STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	**103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint#s: NJ00182194, NJ00181689, NJ00181039, NJ00180085, NJ00177148, NJ00172899, NJ00171613, NJ00168597,NJ162424. Survey Date: 02/24/25 Census: 86 Sample: 19 Residents + 3 closed records 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 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §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	F 640		3/24/25

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

Electronically Signed | 03/16/2025

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

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F 640	Continued From page 1 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. (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 the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 9 of 18 system-selected residents, Resident #3, #10, #16, #21, #35, #39, #153, #157, and #162) and was evidenced by the following:	F 640	The Administrator, Director of Nursing (DON), and MDS Coordinator/Designee reviewed the Timely Transmission of MDS 3.0 Policy on 02/20/2025 and found it to be compliant. On 02/20/2025, the [redacted] were in-serviced on this Policy and Procedure. All Residents have the potential to be	

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F 640	Continued From page 2 On 2/14/25 at 1:11 PM, the surveyor reviewed the facility assessment task, including the Resident's MDS assessment. The MDS is a comprehensive tool federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 2/17/25 at 10:21 AM, the surveyor provided the US FOIA (b)(6) with the list of nine (9) system-selected residents who had not completed an MDS in over 120 days. The surveyor also requested a copy of the resident's final validation report (a report that is generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On 2/18/25 at 10:35 AM, the surveyor interviewed the US FOIA (b)(6), who started working in NJ Exec Order 28.4b1 US FOIA (b)(6) added that she tried to submit it at least twice every week. The US FOIA (b)(6) further stated that they followed the RAI (Resident Assessment Instrument, a tool that helps gather information about a resident's strengths and needs, which is used to create an individualized care plan) Manual. The US FOIA (b)(6) stated that she could not speak about what had happened previously in the late MDS submission. The surveyor and the US FOIA (b)(6) reviewed the 9 residents' MDS assessments that were not submitted within fourteen days of completion as follows:	F 640	affected, however, no residents were affected. The MDS Coordinator/Designee will conduct monthly audits on MDS Submission for the first 3 months then quarterly thereafter to ensure compliance. Any negative findings will have immediate corrective actions taken by MDS Coordinator. Administrator and DON/Designee will analyze audits for patterns and trends, all findings of the audits will be presented during Quality Assurance and Performance Improvement (QAPI) committee quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data.	

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F 640	Continued From page 3	F 640		

1. Resident #3 had a Q/MDS assessment with an ARD [redacted] that was signed as completed on [redacted] and was not transmitted until [redacted].

2. Resident #10 had the following assessment and was completed late:
a. The annual MDS (An/MDS) assessment has an assessment reference date (ARD) of [redacted]. It was signed as completed on [redacted] and was not transmitted until [redacted].
b. The quarterly MDS (Q/MDS) assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted].
c. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted].
d. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted].

3. Resident #16 had the following assessment and was completed late:
a. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted].
b. The significant change MDS (Sc/MDS) assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted].
c. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted].
d. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted].

4. Resident #21 had a Q/MDS assessment with an ARD of [redacted] that was signed as completed on [redacted] and was not transmitted until [redacted].

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F 640	Continued From page 4 5. Resident #35 had the following assessment and was completed late: a. The An/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted]. b. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted]. c. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and was not transmitted until [redacted] 6. Resident #39 had the following assessment and was completed late: a. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and not transmitted until [redacted] b. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and transmitted on [redacted]. c. The An/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and not transmitted until [redacted] d. The Q/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and not transmitted until [redacted]. e. The An/MDS assessment with an ARD of [redacted] was signed as completed on [redacted] and not transmitted unti[redacted] 7. Resident #153 had an admission MDS (Ad/MDS) assessment with an ARD of [redacted]. It was signed as completed on [redacted] and was not transmitted unti[redacted]. 8. Resident #157 had the following assessment and was completed late: a. The Q/MDS assessment with an ARD of	F 640		

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F 640	Continued From page 5 NJ Exec Order 26.4 that was signed as completed on NJ Exec Order 26.4 and was not transmitted until NJ Exec Order 26.4b. b. The Q/MDS assessment with an ARD of NJ Exec Order 26.4b that was signed as completed on NJ Exec Order 26.4b and was not transmitted until NJ Exec Order 26.4b1. c. The Q/MDS assessment with an ARD of NJ Exec Order 26.4 that was signed as completed on NJ Exec Order 26.4 and was not transmitted until NJ Exec Order 26. 9. Resident #162 had the following assessment and was completed late: a. The Q/MDS assessment with an ARD of NJ Exec Order 26.4 was signed as completed on NJ Exec Order 26. and was not transmitted until NJ Exec Order 26.4. b. The Q/MDS assessment with an ARD of NJ Exec Order 26.4b was signed as completed on NJ Exec Order 26.4 and was not transmitted until NJ Exec Order 2. On 2/20/25 at 1:01 PM, the surveyor met with the US FOIA (b)(6) and US FOIA (b)(6)) regarding the above concern and no further information was provided.	F 640		
F 641 SS=D	NJAC 8:39-11.1 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on interviews and record reviews, it was determined that the facility failed to accurately	F 641	1. Resident #39 Minimum Data Set (MDS) has been corrected to reflect the correct coding by modifying the resident assessment.	3/24/25

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F 641	Continued From page 6 code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 2 of 18 residents (Residents #39, and #157) reviewed for accuracy of MDS coding. This deficient practice was evidenced by the following: 1. On 2/14/25 at 11:10 AM, the surveyor observed Resident #39 in bed watching television, unable to answer the surveyor's inquiry. On 2/18/25 at 11:51 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #39, which revealed the following: A review of the Admission Record (an admission summary) (AR) reflected that Resident #39 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]. A review of the recent Annual Minimum Data Set (An/MDS), with an ARD of NJ Exec Order 26.4b1 [redacted] indicated that the facility assessed the residents' NJ Exec Order 26.4b1 [redacted] status using a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident had NJ Exec Order 26.4b1 [redacted]. Further review of the An/MDS in Section NJ Exec Order 26.4b1 [redacted] revealed that NJ Exec Order 26.4b1 [redacted] 1. Is taking - not checked. A review of the Order Summary Report (OSR) with an active order as of NJ Exec Order 26.4b1 [redacted] revealed an order of NJ Exec Order 26.4b1 [redacted] by mouth at bedtime related to NJ Exec Order 26.4b1 [redacted] with an order date of NJ Exec Order 26.4b1 [redacted]	F 641	All residents have the potential to be affected, however, no residents were affected. The US FOIA (b)(6) [redacted] was in-serviced by the Administrator regarding the importance of ensuring the accuracy of MDS coding. The MDS coordinator reviewed the medical record of the resident identified, to accurately code the MDS 3.0 of the high drug classes used during the look back period. The DON/ designee will monitor five MDS entries prior to submission monthly x2. Findings related to MDS accuracy will be reported at the next QAPI meeting. Administrator and DON will analyze audits for patterns and trends, all findings of the audits will be presented during QAPI committee quarterly x2 for review and any further recommendations, then quarterly plan will be adjusted based on data. 2. Resident #157 Minimum Data Set (MDS) has been corrected to reflect the correct coding by modifying the resident assessment. All residents have the potential to be affected, however, no residents were affected. On 02/20/2025, US FOIA (b)(6) [redacted] was in-serviced by Administrator/DON regarding the importance of ensuring the accuracy of MDS 3.0 coding. The MDS coordinator reviewed the medical record	

