, they both signed the declining inventory sheet as witness.

On 10/17/23 11:02 AM, the surveyor interviewed the DON who stated she was aware of the entries that were not documented. The DON further stated that two nurses must count and sign the NJ Exec Order 26.4b1 at the start and at the end of each shift. She further stated when a NJ Exec Order 26.4b1 medication needed to be wasted two nurses needed to destroy the medication and then both must sign the declining inventory sheet.

4. On 10/17/23 at 10:40 AM, the surveyor conducted a review of medical records for Resident #246 which revealed the following:

A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility NJ ex order 26.4b1 [redacted]

A review of the resident's physician orders (PO) included an order dated NJ ex order 26.4b1 for NJ ex order 26.4b1 [redacted]

A review of the NJ ex order 26.4b1 Medication Administration Record (MAR) revealed the resident received their first dose of the ordered NJ ex order 26.4b1 on NJ ex order 26.4b1 at 9:00 PM.

A review of the resident's individualized

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F 755	Continued From page 64	F 755		

resident-centered Care Plan included a focused care area which an indicated the resident was at NJ ex order 26.4b1 and included interventions which included to NJ ex order 26.4b1 [redacted]

A review of nursing and provider (doctor and nurse practitioner) progress notes included the following:

NJ ex order 26.4b1 at 9:30 PM the nurse practitioner (APN) noted "NJ ex order 26.4b1 [redacted] . NJ ex order 26.4b1 although scripts have been written since day of admission. Per staff, pharmacy didn't have NJ Exec Order 26.4b1, so they requested new NJ Exec Order 26.4b1. Nursing staff has reportedly been in touch with pharmacy again today."

6/27/2022 at 3:00 PM, the APN noted "will continue other meds as they are. NJ ex order 26.4b1 [redacted]

On 10/18/23 at 10:35 PM, the surveyor interviewed Licensed Practical Nurse/ Unit Manager #1 (LPN/UM #1) who informed the surveyor that typically medications can be ordered and delivered from the pharmacy quickly. She informed the surveyor that with NJ Exec Order 26 medications, the doctor (MD) was notified, and usually they sent the written prescription to the

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pharmacy by fax the same night and the pharmacy delivered it the next day. She also added that the pharmacy had multiple deliveries per day and sometimes overnight. LPN/UM #1 also stated that if a medication was not available and the pharmacy recommended another available strength, then the MD was notified, and they usually were able to send a new script to the pharmacy "right away."

On 10/18/23 at 10:56 AM, the surveyor interviewed the DON, who confirmed that the pharmacy had scheduled deliveries at approximately 6:00 AM, 4:00 PM, and 11:00 PM daily and if necessary, STAT (immediate) deliveries were available. The DON also stated that four (4) days was not an appropriate or acceptable time frame for ordered medication to be delivered and administered to the resident. She stated that it was expected that if the nurse had a situation where medication was unable to be delivered and administration was delayed that they relay that information to the unit manager who would "stay on top of it in order to receive the medication timely."

On 10/18/23 at 11:25 AM, the surveyor called and spoke with the pharmacist (RPh) at the provider pharmacy utilized by the facility. The RPh stated that going through the documentation on their end, she was able to locate one script for NJ ex order 26.4b1 and a second one with the same order dated NJ ex order 26.4b. The RPh confirmed that the prescription dated NJ ex order 26.4b was filled and delivered on NJ ex order 26.4b, and the prescription dated NJ ex order 26.4b was filled and delivered on NJ ex order 26.4b. The RPh was unable to locate any further documentation or reason why there was a delay

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F 755	Continued From page 66	F 755		

in delivering the medication for four days.

On 10/19/23 at 11:50 AM, in the presence of the survey team, the facility's Licensed Nursing Home Administrator (LNHA), DON, and the Regional Nursing Coordinator (RNC) confirmed the four-day delay in obtaining the [redacted] for Resident #246. When asked if it was acceptable to wait that long for medication, the RNC replied "of course not, no" and the DON informed the team that the primary provider pharmacy had a backup pharmacy if they could not provide a medication. The administrative team stated they "don't disagree, there should not have been a delay that long for the resident to have received their medication from the pharmacy."

A review of the facility's "Controlled Substance Medication Policy and Procedure" revised 10/1/2018... "When CDS medication is administered, in addition to following proper procedure for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/her initials. An inventory count of all CDS medications stored on each nursing unit shall be performed at each change of each shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form."

A review of the facility's "Delivery of Medications from Satellite (Back-up) Pharmacy" with revision dated 10/1/2018 and included... "Purpose: to provide medications in a timely manner by utilizing satellite (back-up) pharmacies to dispense medications that are needed by a facility sooner than the regularly scheduled delivery."

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F 755	Continued From page 67 Under the section labeled "Policy" it included the pharmacy "strives to provide all medications in a timely manner that is acceptable by the facility and more importantly by the resident ..." The section labeled "Procedure" included: "if a medication is needed by a facility within a time frame that is unreasonable to be dispensed ... the facility may call the pharmacy and request a STAT delivery"... has a 2-3-hour window to deliver a medication as a STAT from our main location. If a medication is needed in a more immediate time frame, the medication may be processed via a back-up pharmacy closer to the location of the facility." NJAC 8:39-29.2(d); 29.7(c)	F 755		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Complaint # NJ 159503, NJ 160417, NJ 162667 Based on observation, interview, and review of facility documentation it was determined that the facility failed to consistently serve foods at safe and appetizing temperatures. This deficient	F 804	Plan of Correction F804 Level F Completion Date: 11/27/2023 Corrective Action: • Sample tray discarded and new tray	11/27/23

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F 804	Continued From page 68 practice was identified for 2 of 2 units reviewed and was evidenced by the following: 1. On 10/05/23 At 12:25 PM, the surveyor observed large stainless trays with lunch food arrive to the day room one steam table. There were 13 residents seated in day room one waiting for lunch to be served. All of the other unit residents from the first floor had lunch in their rooms. The food service staff began making lunch trays from the steam table. As the trays were being prepared for the residents some trays were handed to the residents in day room one and other trays were placed on a silver open tray cart to be distributed to resident rooms. Trays were placed on the cart for delivery to rooms prior to all of day room one residents receiving their trays. On 10/05/23 at 12:45 PM, the open cart with the resident trays left the dining room and was placed in the hallway on the unit. On 10/05/23 at 12:49 PM, the unit staff began handing out the seven trays for the first-floor wing being observed. At 01:05 PM, just prior to the final tray being handed to the resident the surveyor requested the FSD to obtain food temps on that selected tray. The temperatures were as follows: Cheeseburgers @ 121.5 degrees Fahrenheit (F), Onion rings @ 101.3 degrees F Green bean salad (warm salad per FSD) @ 111.6 Four ounce carton of milk @ 58 degrees F. The tray was discarded after temperatures were obtained. Immediately following completing the	F 804	made • Dietary Cook was provided 1:1 in-service on food temperatures to prevent food born illness ID Other Residents: • Residents who require nutrition from the Dietary Department Systemic Change: • In-service – “Acceptable Food Temperatures” to the Dietary Department by Dietary Director • In-service –“Meal Tray Distribution” facility wide by Nursing Administration • Purchase of insulated food carts • Purchase of steam table lids • Purchase of additional insulated plate bases and lids • Cart distribution list adjusted Monitoring: • Audit - “Meal Temperature” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Audit - “Meal Tray Distribution” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 804	Continued From page 69	F 804		

temperature checks, the FSD responded, "I know none of them meet temp."
2. On 10/10/23 at 7:58 AM, the surveyor observed large stainless trays with breakfast food arrive to the second floor day room 2 steam table. There were no residents in day room 2; all residents who reside on the second floor were served breakfast in their rooms. The Dietary Cook (DC) in the presence of the surveyor took food temperatures with his calibrated thermometer.