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F 641	Continued From page 7 A review of the [NJ Exec Order 26.4b1] electronic Medication Administration Record (eMAR) revealed that the above order was signed as given by the nurses from [NJ Exec Order 26.4b1] at 9:00 PM. 2. On 2/18/25 at 12:01 PM, the surveyor reviewed the eMR of Resident #157, which revealed the following: A review of the AR reflected that Resident #157 was admitted with diagnoses that included but were not limited to [NJ Exec Order 26.4b1] A review of the recent quarterly Minimum Data Set (Q/MDS), with an ARD of [NJ Exec Order 26.4b1] indicated that the facility assessed the residents' [NJ Exec Order 26.4b1] status using a BIMS score of [NJ Exec Order 26.4b1] out of 15, which indicated that the resident had [NJ Exec Order 26.4b1] in [NJ Exec Order 26.4b1] Furthermore, the Q/MDS in Section [NJ Exec Order 26.4b1] - [NJ Exec Order 26.4b1] revealed, "Has the resident had any [NJ Exec Order 26.4b1] since admission/entry or reentry or the prior assessment ...Enter code [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] A review of the Progress notes (PN) dated [NJ Exec Order 26.4b1] revealed that Resident #157 had a [NJ Exec Order 26.4b1] incident inside the room, [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b1]. A review of the individualized person-centered care plan (CP) under focus revealed that, on [NJ Exec Order 26.4b1], Resident #157 had a [NJ Exec Order 26.4b1] inside their room with [NJ Exec Order 26.4b1] and noted [NJ Exec Order 26.4b1].	F 641	of the resident identified, to accurately reflect the resident status and that it is coded accurately on the MDS. The DON /Designee will monitor five MDS entries prior to submission monthly x2. Findings related to MDS accuracy will be reported at the next QAPI meeting. Administrator and DON will analyze audits for patterns and trends, all findings of the audits will be presented during QAPI committee quarterly x2 for review and any further recommendations, then quarterly plan will be adjusted based on data.	

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F 641	Continued From page 8 On 2/20/25 at 9:32 AM, the surveyor interviewed the[US FOIA (b)(6)] who stated that she missed coding the [NJ Exec Order 26.4b1] and the fall. The [US FOIA (b)(6)] added that they follow the RAI (Resident Assessment Instrument-a tool that helps gather information about a resident's strengths and needs, which is used to create an individualized care plan) Manual. On 2/20/25 at 1:01 PM, the surveyor met with the [US FOIA (b)(6)] but did not provide further information.	F 641		
F 655 SS=D	NJAC 8:39-33.2 (c) Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		3/24/25

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F 655	Continued From page 9 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to initiate a baseline care plan (CP) for a resident who had a [redacted] and was a [redacted]. This deficient practice was identified for 2 of 22 residents (Resident #155 and #153) and was evidenced by the following: 1. On 2/19/25 at 9:03 AM, the surveyor reviewed Resident #155's medical records, which revealed the resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted]	F 655	Resident 155 and 153 Baseline Care plan was reviewed and noted to not reflect admission assessment, baseline care plan not completed within 48 hour window, Resident 153 and 155 have been discharged. All residents have the potential to be affected, however, no residents were affected. The Director of Nursing (DON), Unit Manager/Designee completed an audit for	

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F 655	Continued From page 10 NJ Exec Order 26.4b1 Resident #155 was discharged to the hospital on NJ Exec Order 26.4. A review of NJ Exec Order 26.4b1 revealed a score of NJ Exec indicating that the resident was a NJ Exec Order 26. A review of Resident #155 interdisciplinary person-center comprehensive care plan (CP) did not identify that the resident was NJ Exec Order 26.4b1. On 2/21/25 at 10:34 AM, the surveyor interviewed the US FOIA (b)(6)), who acknowledged that the CP did not address the resident was a NJ Exec Order 26.4. A review of the facility's policy titled "Care Plan-Comprehensive" with a review date of 1/25 revealed a resident baseline care plan will be developed with 48 hours of admission. A compressive care plan will be developed with 7 days of admission. 2. On 2/18/25 at 10:11 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #153, which revealed the following: A review of the Admission Record (an admission summary) (AR) reflected that Resident #153 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1	F 655	all newly admitted residents to confirm that a Baseline Care Plan was initiated at the time of admission. The DON/Designee in-serviced all nurses regarding the purpose, components, and time frame of completing a resident Baseline Care Plan. The DON/ Designee will conduct baseline care plan audit of 5 resident charts weekly x4, then monthly for 3 months to ensure that newly admitted residents Baseline Care Plan has been initiated and completed. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility corrective action for the deficient practice will not reoccur.	

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F 655	Continued From page 11	F 655		

NJ Exec Order 26.4b1

A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) with an assessment reference date (ARD) (the last day of the observation period) of NJ Exec Order 26.4 indicated that the facility assessed the residents' NJ Exec Order 26.4b1 using a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that the resident had an NJ Exec Order 26.4b1. Further review of the A/MDS in Section NJ E NJ Exec Order 26.4b1 Enter Number 1.

A review of the universal transfer form from the hospital NJ Exec Order 26.4b1 stated under 15. NJ Exec O condition: Mark it with 'NJ Exec Orde NJ Exec Order 26.4b1

A review of the timeline given by the US FOIA (b)(6) on 2/18/25 revealed that Resident #153 was admitted to the facility with NJ Exec Order 26.4b1 to the NJ Exec Order 26. on NJ Exec Order 26.4b

A review of the individualized person-centered care plan (CP) revealed under "Focus" that Resident #153 has an NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 - Location: NJ Exec Order 26.4 and under "Goal" that Resident #153 NJ Exec Order 26. will NJ Exec Order 26.4b1 in NJ Exec O by NJ Exec ....date initiated on NJ Exec Order 26.4b

Further review of the CP showed that the facility did not initiate Resident #153's NJ Exec Order 26 of care from the day the resident was admitted.

A review of the Progress Notes on NJ Exec Order 26.4 under Admission Summary revealed that Resident #153 NJ Exec Order 26.4 NJ Exec Orde assessment.

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	315416	A. BUILDING _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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F 655	Continued From page 12	F 655		

A review of the timeline given by the [US FOIA (b)(6)] on [NJ Exec Order 26.4] revealed that Resident #153 was admitted to the facility with [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b] and the admitting nurse was unable to [NJ Exec Order 26.4b1] the [NJ Exec Order 26.] at the time due to the resident's [NJ Exec Order 26.]

Furthermore, Resident #153's Progress Notes (PN) revealed that on [NJ Exec Order 26.4], the resident [NJ Exec Order 26.4] medication; on [NJ Exec Order 26.4b1] the resident [NJ Exec Order 26.4] to be [NJ Exec Order 26.4b1] [NJ Exec Order 2] care to the [NJ Exec Order 26] and [NJ Exec Order 26.4] on NJ Exec Order 26.4b1

On 2/20/25 at 10:10 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that baseline CP is in the assessment pocket and goes automatically to the CP tab. The baseline CP should be initiated within 24-48 hours upon admission. The [US FOIA (b)(6)] added that the [NJ Exec] should be captured in the CP for at least 0-3 days because the resident has [NJ Exec Order 26.4] from the hospital. The US FOIA (b)(6) will assess the [NJ Exec Or] If the resident [NJ Exec Order 26.] to be assessed on the 1st day, the staff will try it the following day. If the [NJ Exec] is more than [NJ Exec Order 26.4b] the US FOIA (b)(6) will assess the resident. If there is a [NJ Exec Order 2] and [NJ Exec Order 2] of care, the nurse should put it in the CP within 3 days of admission.

On 2/20/25 at 11:20 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the CP should be initiated at least during admission. If there is a [NJ Exec Order 2] and [NJ Exec Order 2] of care, it should be in the CP.

On 2/20/25 at 1:01 PM, the surveyor met with the US FOIA (b)(6)) and no further information was provided

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F 655	Continued From page 13 A review of the facility's policy title, "Care Plans-Comprehensive," with the reviewed date 1/2025, revealed under "Policy Interpretation and Implementation 11. "Residents' baseline care plan will be developed within 48 hours of admission, and a comprehensive care plan will be developed within 7 days of admission. Further care plan updates will be ongoing and in correlation with the MDS assessment schedule."	F 655		
F 656 SS=D	NJAC 8:39-11.2(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 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	F 656		3/24/25

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F 656	Continued From page 14 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: Complaint #: NJ00180085 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to failed to develop and implement a comprehensive person-centered care plan (CP) that include the use [redacted] The deficient practice was identified for 1 of 22 residents (Resident #158) reviewed for Care Plans. This deficient practice was evidenced by the following: 1. On 2/18/25 at 9:27 AM, the surveyor reviewed	F 656	Resident #158 comprehensive care plan has been reviewed, however resident #158 is [redacted] in facility as of [redacted]. All residents residing in the facility have potential to be affected by these deficient practices. A comprehensive review of care plans will be conducted by Director of Nursing (DON), Unit Mangers /designee to ensure the residents care plans are up to date and revised as information about resident conditions change. The DON /designee provided in-services	

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F 656	Continued From page 15 closed electronic medical record (E-mar) with Resident #158. A review of Resident #158's E-mar revealed the following: A review of Resident #158's Face sheet (FS) (an admission summary) was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 A review of the admission MDS, (an assessment tool used to facilitate care management) dated NJ Exec Order 26.4b1, revealed a Brief Interview for Mental Status (BIMS) score of NJ Exe out of 15 which indicates the residents had NJ Exec Order 26.4b1 The MDS also revealed the resident was on NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 Physician Order Sheet (POS) revealed an ordered dated NJ Exec Order 26.4b1, "NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1." A review Resident #158's care plan (CP) with a start date of NJ Exec Order 26.4b1 and a last reviewed date of NJ Exec Order 26.4b revealed that no care plan for the use of NJ Exec Order 26.4b1 had been initiated. On 2/20/25 at 11:55 AM, the surveyor conducted an interview with US FOIA (b)(6)) who stated any residents receiving NJ Exec Order 26 should have a care plan indicating NJ Exec Order 26 use. The US FOIA (b) also confirmed Resident #158 did not have an NJ Exec Order 26 care plan in place, and did not provide any further information as to why the care plan was not in place. On 2/20/25 at 12:30 PM, the US FOIA (b)(6)) provided the	F 656	to licensed nursing staff on Comprehensive Person-Centered Care Plan Policy which includes assessments of resident are ongoing and care plan are revised as information about resident condition change. The systemic changes will be during daily clinical meetings, identified problem areas are discussed and care plans reviewed by the clinical team to ensure necessary updates are made. The Unit managers will also conduct a comprehensive review of residents upon admission/readmission, quarterly and with change in condition prior to the care plan conference which is held after admission/readmission, quarterly, and with significant change in condition and will be reviewed by Interdisciplinary Care Team members during the meeting. The DON, Unit Manager /designee will conduct weekly audits x4 weeks of 10 residents, then monthly x 3 months of current resident care plans to ensure they are up to date and have been revised as information about resident and resident condition changes. The results of this audit will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility corrective actions for the deficient practice will not reoccur.	