The following temperatures were obtained:
Strawberries with syrup @ 100 degrees Fahrenheit (F)
Pureed French toast @ 138 degrees F
Boiled eggs @132 degrees F
At that same time, the DC stated that he would have to bring the above items back to the kitchen because the temperatures needed to be at least 145 degrees F and that all other food temps were above 145 degrees F.

On 10/10/23 at 8:07 AM, the DC brought the above items back to the kitchen.

On 10/10/23 at 8:19 AM, the DC returned to day room 2 with the aforementioned foods and again sampled the temperatures.
The following temperatures were obtained:
Boiled eggs @ 155 degrees F
Pureed French Toast @145 degrees F
Strawberries with syrup @ 130 degrees F

On 10/10/23 at 8:28 AM, the surveyor observed the following:
At 8:28 AM, the first meal was plated.
At 8:34 AM, the first silver open food cart was brought to the Ivy Unit for distribution.

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F 804	Continued From page 70	F 804		

At 9:40 AM, the Food Service Director (FSD) arrived to day room 2 with an additional large stainless tray with cream of wheat which he placed on to the steam table.
At 9:41 AM, the last meal was plated.
At 9:42 AM, the last open cart was brought to the Rose Garden Unit for distribution.
At 9:43 AM, the surveyor asked the DC to temp the french toast, strawberries with syrup and sausage patty. The DC stated he misplaced his thermometer.
At 9:46 AM, the DC dumped all the bowls out of a large box and discovered the thermometer. The DC told the surveyor that he still couldn't take temps with that thermometer because it was, "acting up". The FSD stated that he would go get a new calibrated thermometer.

On 10/10/23 at 9:59 AM, the surveyor observed the last tray served which contained french toast, ground sausage patty and coffee.

At that time, the surveyor requested the DC to again sample the food temperatures. Then with a new calibrated thermometer the following temperatures were obtained:
french toast with strawberries in syrup @ 127 degrees F
ground sausage patty @ 111 degrees F.
The DC stated that the temperatures were not within regulation. The DC further stated that meal service should have been completed within one hour, not two hours and that he didn't know what happened.

On 10/10/23 at 10:30 AM, the surveyor interviewed the Food Service Director (FSD). The FSD stated that hot foods should be above 140 degrees F and cold foods should be below 41

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F 804	Continued From page 71	F 804		

degrees F in order to prevent food-born bacteria. The FSD agreed that the temperatures were not maintained at appetizing temperatures for the residents. The FSD stated that meal service should take no more than an hour, definitely not two hours.

On 10/11/23 at 9:36 AM, the surveyor observed the last breakfast tray delivered to the room of an unsampled resident.

On 10/11/23 at 9:38 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #2, who stated that meal service should be completed within one hour and that all available staff were expected to help pass out trays. The LPN/UM #2 further stated that she did not have a list of residents, nor was she aware of which residents preferred to receive early meal trays so that they could attend activities of their choice including church services.

On 10/18/23 at 12:16 PM, the survey team discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Regional Clinical Nurse. The DON stated that when the DC removed the trays of food from the steam table they should have been placed back into the heated truck and transported back to the kitchen. No further information was supplied.

A review of a facility policy titled, "Food Temperatures", with an effective date of 11/30/17 indicated that the foods are stored, prepared, and served at proper temperatures. Under the process section of the policy, it revealed that all time/temperature control for safety food must maintain an internal temperature of 41 degrees

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F 804	Continued From page 72 Fahrenheit or lower for cold foods and 140 degrees Fahrenheit or higher for hot foods while being held for service, internal cooking temperature, and holding temperatures of foods. NJAC 8:39-17.4(e)	F 804		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Complaint # 159668 Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident was provided water consistent with the need to maintain resident [redacted]. This deficient practice was identified for 1 of 1 resident (Resident #59) reviewed for choices and was evidenced by the following: On 10/03/2023 at 11:08 at 10:56 AM, the surveyor observed the resident seated in a wheelchair by the doorway. Resident #59 stated that they were not offered water and had to request water that day. When asked if water was offered throughout the day, Resident #59 denied. On 10/04/2023 at 11:46 AM, the surveyor observed the resident sitting by the doorway of their room. There was no water cup at the	F 807	Plan of Correction F807 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #59 – water provided at bedside • Resident #59 – [redacted] ID Other Residents: • Residents who are not on fluid restrictions Systemic Change: • In-service – "Rounding at the Beginning of the Shift" to the Nursing Department by Nursing Administration	11/27/23

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F 807	Continued From page 73 resident's bedside. The resident stated that they had requested water and did not get any that day. The surveyor reviewed the medical record for Resident #59. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that NJ ex order 26.4b1 [redacted] A review of the most recent Significant Change in Status Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a Brief Interview for Mental Status (BIMS) score of [redacted] out of 13, which demonstrated NJ ex order 26.4b1. The MDS also identified Resident #59 NJ ex order 26.4b1 [redacted] A review of the individualized comprehensive care plan (ICCP) included a focus area initiated on NJ ex order 26.4b1, that the [Resident] NJ ex order 26.4b1 [redacted], with a NJ ex order 26.4b1 [redacted] Another focus area included that the [Resident] NJ ex order 26.4b1 [redacted] On 10/05/2023 at 12:10 PM, the surveyor interviewed Certified Nursing Aide (CNA #1) who acknowledged that water was one of the first things that they were to check and ensure that it was available for the resident at the beginning of the shift.	F 807	• Fresh ice water to be provided each shift to residents not on fluid restrictions Monitoring: • Audit - "Hydration at Bedside" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 807	Continued From page 74 On 10/11/2012 at 9:33 AM, the surveyor interviewed CNA #2, who also confirmed that water is offered in the overnight shift and is usually "still icy in the morning" so water was given around 10-11am. However, CNA #2 confirmed that water was still checked to make sure the cup was full. When asked what happens if there was no cup visible around the resident CNA#2 responded that they were to offer another cup of water. On 10/12/2012 at 11:01 AM, the surveyor interviewed the Director of Nursing (DON) who reported that water was offered every shift to those that had the proper [redacted] orders. The DON confirmed that the CNAs should check on the water during their morning rounds. The DON also confirmed that residents should always have a fluid cup readily available and that not having proper fluids nearby could be a concern for their [redacted] status. A review the facility's undated "Resident Hydration and Prevention of Dehydration" document included "6. Fresh water will be provided at bedside to those residents who are permitted [...] 7. Nursing will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care..." NJAC 8:39-17.4(c), (e)	F 807		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		11/27/23

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F 812	Continued From page 75 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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 pertinent facility documents, it was determined that the facility failed to a.) properly label, date and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and dishware in a manner to prevent microbial growth and cross contamination and c.) ensure activity staff were wearing hair nets when entering the kitchen. This deficient practice was observed and evidenced by the following: 1. On 10/03/2023 at 09:45 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and observed the Assistant Food Service Director (AFSD) attempt to remove two boxes of croissants that were not properly labeled with open or discard dates. The first box contained 7 unwrapped croissants and	F 812	Plan of Correction F812 Level E Completion Date: 11/27/2023 Corrective Action: • Unlabeled/unwrapped items removed and discarded • Sandwiches discarded • Spices/sauces: received date/expiration date placed • Coffee filters discarded • Dented can removed • Mixing bowl cleaned and covered • Warming carts cleaned • Dumpster area cleaned • Coffee cups destained • In-service – Activity Staff #1 & #21:1 in-service provided on use of hair nets in food service area	

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F 812	Continued From page 76 the second box was unopened and did not include a received or a discard date. The surveyor interviewed the AFSD, who confirmed that the 2 boxes of croissants were being discarded because they were not properly labeled. In the walk-in refrigerator, there was a large cart full of sandwiches that not properly labeled. The FSD stated the items were taken from the boxes that were labeled and placed in the cart that they use daily. The FSD confirmed that the sandwiches should have been dated. In the walk-in freezer, there were three large silver trays that contained unwrapped food exposed to the air. The AFSD placed a piece of paper over the top of the trays with a date of 10/03/2023 which was the date of the tour. The FSD confirmed that the trays should have been thoroughly wrapped, labeled, and stored properly. Upon exiting the walk-in refrigerator, the surveyor observed the AFSD with a black marker writing on large containers from the spice rack. The surveyor observed 13 large bottles of spices and sauces to include soybean oil, barbeque sauce, and soy sauce that were not properly labeled with received, opened, or discard dates. The FSD confirmed that the spices and sauces should have been dated when they were received and should include an expiration date. On that same day at 9:57 AM, the surveyor observed two boxes of white coffee filters that were open, uncovered and exposed to air in the paper product storage area. The FSD stated that the coffee filters should have been covered to prevent dust, debris, and any dirt from coming in	F 812	ID Other Residents: • Residents who require nutrition from the Dietary Department Systemic Change: • In-service – “Expectations of the Dietary Department” to the Dietary Department by the Dietary Director • In-service –“Usage of Hairnets” facility wide by the Dietary Director • Housekeeping/maintenance to check dumpster area daily for cleaning Monitoring: • Audit - “Dietary Department Walkthrough” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by the Dietary Director • Audit - “Hair Net” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by the Dietary Director • Results of the audits will be brought to QA/QAPI on a quarter basis	

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contact with them. The surveyor observed a dented can in the non-dented can area in the dry storage area. The FSD confirmed the dented can should not be with the non-dented cans.

On 10/03/2023 at 10:06 AM, the surveyor observed two tall food warming carts that had buildup of a black, greasy substance on the inside doors, on three trays that were inside, and on the warmer bottoms. The FSD stated the warmers were used for breakfast and acknowledged there were lunch items in the warmers. The FSD confirmed there was debris in the warmers and stated the warmers should have been cleaned between each meal preparation to prevent cross contamination.

On the same day at 10:12 AM, the surveyor observed an uncovered mixing bowl exposed to the air. The FSD stated that the mixing bowl was clean and should have been covered.

On 10/03/2023 at 10:17 AM, the surveyor observed the dumpster area which had debris on both sides of the compactor to include used face masks, wooden sticks, 2 broken florescent bulbs, plastic bags, newspapers, a juice cup, and a milk carton. The FSD acknowledged the debris.

2. On 10/04/23 11:18 AM, the surveyor observed 18 place settings for lunch meal in the main dining room. The place settings included an inverted plastic blue mug, two clear plastic cups, utensils, and a napkin. The surveyor observed the inside of the mugs. Two of the mugs had a brown powder like debris, one had a brown powder like debris and a piece of a wet white substance, one had a brown powder like debris

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and several white spots. The surveyor interviewed a cook who acknowledged that the mugs were not clean and stated, "Not at all, I'm sorry." Upon further interview the cook stated there was no specific staff member who was responsible for the place settings.

On 10/11/23 at 11:01 AM, the surveyor observed 18 place settings for lunch meal in the main dining room which included inverted plastic blue mugs. Two of 18 mugs had a brown powder like debris and one mug also had two brown particles.

On 10/12/23 at 10:39 AM, the surveyor interviewed a dietary staff member (DS) regarding the table settings. The DS told the surveyor that the task of setting the tables was rotated among staff, and it changes daily. She stated, "I haven't done this in four months." The DS further stated that the staff check the cups for cleanliness. She also described the cleaning process for the mugs as follows: "They get soaked every Sunday only, we can't do it every day because if it's lunch time and we would be behind because there are only so many cups, and we only have enough cups for one meal setting. If cups are soiled, we would remove it and sometimes we have an extra staff person who can soak a few cups on that day."

On 10/13/23 at 11:52 AM, the surveyor interviewed the Food Service Director (FSD) regarding the cleaning process of the plastic mugs. The FSD stated the mugs were de-stained on Sundays, "Every Sunday, we soak them in an urn with cleaner, then each one gets hand wiped on the inside and then sent through the dish machine." The FSD stated, "I notice a few of them have not been completely clean and they

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should be checked before they put them out."

3. On 10/4/23 at 12:03 PM, the surveyor was conducting a dining observation in the main dining room. The surveyor observed a sign by the entrance to the kitchen that read, "Hair nets" "All staff members are required to wear a hairnet prior to entering the kitchen." Located below the sign was a mounted bin that contained hair nets.

On 10/04/23 at 12:26 PM the surveyor observed Activity Aide (AA) #1 enter the kitchen, walk around, exited and reentered the kitchen. AA #1 had long hair and was not wearing a hair net.

At 12:26 PM, the surveyor observed AA #2 enter the kitchen walked around kitchen, left the kitchen, entered the kitchen again and exit the kitchen. AA #2 had visible hair on his head and was not wearing a hair net.

During an interview with the surveyor on 10/04/23 at 12:28 PM, AA #2 stated that she was getting cups and was not sure if she needed to wear a hair net. The surveyor showed the sign by the kitchen entrance to AA #2. AA #2 replied that she didn't know.

During an interview with the surveyor on 10/04/23 at 12:55 PM, AA #1 stated he was not aware he needed to wear a hair net when entering the kitchen.

During an interview with an additional surveyor on 10/13/23 at 10:29 AM, the FSD stated that hair nets need to be worn before entering the kitchen so there's no hair or foreign debris in the food and also for the plates and the cups.

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The surveyor reviewed the facility's revised policy dated 10/18/2023 titled, "Received on Date/Expired Items" which revealed the facility would follow established methods for dating items that were delivered and discarding out of date items immediately. "Procedure: 1. When receiving any food items from the vendors, each item will have a "Received on Date" written on the packaging. If an item is removed out of the packaging (i.e. Apple Pie") the "received on date" will be written on the individual item, using the original date. 2. During opening and closing rounds, the management team or designee will check to make sure all appropriate dating is found and accurate."

The surveyor reviewed the facility's revised policy dated for 10/18/2023 titled, "Labeling and Dating of Pulled Frozen Items," which revealed the purpose was to safely and correctly label and date frozen foods being thawed. "Procedure: 1. Any item that is pulled from the freezer to the refrigerator for thawing shall have the following information listed on the parchment paper/label a. item description, b. pulled on date, c. amount pulled for thawing, d. which meal the item is for, e. use by date, f. employee initials. 2. Parchment paper/label will be replaced when soiled using the same information listed above."