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F 656	Continued From page 16 surveyor with a facility policy titled, "Care Plan - Comprehensive" with a revised date of 1/2025. Under the policy interpretation and implementation section of the policy it states, 2. The comprehensive care plan is based on a through assessment that includes: but is not limited to, the MDS. 3. Each resident's comprehensive care plan is designed to: a. incorporate identified problem area." On 2/20/25 at 12:35 PM, the surveyor met with the US FOIA (b)(6) to review facility concerns. On 2/24/25 at 11:50 AM, the surveyor met with the US FOIA (b)(6) for the exit conference. No further information provided by the facility staff.	F 656		
F 658 SS=D	NJAC 8:39-11.2 (e) 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: REPEAT DEFCIENCY Complaint # NJ181689 Based on observation, interview, record review and policy review it was determined the facility failed to a. record NJ Exec Order 26.4b1 every shift in accordance with the physician's order (PO) and b. the primary physician (MD)	F 658	1. Resident # 160 treatment administration record (TAR) reviewed was noted to reflect omissions of NJ Ex Order 2 [redacted], NJ Ex Order 26 monitoring and recording is required for all shifts, Resident # 160 have NJ Ex Order 26.4(b)(1). Residents with indwelling catheters and orders for recording of outputs have the	3/24/25

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F 658	Continued From page 17 failed to accurately document the resident's NJ Exec Order 2 assessment. This deficient practice was observed for 2 of 7 residents, (resident #160 and resident #153) was evidenced by the following: 1. On 2/14/25 11:52 AM, the surveyor reviewed closed electronic medical record (E-mar) with Resident #160. A review of Resident #160's E-mar revealed the following: A review of Resident #160's Face sheet (FS) (an admission summary) was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 . A review of the quarterly MDS, (an assessment tool used to facilitate care management) dated NJ Exec Order 26.4, revealed a Brief Interview for Mental Status (BIMS) score of NJ Exec out of 15 which indicates NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 Physician Order Sheet (POS) revealed an ordered dated NJ Exec Order 26.4b NJ Exec Order 26.4b1 every shift for Monitoring." A review of the Resident #160's treatment administration record (TAR) from NJ Exec Order 26.4b1 revealed multiple occasions of the NJ Exec Order 26.4b1 was not recorded. In NJ Exec Order 26.4b1 was not record in 1 of 7 opportunities, in NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 was not recorded in 6 of 90 opportunities, in NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 was not recorded in 4 of 90 opportunities, and in NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 was not recorded in 7 of 88 opportunities.	F 658	potential to be affected by the deficient practice. A comprehensive review of all residents with indwelling catheters and orders for output recording will be conducted by the Director of Nursing (DON), Unit Managers /designee to ensure that supplemental documentation for output is in place and outputs are being documented as per physician□s order. The DON, Unit Manager /designee will provide in-services to all nursing staff regarding recording and documentation of output. The systemic change will be that upon reviewing each new admission that has an indwelling urinary catheter or if a urinary catheter is placed during facility stay, orders will be reviewed for supplemental documentation for urinary output. The DON /designee will conduct an initial comprehensive audit on all Residents with indwelling Foley catheters to ensure that an order is in place for output recording every shift. Weekly audits x4 weeks of 3 residents that have orders for output recoding will be conducted, then monthly x 3 months to ensure that outputs are being recorded in TAR as per physician orders. Ongoing in-services will be conducted until the deficient practice is obsolete. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility corrective action for the deficient practice	

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F 658	Continued From page 18 On 2/20/25 at 11:55 AM, the surveyor conducted an interview with the US FOIA (b)(6) who stated all physician orders should be followed by every shift and missing NJ Exec Order 26.4b1 in the TAR is unacceptable. US FOIA (b) unable to state why the NJ Exec Order 26.4b1 was not recorded in the TAR. On 2/20/25 at 12:30 PM, the US FOIA (b)(6) provided the surveyor with a facility policy titled," Care of the resident with a foley catheter", with a revised date 1/2025. Under the assessment portion of the policy it states, "11. Licensed Nurses will monitor residents" urine output." Under the documentation portion of the policy it states, "Chart every shift on the electronic accountability record." On 2/20/25 at 12:35 PM, the surveyor met with the US FOIA (b)(6) to review facility concerns. On 2/24/25 at 11:50 AM, the surveyor met with the US FOIA (b)(6) for the exit conference. No further information provided by the facility staff. 2. On 2/18/25 at 10:11 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #153, which revealed the following: A review of the Admission Record (an admission summary) (AR) reflected that Resident #153 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1	F 658	will not recur. 2. Resident #153 was admitted to the facility with diagnosis that included but not limited to NJ Exec Order 26.4b1 the Physician Progress Notes revealed NJ Exec Order 26.4b1 . Resident # 153 have been discharged. All residents admitted to the facility have the potential to be affected by the deficient practice. The Administrator, DON /designee provided in-services to U.S. FOIA (b) (6) regarding proper recording and documentation of wound stages. The systemic change will be that upon reviewing each new admission that has a PU, PU stage will be reviewed by outside wound company and Physician documentation will be reviewed by DON/designee. The DON /designee will conduct an initial PPN audit on all Residents with PU to ensure that physician documentation is accurate. Weekly audits x4 weeks of 3 residents that have PU will be conducted, then monthly x 3 months to ensure that PPN are being recorded at the time of the time of each visit including a review of the resident total program of care and appropriate documentation. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility	

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F 658	Continued From page 19 NJ Exec Order 26.4b1). A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) with an assessment reference date (ARD) (the last day of the observation period) of NJ Exec Order 26.4 indicated that the facility assessed the residents' NJ Exec Order 26.4b1 using a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that the resident had an NJ Exec Order 26.4b1. Further review of the A/MDS in NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 A review of the universal transfer form from the hospital on NJ Exec Order 26.4 stated under NJ Exec Order 26.4 Mark it with ' NJ Exec Orde NJ Exec Order 26.4b1 A review of the NJ Ex Order 26.4(b)(1) timeline given by the US FOIA (b)(6) on NJ Exec Order 26.4 revealed that Resident #153 was admitted to the facility with NJ Exec Order 26.4b1 to the NJ Exec Order 26.4 on NJ Exec Order 26.4 A review of the Order Summary Report (OSR) revealed an order dated NJ Exec Order 26.4, to NJ Exec Order 26.4 the NJ Exec Order with NJ Exec Order 26.4b1), NJ Exec Order 26, and apply NJ Exec Order 26.4b1 every shift. A review of the individualized person-centered care plan (CP) revealed under "Focus" that Resident #153 had an NJ Exec Order 26.4b1 and under "Goal" that Resident #153 NJ Exec Order 26 will NJ Exec Order 26.4b1 in NJ Exec O by NJ Exec Order date initiated on NJ Exec Order 26.4.	F 658	corrective action for the deficient practice will not recur.	