The surveyor reviewed the revised policy dated for 10/18/2023 titled, "Dented Cans" which revealed the facility will ensure that no dented cans were utilized in daily production. "Procedure: Any employee that comes across a dented can must remove said can and place on the dented can rack which is clearly labeled and visible in the kitchen. 2. The employee shall alert

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F 812	Continued From page 81 a manager who will then take the appropriate actions." The surveyor reviewed the policy dated for 05/30/2022 titled, "Cup Destaining." The purpose of the policy was to maintain a clean and stainless hot beverage cup. Under the section titled process, it included the process for the cup destaining and that the cups were destained every Sunday. The policy did not have a process to destain if needed on any day other than a Sunday. A review of a facility policy with a subject titled, "Hair Covering and Beard Covering" revised on 1/14/2019 included that the facility would follow established methods for use of hair nets and beard covers. The purpose was to ensure no foreign items specific to bodily hair, are to contaminate not only food items, but also other equipment. The procedure indicated that any employee or guest entering the food and nutrition department, kitchen or tray line service area will be required to wear at all times a hair covering for the head. NJAC 8:39-17.2(g)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		11/27/23

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to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 83 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint # 159668 Based on interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to maintain medical records accurately and completely in accordance with acceptable standards and practice by not documenting pertinent clinical documentation on the resident's medical record for a resident who was transferred to the hospital. This deficient practice was identified for 1 of 4 residents (Resident #249) reviewed for hospitalization and was evidenced by the following: The surveyor reviewed the medical record for Resident #249. A review of the Admission Record face sheet (an admission summary) reflected that the resident	F 842	Plan of Correction F842 Level D Completion Date: 11/27/2023 Corrective Action: • Resident #249 – unable to correct due to resident being discharged from the facility ID Other Residents: • Residents with a change in condition requiring a transfer to the hospital Systemic Change: • In-service – “Clinical Conditions – Assessment and Documentation” to the Nursing Department by Nursing Administration	

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F 842	Continued From page 84 was admitted to the facility with diagnosis that NJ ex order 26.4b1 [redacted] A review of the Significant Change in Status Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b, reflected a brief interview for mental status (BIMS) score of NJ ex out of 15, which demonstrated NJ Exec Order 26.4b1. The MDS also identified Resident #249 NJ ex order 26.4b1 [redacted] A review of the Nursing Progress Notes included a note dated NJ ex order 26.4b1 at 2:57 PM that indicated, 'NJ ex order 26.4b1 [redacted] Supervisor made aware of family request at [2:30 PM]. NJ Exec Order 26.4b contacted and message left for nurse at [2:35 PM]. NJ Exec Order 26 Nurse returned call at [2:45 PM]-notified of resident transfer. [Transport Company] contacted to arrive at [5:50 PM]. Oncoming nurse notified of resident status-need to contact POA [related to] transport." There was no documented evidence of the resident's clinical condition, including patient condition, vital signs, and physician notification, for Resident #249's transfer to the hospital. A review of the New Jersey Universal Transfer Form (UTF) documented the incorrect date of transfer NJ ex order 26.4b1 and time of transfer (12:00 AM). The UTF further failed to indicate the reason for transfer, NJ ex order 26.4b1 [redacted].	F 842	• In-service – "Universal Transfer Forms" will be given to the Nursing Staff by Nursing Administration • Carbon copy Universal Transfer Forms will be utilized Monitoring: • Audit - "Clinical Conditions/Universal Transfer Form" will be completed on the following schedule: (3) weekly x's 2 weeks then (3) monthly x's 2 months then (3) quarterly x' 1 quarter by Nursing Admistration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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During an interview with the surveyor on 10/6/23 at 9:02 AM, Licensed Practical Nurse Unit Manager (LPN/UM #3) reviewed the referenced Nursing Progress Note. LPN/UM #3 confirmed that the progress note was not a complete assessment. LPN/UM #3 further explained that the following information was missing: cognitive status, documentation as to whether the resident is stable, physician notification, vital signs, and body checks.

During an interview with the Licensed Nursing Home Administrator (LNHA) on 10/6/23 at 11:17 AM, the surveyor questioned if the provided UTF was correct. The LNHA responded, "that is what the Director of Nursing (DON) gave me." When asked about the date of transfer identified on the UTF the LNHA stated, "oh [the resident] was out of the building by the NJ ex order 3, I believe."

During an interview with the surveyor on 10/10/23 at 11:20 AM, when questioned regarding the patient condition, the author of the first Nursing Progress Note, Licensed Practical Nurse (LPN #4), stated that "considering the circumstances, I don't recall what was going on at the time" and would not elaborate further.

During an interview with the surveyor on 10/12/23 at 11:01 AM, the Director of Nursing (DON) confirmed that a NJ ex order 26.4b1 required a full assessment including NJ ex order 26.4b1 The DON further confirmed that the UTF dated NJ ex order 26.4b1 was not the correct form.

During an interview with the surveyor on 10/13/23 at 11:30 AM, Nurse Practitioner (NP #1) reported

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that there was an expectation that an assessment for [redacted] included vital signs and a description of how the change presented. When asked if this information should be entered in the electronic charting system NP #1 stated, "Yes all this information is to be in there."

During an interview with the surveyor on 10/13/23 at 1:49 PM, the LNHA stated that they had requested a copy of the UTF from the hospital. When asked if the UTF was part of the patient's medical record and to be kept in the facility the LNHA confirmed and stating "yes."

During an interview with another surveyor on 10/17/23 at 10:21 AM, the LNHA provided written acknowledgement that there was no documentation of Resident #249's clinical status in the progress notes.

A review the facility's "Hospital Transfer Process" document dated 8/2017, included...When it is necessary to transfer a resident to the hospital, an assessment should be completed by the charge nurse.

A review the facility's "Transfer Process" document dated 10/2019, included...when a resident requires transfer to the hospital or another facility a New Jersey Universal Transfer Form is to be completed and sent with the resident. A copy of the New Jersey Transfer Form is to be kept in the resident chart.

A review the facility's "Change in Resident Condition" policy, with an effective date 5/2018 and revised date of 2/2022, included...2. prior to notifying the Physician/healthcare provider, and authorized representative, the nurse will gather

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F 842	Continued From page 87 relevant and pertinent information. A review the facility's "Job Description- LPN" document, with an revision date 5/13, included...assess, monitor and evaluate the residents' physical and emotional status for significant changes on a continual basis and document such in the medical record [...] take temperature, pulse, blood pressure and other vital signs to detect deviations from normal and assess condition of residents. NJAC 8:39-35.2(d)6,16(e)	F 842		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the	F 865		11/27/23

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promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership

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(or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as

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F 865	Continued From page 90 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that their Quality Assurance and Performance Improvement Program's (QAPI) sources of quantitative data was being analyzed to evaluate program effectiveness and implement new processes. This deficient practice was identified during the standard survey and was evidenced by the following: Refer to F 804 F During the standard survey, the surveyors conducted meal observations on 10/5/23 and on 10/10/23. On 10/5/23 beginning at 12:25 PM, the surveyor observed the lunch service in day room one. The surveyor observed the lunch tray preparation begin at 12:25 PM, and ended with the last lunch tray served at 1:05 PM. During the observation, some trays were handed to the residents in the day room one, and some tray were placed on an open tray cart to be delivered to the resident rooms. On that same day at 12:45 PM, the open food cart contained the resident lunch trays and left the day room and were placed in the hallway. On that same day at 1:05 PM, as the last tray was to be hand to the resident, the surveyor requested the FSD to obtain food temperatures on that tray. The FSD obtained the food temperatures which	F 865	Plan of Correction F865 Level F Completion Date: 11/27/2023 Corrective Action: • Hot box utilization for meal delivery and warming • In-service – "Tray Distribution Expectations" to Dietary, Nursing and Activities • Nursing Units added to "Tray Temperature" Audits ID Other Residents: • Residents who receive meal trays Systemic Change: • In-service – "Acceptable Food Temperatures" to the Dietary Department by Nursing Home Administrator • In-service –"Meal Tray Distribution" facility wide by Nursing Home Administrator • Purchase of insulated food carts • Purchase of steam table lids • Purchase of additional insulated plate bases and lids • Cart distribution list adjusted • Meal Tray Temperatures will be a "focus" for QAPI • Meal Tray Temperature audits will be conducted by non-dietary department personnel • Data will be collected on the following	