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F 658	Continued From page 20 A review of the Physician Progress Notes (PPN) with a created date of [NJ Exec Order 26.4b1] and an effective date of [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] under integumentary revealed NJ Exec Order 26.4b1. The PPN with an effective on [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] stated NJ Exec Order 26.4b1. On 2/20/25 at 11:49 AM, the surveyor interviewed [US FOIA (b)(6)] regarding the above concern. The [US FOIA (b)(6)] stated that he thought the NJ Exec Order 26.4b1 was [NJ Exec Order 26.4b1] at that time, but it suddenly became [NJ Exec Order 26.4b1]. He added that it was somewhere between [NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1. On 2/20/25 at 1:01 PM, the surveyor met with the US FOIA (b)(6)) and US FOIA (b)(6)) who did not provide any further information. A review of the facility's policy titled "Physician Visits" with a reviewed date of 1/2025 is stated under Policy Interpretation and Implementation 5. The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation, and 9. The resident's attending physician must write, sign, and date the physician progress notes after each visit."	F 658		
F 711 SS=D	NJAC 8:39-29.3(a), 23.2(a) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711		3/24/25

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F 711	Continued From page 21 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's primary physician (MD) accurately dated their physician progress notes (PPN) during their visit to ensure the resident's current medical regimen was up to date. This deficient practice was observed for 3 of 18 residents (Resident #39, #153, and # 157,). This deficient practice was evidenced by the following: 1. On 2/18/25 at 10:11 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #153, which revealed the following: A review of the Admission Record (an admission summary) (AR) reflected that Resident #153 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1	F 711	Residents #39, #153, and #157 primary physician failed to accurately dated the Physician Progress notes (PPN) during his visit. Resident #39 PPN were reviewed and Resident # 153 and #157 have been discharged. All residents admitted to the facility have the potential to be affected by the deficient practice. The Administrator and Director of Nursing (DON) provided in-service to US FOIA (b)(6) [redacted] regarding accurately date the physician Progress notes (PPN) during his visit and ensure current medical regimen is up to date. The Administrator, DON/designee initiated an in-service for all primary physicians to ensure that they are following the facility Physician visit policy and procedure. The Administrator, DON /designee will	

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F 711	Continued From page 22 NJ Exec Order 26.4b1). A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) with an assessment reference date (ARD) (the last day of the observation period) of NJ Exec Order 26.4b1 indicated that the facility assessed the residents' NJ Exec Order 26.4b1 using a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that the resident had an NJ Exec Order 26.4b1 . A review of the PPNs in the eMR reflected the following "Effective Date," "Created Date," and/or "Late Entry" (any documentation that is recorded in the medical record beyond 24-48 hours of the encounter is classified as a late entry.) designation which indicated the PPN was not documented on the effective date (Date of service): 1. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Ex Order 26.4(b)(1) 2. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1 3. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1 4. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1 5. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1 . 6. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1 7. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1 . 8. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1 9. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1	F 711	conduct a weekly audits x4 of 3 residents to ensure PPN are written, signed and dated at each visit, then monthly x 3 months. The results of these audits will be reviewed at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility corrective action for the deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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F 711	Continued From page 23	F 711		

10. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1.
11. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1.
12. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1.

2. On 2/18/24 at 12:01 PM, the surveyor reviewed the eMR of Resident #157, which revealed the following:

A review of the AR reflected that Resident #157 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted].

A review of the recent quarterly Minimum Data Set (Q/MDS), with an ARD of [redacted] indicated that the facility assessed the residents' NJ Exec Order 26.4b1 status using a BIMS score of [redacted] out of 15, which indicated that the resident had NJ Exec Order 26.4b1 [redacted].

A review of the PPNs in the eMR reflected the following "Effective Date," "Created Date," and/or "Late Entry" designation, which indicated the PPN was not documented on the effective date are the following:

1. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1
2. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1
3. PPN with an effective date of NJ Exec Order 26.4b1 and a created date of NJ Exec Order 26.4b1.

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F 711	Continued From page 24	F 711		

3. On 2/14/24 at 11:10 AM, the surveyor observed Resident #39 in bed watching television, unable to answer the surveyor's inquiry.

On 2/18/24 at 11:51 AM, the surveyor reviewed the eMR of Resident #39, which revealed the following:

A review of the AR reflected that Resident #39 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]

A review of the recent Annual Minimum Data Set (An/MDS), with an ARD of [redacted] indicated that the facility assessed the residents' [redacted] status using a BIMS score of [redacted] out of 15, which indicated that the resident had NJ Exec Order 26.4b1 [redacted]

A review of the PPNs in the eMR reflected the following "Effective Date," "Created Date," and/or "Late Entry" designation, which indicated the PPN was not documented on the effective date are the following:

1. PPN with an effective date of [redacted] and a created date of [redacted].
2. PPN with an effective date of [redacted] and a created date of [redacted].
3. PPN with an effective date of [redacted] and a created date of [redacted]
4. PPN with an effective date of [redacted] and a created date of [redacted].
5. PPN with an effective date of [redacted] and a created date of [redacted].

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	315416	A. BUILDING _____ B. WING _____	C 02/24/2025

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F 711	Continued From page 25	F 711		

6. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1]
7. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1].
8. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1]
9. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1]
10. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1].
11. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1].
12. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1]
13. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1].
14. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1].
15. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1].
16. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1]
17. PPN with an effective date of [NJ Exec Order 26.4b1] and a created date of [NJ Exec Order 26.4b1].

On 2/20/25 at 11:47 AM, the surveyor interviewed [US FOIA] over the phone. [US FOIA] stated that he is aware that he is behind with all the documentation because he is always busy. He added that there was a problem with the computer during that time, and he was catching up on the documentation. That's why he will do the documentation in one day.

On 2/20/25 at 1:01 PM, the surveyor met with the [US FOIA (b)(6)] regarding the concern and no furtherr information was provided.

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F 711	Continued From page 26 A review of the facility's "Physician Visits" policy revealed a review date of 1/2025 under "Policy Interpretation and Implementation." 5. The attending physician must perform relevant tasks at the time of each visit, including reviewing the resident's total program of care and appropriate documentation. 9. The resident's attending physician must write, sign, and date the physician's progress notes after each visit.	F 711		
F 755 SS=D	NJAC 8:39-23.2(b) 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(f). 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.	F 755		3/24/25

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F 755	Continued From page 27 §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 by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to follow a Physician Orders (PO) for the administration of NJ Exec Order 26.4b1 medication for 1 of 1 resident's (Resident #22) reviewed for NJ Exec Order 26.4b1 management. This deficient practice 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 and 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 regimens 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 states:	F 755	Resident #22 Medication Error form was completed, Primary physician notified with no adverse event observed. No changes were made to the regimen by the physician. The NJ Exec Order 26.4b1 is being administered three times a day, will ask physician to consider a once daily NJ Exec Order 26.4b1 medication for Resident, possible an NJ Exec Order 26.4b1, this will immediately reduce the opportunity for errors. All residents residing in the facility that have BP and pulse hold parameters ordered have potential to be affected by these deficient practices. A comprehensive review of resident on Blood pressure medications withhold parameters will be conducted by our pharmacy consultant team in collaboration with the DON and, Unit Mangers/designee. If the hold orders are deemed unnecessary by the physician and can be discontinued and BP monitoring reduced to once weekly, not only does it resolve this potential issue, but saves a tremendous amount of	