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F 865	Continued From page 91 were not within acceptable ranges. The FSD stated that none of the hot and cold food items met acceptable food temperatures. On 10/13/23 beginning at 7:58 AM, the surveyor observed breakfast service on the second floor day room two. At 7:58 AM, the breakfast arrived to day room two. The Dietary Cook (DC) obtained the temperatures of the breakfast food, and returned the food to the kitchen because the food was not hot enough. On that same day at 8:19 AM, the Dietary Cook (DC) returned to dayroom two with the breakfast food, and obtained the temperatures. The surveyor observed the that the first tray was plated at 8:28 AM. The last tray was plated at 9:41 AM and was served at 9:59 AM. At that time, the surveyor requested the FSD to obtain food temperatures on the last tray. The FSD obtained the food temperatures and none of the hot and cold food items met acceptable food temperatures. The FSD stated the temperatures taken were not with in regulation and that the breakfast should not have taken more than one hour to be served. A review of the resident council minutes revealed the following concerns regarding food temperatures: [redacted] NJ Exec Order 26.4b1 - Food did not stay hot, waited too long for dinner to be served. Administrator stated dietary department was working to correct that by using insulated lids, plate warmers, and putting trays on fewer carts. The Administrator acknowledged tray delivery time must be improved.	F 865	areas: o Meal locations o Meal distribution times o Temperatures will be taken pre meal service, during meal service and post meal service for breakfast, lunch and dinner meal o Data will also be collected on date, time and location if deficient practice occurs • Corrective action for any deficient food temperature will be completed at the time of the findings • Data collected will be analyzed for a root cause analysis and additional interventions on a monthly basis Monitoring: • Audit - “Meal Temperature” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 3 quarter by Nursing Administration • Audit - “Meal Tray Distribution” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 3 quarter by Nursing Administration • Results of the audits will be brought to QA/QAPI on a quarter basis	

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NJ Exec Order 26.4b1 -food was cold at breakfast- Administrator stated measures had been taking including insulated lids, fewer trays on a cart, plate warmers, hot boxes, additional staff handing out trays, and cart covers to keep food hot. Resident stated only a few trays were delivered as soon as the cart arrived, and the rest were left sitting in the hallway.

NJ Exec Order 26.4b1 - a resident stated the steam table or plate warmer was not plugged in day room 2, and there were concerns with tray pass and roommates not being served at the same time.

NJ Exec Order 26.4b1 - the eggs were often cold. A resident stated plate warmers were not plugged in early enough to get the food warm.

NJ Exec Order 26.4b1 plated food was sometimes cold "tray passing must be a priority." Food plated in the day room was usually cold by the time it was served.

NJ Exec Order 26.4b1 - food often cold at night. A resident asked if tray cart covers could be purchased to keep the food hotter.

During an interview with the surveyor, in the presence of the survey team on 10/18/23 at 1:16 PM, the Administrator stated that QAPI was held monthly, and all department heads attended. The Administrator stated the QAPI was held for tracking and logging with a current focus on meal temperatures and ticket tray accuracy. The Administrator stated that they set goals and see what can be put into place to reach the goals.

At that time, the surveyor explained the deficiency regarding food temperatures from the prior

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survey, the resident council concerns regarding food temperatures and the temperature and tray pass observations on survey. The surveyor asked what the facility's QAPI plan was and how it was reviewed for effectiveness.

The Administrator stated that the facility "always looks to see what may need to improve" and they are currently "thinking outside of the box." The Administrator stated that the temperatures were not met during the meal observation on on survey because the hot box was not being utilized.

The surveyor was provided with the facility's documentation for their QA on the dietary concerns.

A review of an undated document titled, "Resident Tray Distribution" revealed that the challenge was to ensure that all resident meal trays were passed in a timely manner (with in 7 minutes) once the trays have been delivered to the unit. The goal was to have trays passed in less than 7 minutes from the time the trays are delivered to the unit, until the time the trays were in front of the residents. The plan was to have weekly audits of resident meal tray distribution, with a minimum of 8 per month. The evaluation included monthly meeting with the Administrator, Unit Managers, Director of Nursing, Assistant Director of Nursing, Food Service Director, and Assistant Food Service Director to review the audits and create a plan of action if required. The findings would be reported to the quarterly QA meeting.

A review of a document, titled, "Food and Nutrition Tray Distribution Audit" completed and signed by the FSD included the following questions: "What time trays start getting made for

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test tray cart; What time trays get to unit/hallway; What time did the first tray get passed from the cart, on the unit/hallway; What time was the last tray passed from the cart, on the unit/hallway and What was the time elapsed from beginning the trays were being made to the last tray delivered on unit/hallway." There was no documented evidence on what unit or hallway the trays were observed.

A reviewed of the FSD's monthly Dietary Focused QA Summary from January 2023 to September 2023 revealed, "trays are not always being delivered in a timely manner to residents."

A review of an undated document titled, "Food Temperature & Ticket Accuracy 2023" revealed that the challenge was ensuring all foods were at the correct temperature. The goal was to strive for 90% or better meal temperature. The plan was to conduct weekly audits of resident meal trays with a minimum of 16 per month. The evaluation included weekly meeting with Administrator, Dietician, Department Heads, FSD, AFSD, to review audits and create a plan of action if required. The findings would be reported to the quarterly QA meeting.

A review of the audits revealed that in January 2023, nine (9) trays for food temperature were audited, February 2023, eight (8) trays for temperature were audited, June 2023, eight (8) trays for food temperatures were audited, August 2023, eight (8) trays for food temperatures were audited, and in September 2023, nine (9) trays for food temperatures were audited. For the aforementioned audits, tray temperatures came back with a score of 90%. Those that did not have correct temperatures, lid covers were

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placed, plates were placed in the plate warmer, and insulated bases were implemented each time.

During an interview with the FSD in the presence of the survey team on 10/19/23 at 9:33 AM. The FSD stated he completed his own in-services for his staff. He stated he attended QAPI every quarter and had a QAPI in place due to a deficiency the prior survey. He stated his QA was to take test trays of food temperatures and the temperatures "came back fairly well" with a score of greater than 90%.

The surveyor reviewed the FSD's audits in the presence of the FSD who stated that there was no way to identify which unit the audit was completed on his documentation. The FSD stated that the audits should have included the unit where the temperatures where taken to be able to identify.

When asked what process had changed, the FSD stated that they had opened up the dining rooms and "fallen short" and it had not been effective.

The surveyor reviewed the FSD's monthly Dietary Focused QA Summary with the FSD which indicated from January 2023 through September 2023, "trays are not always being delivered in a timely manner to residents." The FSD stated he had notified the Director of Nursing and the Administrator during the monthly QA meeting and explained that trays were not passed in a timely manner which make the residents wait and the food was losing temperature. The FSD stated that he reports his concerns during the monthly QA meeting and was not provided feedback on his findings to remedy the problem.

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During an interview with the survey team on 10/19/23 at 10:19 AM, the Assistant FSD stated he attends as many resident council meetings as he could and the residents generally complain of cold food. He stated the cold food complaints were reported to the Administrator. He stated hot boxes were purchased, and once the trays go to the cart, they sit for at least twenty minutes before they were passed.

During an interview with the survey team on 10/19/23 at 11:55 AM, the surveyor reviewed the dietary audits with the Administration. The audits did not identify a location of where the audits were conducted. The surveyor reviewed the January 2023 through September 2023, summary of QA dietary department which revealed that every month, "trays are not always being delivered in a timely manner to residents" and asked how this was addressed. The Administrator replied, "I understand, I understand." The Administrator stated dietary should not be doing the audits. The Administrator added, we changed service areas, "we have to think outside of the box, either it's not coming hot enough off steam table." When asked about data collection monitoring, root causes analysis to monitor the effectiveness of their QAPI, the Administrator responded, " I have never done it like that."

Review of an undated facility's "QAPI Purpose Statement" included the facility strived to provide high quality of life for the residents, improved quality measures by evaluating present time data collected, and taking action when needed. "Guiding principles" included, "Our organization uses quality assurance and performance improvement to make decisions and guide our

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F 865	Continued From page 97 day to day operations..the outcome of QAPI in our organization is the quality of care and quality of life of our residents ...QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals ...Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families and other stakeholder ...sets goals for performance and measures progress towards those goals ... ...The goals of QAPI are to improve the quality of life, care and services for individuals in nursing homes. The QAPI philosophy is to ensure a systemic, comprehensive, data-driven approach to care. The results of QAPI may prevent adverse events, promote safety and quality and reduce risks for residents and care givers." NJAC 8:39-31.6 (g); 33.1 (d); 33.2 (a)(b)(c)	F 865		
F 880 SS=E	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 and control program (IPCP) that must include, at a minimum, the following elements:	F 880		11/27/23

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F 880	Continued From page 98	F 880		

§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 by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents

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F 880	Continued From page 99 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, and review of other facility documentation, it was determined that the facility failed to a.) practice appropriate hand hygiene between residents after direct contact with residents during meal service on 1of 2 units (day room 2) b.) perform hand hygiene when handling a contaminated item from the floor on 1 of 2 units (day room 1) and c.) ensure that a NJ Exec Order 26.4b1 was stored in a manner to prevent the spread of infection forone of five residents reviewed for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Order, Resident #137. This deficient practice was evidenced by the following: 1. On 10/4/23 at 12:13 PM, the surveyor observed meal service on the second floor day room 2. At 12:13 PM, the surveyor observed the food truck arrived on the second floor day room 2. At 12:14 PM, the surveyor observed a certified nurses aide (CNA) #6 assisting 4 unsampled residents with hand hygiene using hand wipes.	F 880	Plan of Correction F880 Level E Completion Date: 11/27/2023 Corrective Action: • CNA #6 & #7 – 1:1 in-service provided on hand hygiene between residents during meals • Activity Aide #2 – 1:1 in-service provided on hand hygiene when items fall on the floor • Resident #137 – NJ Exec Order 26.4b1 changed and placed above floor ID Other Residents: • Any resident within the facility • Any resident with an foley catheter in place Systemic Change: • In-service – “Importance of Hand Hygiene” will be given facility wide by Infection Preventionist • In-service – “Foley Catheter Care” will	

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F 880	Continued From page 100 CNA #6 proceeded to cleanse the hands of each unsampled resident without sanitizing or performing hand hygiene between the 4 residents. At 12:18 PM, CNA #7 entered day room 2 and began cleansing the hands of Resident # 80, Resident #108 and two unsampled residents with hand wipes without performing hand hygiene between residents. On 10/13/23 at 12:05 PM, the food truck arrived on the second floor in day room 2. At 12:09 PM, the surveyor observed CNA #6 use hand wipes to clean the hands of 8 unsampled residents. The surveyor observed that CNA #6 did not perform hand hygiene between residents. At 12:15 PM, the surveyor interviewed CNA #6 who acknowledged that she had not performed hand hygiene before and after cleaning the residents hands because she was "rushing today." The surveyor explained to CNA #6 that during meal service on 10/4/23 she observed CNA #6 using hand wipes to clean residents hands and did not observe CNA #6 perform hand hygiene after touching and cleaning each residents hands. CNA #6 stated that she was also rushing on that day but acknowledged the importance of performing hand hygiene in order to prevent the spread of infection. On 10/16/23 at 9:43 AM, the surveyor interviewed CNA #7 in the presence of the Licensed Practical Nurse Unit Manager (LPN/UM) #2. The surveyor asked CNA #7 her process for providing hand hygiene for residents prior to meals. CNA #7 stated she used hand wipes to clean the	F 880	be given to the Nursing Staff by Infection Preventionist Monitoring: • Audit - “Hand Hygiene Before Meals” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Infection Preventionist • Hand Hygiene Competencies will be completed facility wide by Infection Preventionist • Audit – “Foley Catheter Care” will be completed on the following schedule: (3) weekly x’s 2 weeks then (3) monthly x’s 2 months then (3) quarterly x’ 1 quarter by Infection Preventionist • Results of the audits will be brought to QA/QAPI on a quarter basis	

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F 880	Continued From page 101	F 880		

residents hands. The surveyor asked CNA #7 what she did after cleaning the hands of one resident before assisting another resident. CNA #7 replied, "dry their hands." The surveyor asked LPN/UM #2 if it was her expectation that the CNA performed hand hygiene between residents. LPN/UM replied, "of course." CNA #7 acknowledged that she should be performing her own hand hygiene between residents but stated that she "had not been doing that."

2. On 10/04/23 at 1:19 PM, during dining observation in the 1st floor day room, the surveyor observed Activities Aide #2 (AA #2), pick up a cup that had fallen on the floor and without performing hand hygiene continued to assist with passing lunch trays to the residents.

On 10/13/23 at 11:05 AM, the surveyor interviewed AA #2, who stated that when assisting with meal service, if something fell on the floor he would pick it up and put it to the side, so it was not used. He stated he was unaware of the need for hand hygiene after picking up an object off the floor; however, he verbalized the need to perform hand hygiene.

3. On 10/03/23 at 10:41 AM, the surveyor observed Resident #137 resting in bed watching television (TV). The resident had an NJ Exec Order 26.4b1 [redacted] for NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was observed to be resting on the floor under the resident's bed without a NJ Exec Order 26.4b1 and with no protective barrier between it and the floor. The resident informed the surveyor that NJ ex order 26.4b1 [redacted].

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F 880	Continued From page 102 On 10/11/23 at 9:22 AM, the surveyor observed the resident eating breakfast in bed with the NJ ex order 26.4b1 [redacted] A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis which NJ ex order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b1 [redacted], reflected a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated the resident had NJ ex order 26.4b1 [redacted] A further review reflected the resident had an NJ ex order 26.4b1 [redacted]. A review of the resident's individualized resident-centered Care Plan included a focused care area with an initiation date of NJ ex order 26.4b1 [redacted] indicating the resident NJ ex order 26.4b1 [redacted]. A review of the resident's physician's orders (PO) included an active order started on NJ ex order 26.4b1 [redacted] for NJ ex order 26.4b1 [redacted]. On 10/13/23 at 9:36 AM, the surveyor interviewed Certified Nurse Aid #3 (CNA #3) who stated that NJ Exec Order 26.4b1 [redacted] should be	F 880		

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hanging from the side of the bed below waist level in a [redacted] and not on the floor, stating the reason it should not be on the floor is for infection control, since residents can get an infection through the [redacted] if it was on the floor.

On 10/13/23 at 10:38 AM, the surveyor interviewed Licensed Practical Nurse #2 (LPN #2) who stated that [redacted] should never be unprotected on the floor and should be in a [redacted] hanging from the side of the bed below waist level. LPN #2 further added that if the bag was on the floor, it was "definitely an infection control issue" and it should be changed.

On 10/13/23 at 10:48 AM, the surveyor interviewed the Infection Preventionist nurse (IP) who stated that [redacted] should not be on the floor due to infection control, and that having the bag on the floor was not appropriate.

On 10/13/23 at 10:59 AM, the surveyor interviewed the DON who confirmed that having the [redacted] on the floor was not acceptable and was an infection control concern.

On 10/18/23 at 12:16 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing and Regional Clinical Nurse to discuss the above observations and concerns.