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F 755	Continued From page 28 "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." On 2/18/25 at 10:15 AM, the surveyor observed Resident #22 in the 2nd floor dining/activity room. The resident was observed in a recliner chair, the resident was observed with their [redacted]. The surveyor reviewed Resident #22's medical record A review of the Admission Record (an admission summary) (AR) reflected that the resident was admitted to the facility with diagnoses that included but not limited to [redacted]. A review of the significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that the resident's [redacted] for [redacted], which indicated that the resident had [redacted] A review of the Medication Review Report(MRR) revealed a PO dated [redacted], for [redacted]	F 755	nursing time. If hold parameters cannot be discontinued, monitoring will be done to ensure the residents orders are being followed as prescribed by primary physician. The DON/designee provided in-services to licensed nursing staff on Medication Administration Policy which includes check/ verification for allergies to medications and vital signs, if necessary. The systemic changes will be during monthly pharmacist review, residents identified on BP medications will be monitored for following blood pressure parameters as ordered by physicians. The pharmacy consultant in collaboration with the DON, Unit Manager/designee will conduct weekly audits x4 weeks of 5 residents that has BP medication withhold parameters, then monthly x 3 months. The results of this audit will be reviewed at completion of each, and comprehensively at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility corrective actions are met.	

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F 755	Continued From page 29	F 755		

NJ Exec Order 26.4b1), give 2 capsules by mouth every 8 hours for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 electronic Medication Administration Record (eMAR) revealed a PO dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1, give 2 capsules by mouth every 8 hours. NJ Exec Order 26.4b1 with a plotted time of 0600 (6:00 AM), 1400 (2:00 PM) and 2200 (10:00 PM). A Further review of eMAR revealed that the NJ Exec Order 26.4b1 was signed as administered (7) seven times when the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the following dates: NJ Exec Order 26.4b1 at 2:00 PM (NJ Exec Order 26.4b1 at 10:00 PM (NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 electronic Medication Administration Record (eMAR) revealed a PO dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1, give 2 capsules by mouth every 8 hours. Hold for NJ Exec Order 26.4b1 with a plotted time of 0600 (6:00 AM), 1400 (2:00 PM) and 2200 (10:00 PM). A Further review of eMAR revealed that the NJ Exec Order 26.4b1 was signed as administered (7) seven times when the resident's NJ Exec Order 26.4b1 the following dates: NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1 at 2:00 PM NJ Exec Order 26.4b1 at 10:00 PM (NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1

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F 755	Continued From page 30 NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1) and NJ Exec Order 26.4b1 at 10:00 PM NJ Exec Order 26.4b1 On 2/18/25 at 1:40 PM, the surveyor interviewed the resident's medication nurse, Licensed Practical Nurse (LPN#1) who in the presence of the surveyor reviewed Resident #22's physician's orders. LPN #1 stated that the resident's NJ Exec Order 26.4b1 had perimeters to hold the medication when the NJ Exec Or was NJ Exec Order 26.4b1 or when the NJ Exec . In the presence of the surveyor, LPN#1 reviewed the resident's eMAR and acknowledge that Resident #22's NJ Exec Order 26.4b1 was administered on NJ Exec Order 26.4b1 when the resident's NJ Exec Order 26.4b1 and the NJ Exec LPN#1 further stated that whenever administering a medication that a nurse should read the full order including the perimeters and when a medication had an order to hold the nurse must hold that order. On 02/20/25 at 1:00 PM, the surveyor presented the above concerns to the US FOIA (b)(6) There was no additional information provided. A review of facility's policy for "Medication Administration" that was undated and was provided by the LNHA included the following: "3. Medications must be administered in accordance with the orders, including any required time frame." "8. The following information is checked/verified for each resident prior to administering medications:	F 755		

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F 755	Continued From page 31 a. Allergies to medications; and b. Vital signs, if necessary." NJAC 8:39-11.2 (b), 29.2 (d)	F 755		
F 806 SS=F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident's [redacted] preferences were consistently implemented and followed for 4 of 4 residents (Resident #104, #105, #1 and #3) reviewed for [redacted] preferences during meal observations. This deficient practice was evidenced as follows: 1. On 2/18/25 at 11:55 AM, the surveyor was observing the lunch meal on first floor unit. The surveyor observed Resident #104's tray, per the tray ticket, Resident #104 was supposed to receive 4 ounce (oz) assorted ice cream and a 6oz Coffee, both items were missing from the tray.	F 806	Resident #104, #105, #1 and #3, [redacted] orders [redacted] order reviewed. These were compared to [redacted] tickets which reflected appropriate [redacted] orders. Residents #104 and #1 have since been discharged. All residents residing in the facility have potential to be affected by these deficient practice. A comprehensive review of all diet orders, to include food Allergies, general preferences, fortified meal, additional portions and supplements was compared to that of the food tickets to ensure they reflect the same. The Food Service Director (FSD) provided in-services to dietary staff on the system checks to avoid these deficient practices. Upon Arrival of food trucks to unit, The	3/24/25

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F 806	Continued From page 32 On 2/20/25 at 10:00 AM, the surveyor reviewed the electronic medical record (E-mar) for Resident #104. A review of Resident #104's Face sheet (FS) (an admission summary) was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the admission MDS, (an assessment tool used to facilitate care management) dated [redacted], reflected a Brief Interview for Mental Status (BIMS) score was unable to be calculated as Resident #104 was [redacted] to complete a BIMS interview due to [redacted] A review of the Physician Order (PO summary dated [redacted], identified an order with an original date of [redacted], 'NJ Exec Order 26.4b1 [redacted] A review of Resident #104's care plan (CP) revealed a [redacted] CP with an initiation date of [redacted], the intervention portion of the CP revealed two [redacted] interventions, "Provide, serve [redacted] as ordered" with an initiation date of [redacted] and NJ Exec Order 26.4b1 [redacted]", with an initiation date of [redacted]. 2. On 2/18/25 at 11:58 AM, the surveyor was observing the lunch meal on first floor unit. The surveyor observed Resident #105's tray, per the tray ticket Resident #105 was given ½ cup of mandarin oranges instead of ½ cup of sliced pears and was missing a 6 oz Hot coffee. On 2/20/25 at 10:10 AM, the surveyor reviewed the E-mar for Resident #105. A review of	F 806	licensed nurse will check meal tickets and compare meal trays for accuracy of texture, Items listed, to also observe Allergies and food preferences. This check will be carried out at meal passes. All new admissions or any updates to existing residents diet orders will be communicated to kitchen immediately, a new or updated diet slip will be submitted to the FSD. Orders will be inputted or updated in facility E-MAR system accordingly. Weekly Menus will be given to Residents or Family members for food selection, when completed this will be submitted to the kitchen. If meals are served and resident wants and alternative the nursing staff will relate this requests to the kitchen, and follow up to see that alternate was provided. The FSD, Director of Nursing, Unit Manager /designee will conduct weekly audits x4 weeks of 5 residents trays, then monthly x 3 months, this audit will check for the areas of Allergies, Preferences and Substitutes. In-services and Audits will continue until the deficient practice is no longer noted. The results of this audit will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility corrective actions for the deficient practice will not reoccur.	

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F 806	Continued From page 33	F 806		

Resident #105's FS was admitted to the facility with diagnoses that included but were not limited to [redacted].

A review of the admission MDS, dated [redacted] reflected a BIMS score of [redacted] out of 15, indicating Resident #105 [redacted].

A review of the PO summary dated [redacted], identified an order with an original date of [redacted], "[redacted]."

A review of Resident #105's CP revealed a [redacted] CP with an initiation date of [redacted], the intervention portion of the CP revealed two [redacted] interventions both with [redacted] initiation dates, [redacted] as ordered.

3. On 2/20/25 at 9:16 AM, the surveyor was observing the breakfast meal on the second-floor unit. The surveyor observed Resident #1's tray, per the tray ticket Resident #1 was supposed to receive one container of rice crunchy cereal and a ½ cup fruit cocktail, both items were missing from the tray.

On 2/20/25 at 10:15 AM, the surveyor reviewed the E-mar for Resident #1. A review of Resident #1's FS was admitted to the facility with diagnoses that included but were not limited to [redacted].

A review of the quarterly MDS, dated [redacted], reflected BIMS score was unable to be calculated as Resident #1 was [redacted] to complete a BIMS interview due to [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

(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 806	Continued From page 34 A review of the PO summary dated [redacted], identified an order with an original date of [redacted], NJ Exec Order 26.4b1 [redacted]" A review of Resident #1's CP revealed a [redacted] CP with an initiation date of [redacted], the intervention portion of the CP revealed [redacted] interventions, "Staff/nursing to check tray." 4. On 2/20/25 at 9:20 AM, the surveyor was observing the breakfast meal on the second-floor unit. The surveyor observed Resident #3's tray, per the Resident #3's tray ticket, they were supposed to receive an assorted yogurt cup and 2 oz brown gravy, both items were missing from the tray. On 2/20/25 at 10:25 AM, the surveyor reviewed the E-mar for Resident #3. A review of Resident #3's FS was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of the re-admission MDS, dated [redacted] reflected BIMS score of [redacted] out of 15 indicating, NJ Exec Order 26.4b1 [redacted]. A review of the PO summary dated [redacted], identified an order with an original date of [redacted], NJ Exec Order 26.4b1 [redacted]" A review of Resident #3's CP revealed a nutrition CP with an initiation date of [redacted], the intervention portion of the CP revealed two nutrition interventions, NJ Exec Order 26.4b1 [redacted] And "Support the patients	F 806		

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F 806	Continued From page 35 right to make decisions regarding their [NJ Exec O] Make a reasonable effort to provide [NJ Exec O] and [NJ Exec Orde] according to preferences." On 2/20/25 at 09:28 AM, the surveyor interviewed [US FOIA (b] who stated tray accuracy audits are conducted but was unable to explain why residents had incorrect and missing items observed on NJ Exec Order 26.4b1. On 2/20/25 at 12:30 PM, the surveyor met with the US FOIA (b)(6)) to review survey concerns and surveyor findings. On 2/20/25 at 1:30PM, the US FOIA (b)(6)) provided the surveyor with a facility policy titled, "Dining and Food Preferences" with a revised date of 10/2022. Under the policy section of the chart it states, "3. The food preference interview will be entered into the medical chart. 4. Food allergies, food intolerances, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu software system ...7. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies & intolerances, and preferences." On 2/24/25 at 11:50 AM, the surveyor met with the US FOIA (b)(6) for the exit conference. No further information provided by the facility staff	F 806		
F 809 SS=F	NJAC - 17.4(a)1, (e) Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3)	F 809		3/24/25

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F 809	Continued From page 36 §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documents, it was determined that the facility failed to serve and document residents received a nourishing snack in the evening when there was more than a 14-hour span between dinner and breakfast mealtimes. This deficient practice was identified for 6 of 6 (Resident's #9, #34, #41, #53, #60, and #78) residents during the resident council meeting and was evidenced by the following: On 02/18/25 at 11:08 AM, the surveyor conducted a group meeting with six residents who were [redacted] and [redacted] and selected by the facility to participate. Six out of six residents stated they were not offered nor receive snacks in the evening.	F 809	Food service department provides snacks daily and nursing staff will offer snacks provided by food services to Residents at bedtime All residents have the potential to be affected by the deficient practice, however, no residents were affected. A snack log is created to reflect Residents snack acceptance. The Food Service Director (FSD), Director of Nursing (DON), Unit managers /designee will collaborated and provided in-services to staff on the system checks to avoid the deficient practices. A member of the nursing team will sign to	

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F 809	Continued From page 37 On 2/20/25 at 9:50 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that if there was more than 14 hours between dinner and breakfast, the facility was required to provide the residents with a nourishing evening snack. She acknowledged there was more than 14 hours between dinner and breakfast. The US FOIA (b) stated the kitchen provided snacks to all units but were unable to state if the evening snacks were passed out by the nursing staff. On 2/20/25 at 10:30 AM, the surveyor made multiple attempts to contact the US FOIA (b)(6) via telephone, but was unable to contact the US FOIA On 2/20/25 at 10:45 AM, the surveyor conducted a phone interview with the 3-11 PM US FOIA (b)(6) who stated, they think the evening snacks were passed out but there is no record or accountability of the residents receiving evening snacks. 2/20/25 11:25 AM, the surveyor interviewed the US FOIA (b)(6)), who stated there is no record book of evening snacks being passed out and acknowledged the facility needs to have a better system to ensure snacks were offered and provided to all residents. On 2/20/25 at 12:35 PM, the surveyor met with the US FOIA (b)(6) to review facility concerns and surveyor findings. On 2/20/25 at 1:30 PM, the US FOIA (b)(6) provided the surveyor with a facility policy titled, "Snacks" with a revised date of 10/2022.	F 809	receive snacks from the kitchen. Snacks will then be distributed by nursing staff as appropriate with diet and preferences. The FSD, DON, Unit Manager /designee will conduct weekly audits x4 weeks of 3 residents, then monthly x 3 months, this audit 3 alert and oriented Residents will be interviewed to check if snacks were offered. In-services and Audits will continue until the deficient practice is no longer noted. The results of this audit will be reviewed at Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility corrective actions for the deficient practice will not reoccur.	