Review of the facility's Handwashing/Hand Hygiene policy and procedure with an revised date 06/10/2022, revealed the following: "The facility considers hand hygiene the primary means to prevent the spread of infections. The

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F 880	Continued From page 104 policy reflected that...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, soap (antimicrobial or non-antimicrobial) and water..." Review of the facility's "Urinary Catheter Care" policy with a revision date of 3/2021 under the section labeled "Infection Control" included: "Be sure the catheter tubing and drainage bag are kept off the floor." NJAC 8:39-19.4 (a)1(m)(n);27.1(a)	F 880		

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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 # NJ 157605, NJ 160417, NJ 164793 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	Plan of Correction S560 Completion Date: 11/27/2023 Corrective Action: " No residents were identified ID Other Residents: " Potential to affect all resident residing within the facility Systemic Change: " Bonuses are offered for double shifts, extra shifts and weekends " Perfect attendance bonuses are	11/27/23

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

Electronically Signed | 11/08/23

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S 560	Continued From page 1 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 2/01/21: 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. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 06/19/2022 to 06/25/2022, 09/04/2022 to 09/10/2022, 10/16/2022 to 10/22/2022 11/20/2022 to 11/26/2022, 11/27/2022 to 12/03/2022, 06/04/2023 to 06/10/2023, 09/17/2023 to 09/30/2023 revealed the facility was deficient in CNA staffing for residents as follows: For a week of staffing from 11/27/2022 to 12/03/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -11/27/22 had 14 CNAs for 197 residents on the day shift, required at least 25 CNAs. -11/28/22 had 18 CNAs for 197 residents on the day shift, required at least 25 CNAs.	S 560	offered on a weekly basis " In-service □ Lateness and Attendance Policy " Usage of Staffing Agencies to supplement staffing needs " Offering of Certified Nursing Assistant Courses within the facility " Referral Program promoted for staff " Sign on bonuses to assist with staff recruitment " Employee Appreciation parties Monitoring: " Nursing Administration will conduct weekly CNA staffing schedule audits " Nursing Administration will report findings to Administrator " Results of the audits will be brought to QA/QAPI on a quarter basis	

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S 560	Continued From page 2 -11/29/22 had 17 CNAs for 197 residents on the day shift, required at least 25 CNAs. -11/30/22 had 17 CNAs for 197 residents on the day shift, required at least 25 CNAs. -12/01/22 had 16 CNAs for 196 residents on the day shift, required at least 24 CNAs. -12/02/22 had 20 CNAs for 196 residents on the day shift, required at least 24 CNAs. -12/03/22 had 19 CNAs for 195 residents on the day shift, required at least 24 CNAs. For the week of staffing from 06/19/2022 to 06/25/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -06/19/22 had 17 CNAs for 180 residents on the day shift, required at least 22 CNAs. -06/20/22 had 14 CNAs for 179 residents on the day shift, required at least 22 CNAs. -06/21/22 had 18 CNAs for 179 residents on the day shift, required at least 22 CNAs. -06/22/22 had 19 CNAs for 179 residents on the day shift, required at least 22 CNAs. -06/23/22 had 20 CNAs for 179 residents on the day shift, required at least 22 CNAs. -06/24/22 had 19 CNAs for 179 residents on the day shift, required at least 22 CNAs -06/25/22 had 16 CNAs for 180 residents on the day shift, required at least 22 CNAs. For the week of staffing from 09/04/2022 to 09/10/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -09/04/22 had 14 CNAs for 190 residents on the day shift, required at least 24 CNAs. -09/05/22 had 17 CNAs for 190 residents on the	S 560		

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day shift, required at least 24 CNAs.
-09/06/22 had 15 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-09/07/22 had 20 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-09/08/22 had 16 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-09/09/22 had 17 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-09/10/22 had 15 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-09/10/22 had 9 CNAs to 20 total staff on the evening shift, required at least 10 CNAs.

For the week of staffing from 10/16/2022 to 10/22/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows:

-10/16/22 had 13 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-10/17/22 had 16 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-10/17/22 had 19 total staff for 199 residents on the evening shift, required at least 20 total staff.
-10/18/22 had 17 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-10/19/22 had 22 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-10/20/22 had 21 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-10/21/22 had 19 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-10/22/22 had 14 CNAs for 198 residents on the day shift, required at least 25 CNAs.

For the week of staffing from 11/20/2022 to 11/26/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30402	A. BUILDING: _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALT	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 follows: -11/20/22 had 13 CNAs for 196 residents on the day shift, required at least 24 CNAs. -11/21/22 had 16 CNAs for 196 residents on the day shift, required at least 24 CNAs. -11/22/22 had 23 CNAs for 194 residents on the day shift, required at least 24 CNAs. -11/23/22 had 16 CNAs for 194 residents on the day shift, required at least 24 CNAs. -11/24/22 had 22 CNAs for 194 residents on the day shift, required at least 24 CNAs. -11/25/22 had 22 CNAs for 194 residents on the day shift, required at least 24 CNAs. -11/26/22 had 16 CNAs for 196 residents on the day shift, required at least 24 CNAs. For the week of Complaint staffing from 06/04/2023 to 06/10/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -06/04/23 had 21 CNAs for 201 residents on the day shift, required at least 25 CNAs. -06/05/23 had 17 CNAs for 199 residents on the day shift, required at least 25 CNAs. -06/06/23 had 24 CNAs for 199 residents on the day shift, required at least 25 CNAs. -06/07/23 had 20 CNAs for 199 residents on the day shift, required at least 25 CNAs. -06/08/23 had 23 CNAs for 199 residents on the day shift, required at least 25 CNAs. -06/10/23 had 19 CNAs for 199 residents on the day shift, required at least 25 CNAs. For the 2 weeks of staffing prior to survey from 09/17/2023 to 09/30/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30402	A. BUILDING: _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALT	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(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 5 -09/17/23 had 19 CNAs for 201 residents on the day shift, required at least 25 CNAs. -09/18/23 had 17 CNAs for 201 residents on the day shift, required at least 25 CNAs. -09/19/23 had 20 CNAs for 201 residents on the day shift, required at least 25 CNAs. -09/21/23 had 20 CNAs for 201 residents on the day shift, required at least 25 CNAs. -09/22/23 had 23 CNAs for 201 residents on the day shift, required at least 25 CNAs. -09/23/23 had 22 CNAs for 201 residents on the day shift, required at least 25 CNAs. -09/24/23 had 24 CNAs for 201 residents on the day shift, required at least 25 CNAs. During an interview with a surveyor on 10/16/23 at 12:05 PM, the Staffing Coordinator stated that they were aware of the staffing ratio requirements.	S 560		

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
315060 Y1	A. Building B. Wing Y2	11/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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	F0550	Correction	ID Prefix	F0558	Correction	ID Prefix	F0578	Correction
Reg. #	483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. #	483.10(e)(3)	Completed	Reg. #	483.10(c)(6)(8)(g)(12)(i)-(v)	Completed
LSC		11/27/2023	LSC		11/27/2023	LSC		11/27/2023
ID Prefix	F0609	Correction	ID Prefix	F0610	Correction	ID Prefix	F0640	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.12(c)(2)-(4)	Completed	Reg. #	483.20(f)(1)-(4)	Completed
LSC		11/27/2023	LSC		11/27/2023	LSC		11/27/2023
ID Prefix	F0641	Correction	ID Prefix	F0656	Correction	ID Prefix	F0658	Correction
Reg. #	483.20(g)	Completed	Reg. #	483.21(b)(1)(3)	Completed	Reg. #	483.21(b)(3)(i)	Completed
LSC		11/27/2023	LSC		11/27/2023	LSC		11/27/2023
ID Prefix	F0684	Correction	ID Prefix	F0686	Correction	ID Prefix	F0695	Correction
Reg. #	483.25	Completed	Reg. #	483.25(b)(1)(i)(ii)	Completed	Reg. #	483.25(i)	Completed
LSC		11/27/2023	LSC		11/27/2023	LSC		11/27/2023
ID Prefix	F0698	Correction	ID Prefix	F0755	Correction	ID Prefix	F0804	Correction
Reg. #	483.25(l)	Completed	Reg. #	483.45(a)(b)(1)-(3)	Completed	Reg. #	483.60(d)(1)(2)	Completed
LSC		11/27/2023	LSC		11/27/2023	LSC		11/27/2023