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F 809	Continued From page 38 Under the policy statements section of the policy it states, "Bedtime (HS snacks) snacks will be provided for all residents." Under the procedures section of the policy it states, "4. The dining services department will assemble and deliver to each unit the individually planned snack items and bilk snack items to be offered at bedtime. 6. Nursing services is responsible of delivering the individual snacks to the identified residents and for offering evening snacks to all other residents." On 2/24/25 at 11:50 AM, the surveyor met with the US FOIA (b)(6) for the exit conference. No further information provided by the facility staff.	F 809		
F 812 SS=F	NJAC 8:39-17.2 (f))(1) (i) (ii) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		3/24/25

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F 812	Continued From page 39 standards for food service safety. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 2/14/25 at 10:23 AM, the surveyor in the presence of the US FOIA (b)(6)) observed the following during the kitchen tour: 1. Upon entering the kitchen, the surveyor observed the US FOIA (b)(6)) and three dietary aides (DA) all wearing large earrings. US FOIA (b) alerted staff and earrings were removed. 2. In the cooking area of the kitchen the surveyor observed on top of the 2-door standing oven, burnt-on debris and a large build up of a greyish dust like substance. The US FOIA (b) stated all kitchen equipment would be cleaned immediately. 3. In the preparatory area the surveyor observed a 1-gallon bottle of white vinegar no lid. The US FOIA (b) was unable to state why the vinegar was missing the lid and was discarded immediately. 4. In the walk-in refrigerator, the surveyor observed 2 fans with blackish dust-like debris. The US FOIA (b) stated the fans would be cleaned immediately.	F 812	1. Reginal FSD and three dietary aides removed earrings immediately. All residents have the potential to be affected, however, no residents were affected. US FOIA (b)(6)) and dietary staff were in-serviced on proper uniforms and what jewelry is acceptable to wear in the kitchen. FSD to monitor the dietary staff attire as part of her morning walkthrough of the department, Staff will no longer wear earrings while at work. Findings will be reported at the next QAPI meeting. Administrator/designee will analyze audits for patterns and trends, all findings of the audits will be presented during QAPI committee quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data. 2. the 2-door standing oven was cleaned immediately by the FSD. All residents have the potential to be affected, however, no residents were affected. US FOIA (b) and Dietary Staff were in-serviced on the proper sanitation of the ovens.	

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F 812	Continued From page 40 5. In the dry storage area, the surveyor observed a 7 pound (lb.) can vanilla pudding observed dented in regular rotation. The [redacted] stated all dented cans should be removed from the regular rotation and put in the dented can area. On 2/20/25 at 12:35 PM, the surveyor met with the [redacted]) to review facility concerns. The [redacted] stated the facility just hired a new company to run the food service department and all concerns would be addressed immediately. On 2/20/25 at 1:30 PM, the [redacted] provided the surveyor with copies of four facility policies. The facility policy titled, "Staff Attire" with a revised date of 10/2023, stated under the procedures section, "5. Hand jewelry will be limited to a plain band. Arm jewelry and dangling jewelry is not permitted." The facility policy titled, "Equipment" with a revised date on 9/2017, stated under the procedures section, "1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's direction and training material. 6. All non-food contact equipment with be cleaned and free of debris." The facility policy titled, "Food Storage" with a revised date of 2/2023, stated under the procedures section, "All packaged and canned food items will be kept clean, dry, and properly sealed." The facility policy titled, "Receiving" with a revised date of 2/2023, stated under the procedure section, "4. All canned goods with be appropriately inspected for dents, rust or bulges. Damaged cans will be segregated and clearly identified for return to vendor or disposal." On 2/24/25 at 11:50 AM, the surveyor met with	F 812	The FSD /designee will monitor the kitchen ovens weekly x4 then monthly x2. Findings will be reported at the next QAPI meeting. Administrator/designee will analyze audits for patterns and trends, all findings of the audits will be presented during QAPI committee quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data. 3. and 5. one- Gallon bottle of white vinegar with no lid and all dented cans were discarded immediately. All residents have the potential to be affected, however, no residents were affected. [redacted] and Dietary Staff were in-serviced on the proper food storage. The FSD /designee will monitor the proper food storage weekly x4 then monthly x2. Findings will be reported at the next QAPI meeting. Administrator/designee will analyze audits for patterns and trends, all findings of the audits will be presented during QAPI committee quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data. 4. The two fans in the walk-in refrigerator were cleaned immediately by the FSD. All residents have the potential to be affected, however, no residents were affected.	

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F 812	Continued From page 41 the US FOIA (b)(6) for the exit conference. No further information provided by the facility staff. NJAC 8:39-17.2(g)	F 812	US FOIA (b) and Dietary Staff were in-serviced on the proper sanitation of the Fan shroud. The FSD /designee will monitor the proper sanitation of the Fan shroud weekly x4 then monthly x2. Findings will be reported at the next QAPI meeting. Administrator/designee will analyze audits for patterns and trends, all findings of the audits will be presented during QAPI committee quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30707	A. BUILDING: _____ B. WING _____	C 02/24/2025

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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 43 E, Enforcement of Licensure Regulations.	S 000		
S 140	8:39-2.9(c)(7) Licensure Procedure (c) Hemodialysis services may be provided to residents of the long-term care facility by separately licensed dialysis providers under the following circumstances: 7. Hemodialysis shall be listed as a "service" on the facility's license; and This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews of pertinent facility documentation, it was determined that the facility failed to ensure newly hired employees completed the required NJ Exec Orde [redacted] or NJ Exec Order 26.4b1 [redacted] upon hire. The deficient practice was identified for 1 (one) of	S 140	Healthcare record for Staff# 1 reviewed and noted to have NJ Exec Order 26.4b1 outside of the date range for required NJ Exec Order 26.4b1 Employee was informed to NJ Exec Order 26.4b1 in order to return to work. Staff# 1