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

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
315060 Y1	A. Building B. Wing Y2	11/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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	F0807	Correction	ID Prefix	F0812	Correction	ID Prefix	F0842	Correction
Reg. #	483.60(d)(6)	Completed	Reg. #	483.60(i)(1)(2)	Completed	Reg. #	483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC		11/27/2023	LSC		11/27/2023	LSC		11/27/2023
ID Prefix	F0865	Correction	ID Prefix	F0880	Correction			
Reg. #	483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed			
LSC		11/27/2023	LSC		11/27/2023			

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?
10/19/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
30402		11/28/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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 11/27/2023	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/19/2023	☐ 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
	315060	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/4/23 and 10/5/23 at St. Mary's Center for Rehabilitation and Healthcare, and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. St. Mary's Center for Rehabilitation and Healthcare is a two story building with a partial basement, Type II protected building that was built in the 80's. The facility is divided into 13 smoke zones. The interior diesel generator does 70 to 80% of the building. The facility has 215 licensed beds and is currently at 195 at entrance.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/5/23, in the presence of the Maintenance Director (MD) and Vice-President of Operations (VPO), it was	K 211	K-0211 (E) Means of Egress It is the practice of the facility to maintain	11/27/23

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

Electronically Signed | 11/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

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K 211	Continued From page 1 determined that the facility failed to ensure that means of egress were continuously maintained free of all obstructions in the event of an emergency. This deficient practice was evidenced by the following: At 11:15 a.m., the surveyor observed outside the St.Josephs fire exit/egress route that the approximately 6' x 5' concrete pad was seperated approximately 4' from the next concrete pad. This seperated space had dirt and grass growing and posed a tripping hazard in the event of an emergency evacuation. An interview was conducted during this observation with the Maintenance Director, who verbally agreed that the exit outside the St. Joseph's wing door contained an impediment to egress due to the tripping hazard from the concrete slab seperation. The Administrator was informed of the finding's at the Life Safety Code exit conference on 10/5/23. N.J.A.C. 8:39-31.2(e)	K 211	egress path outside fire exits. 1. The egress path out of the St Josephs entrance has had the concrete pad replaced and free of tripping hazards. 2. Facility wide inspection of exit egress paths have been inspected and found to be in good condition as of 11/1/23. 3. Education completed with Maintenance staff to observe conditions of exit paths. 4. Every month the Maintenance Director or designee will check a random exit path throughout the facility to ensure exit path functions. This information will then be entered on a log and will be presented to the monthly QAPI meeting. Date of Compliance: 11/27/23	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321		11/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(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 321	Continued From page 2 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/5/23, in the presence of the Maintenance Director (MD) and Vice President of Operations (VPO), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in 1 of 8 hazardous storage areas in the facility and was evidenced by the following: 1.) At 11:38 AM, the surveyor, MD, and VPO	K 321	0321 (E) Hazardous Enclosures It is the practice of the facility to maintain proper function of a door and ceiling leading to hazardous areas. 1. The basement housekeeping closet has had a door closure installed. The two white double doors to the kitchen have had the paint removed from the fire rating label showing fire ratings as of 11/1/23. The set of wooden doors leading to the kitchen will be inspected by a professional door company. 2. Facility wide inspection of fire doors and missing door closures was completed on 11/1/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**10/19/2023**

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K 321	Continued From page 3 observed, in the basement's housekeeping storage room, over 100 combustible filled cardboard boxes. The room was more than 50 square feet in size and the door did not feature an auto-closing device. At the time of the observation, the surveyor interviewed the MD who confirmed that hazardous storage areas must have a door with a self-closing device. 2.) At 12:10 PM, the surveyor, MD and VPO observed that one of the two white double doors to the kitchen had paint on the fire rating label which made it illegible. 3.) At 12:15 PM, the surveyor, MD and VPO observed that the set of wooden doors leading from the kitchen to the dining room did not have a fire rating label. The MD and VPO confirmed the finding's, during the kitchen observations The Administrator was informed of the findings at the Life Safety Code Exit Conference on 10/5/23. NJAC 8:39-31.2(e)	K 321	3. Education completed with Maintenance staff to observe during rounds for any hazardous areas with doors not functioning as designed and missing fire ratings. 4. Every month the Maintenance Director or designee will check a random floor of the facility to ensure proper function of doors leading into hazardous areas as well as any fire doors. This information will then be entered on a log and will be presented to the monthly QAPI meeting. Date of Compliance: 11/27/23	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		11/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(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 363	Continued From page 4 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/5/23, in the presence of the Maintenance Director (MD) and Vice President of Operations (VPO), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6,	K 363	K-0363 (E) Corridor- Doors It is the practice of the facility to ensure corridor doors will close and latch as per design. 1. Doors were repaired to allow for closure on 11/1/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 5 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring complete bedroom door closure for confinement of smoke/fire products was identified in 5 of 30 resident room (RR) doors observed and was evidenced by the following: During the building tour on 10/5/23 from 9:15 AM to 01:45 PM, the surveyor in the presence of the MD and VPO, toured the facility and observed the following compromised RR doors. RR # 118 door would not close into its frame, due to resident door decoration, restricting operation into its frame and latching. RR # 210 door would not close into its frame and latch. RR # 239 door would not close into its frame, due to resident door decoration, restricting operation into its frame and latching. RR # 243 door did not fully close into its frame due to resident installed (2) over door hooks. RR # 259 door would not close into its frame and latch. At the time of observations, the surveyor interviewed the MD, who confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/5/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	2. Doors throughout the facility were checked to allow for closure on 11/1/23. 3. Education completed with Maintenance staff regarding monitoring doors to ensure they close properly. 4. Every month the Maintenance Director or designee will check random doors throughout the facility to ensure the doors fully close. This information will then be entered on a log and will be presented to the monthly QAPI meeting. Date of Compliance: 11/27/23	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		11/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(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 374	Continued From page 6 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 10/4/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 8 smoke barrier door sets observed and was evidenced by the following: At 12:52 PM, the surveyor observed that 1 of 2 smoke barrier doors by resident room 215 and 227 were blocked from fully closing by a stored blue linen cart. The linen cart was directly in front of the right-side door by resident room 215, when released from the electro-magnetic hold open device 1 of 2 doors released and closed and one door remained open due to the linen cart blocking the door. The Maintenance Director, confirmed the findings	K 374	K-0374 (E) NFPA 101 Subdivision of Building Spaces-Smoke Barrier It is the practice of the facility to ensure smoke barrier door free to close to resist smoke passage. 1. The carts were moved to allow for closure on 11/1/23. 2. Doors throughout the facility were checked to be free of obstruction on 11/1/23. 3. Education completed with Maintenance staff regarding monitoring doors to remain free of carts or other obstructions. 4. Every month the Maintenance Director or designee will check random doors throughout the facility to ensure the doors are free from obstructions. This information will then be entered on a log and will be presented to the monthly QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**10/19/2023**

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K 374	Continued From page 7 above during the observation. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference on 10/5/23. NJAC 8:39-31.1(c), 31.2(e)	K 374	meeting. Date of Compliance: 11/27/2023	

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
315060 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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 K0211	11/27/2023	LSC K0321	11/27/2023	LSC K0363	11/27/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0374	11/27/2023	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	
10/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO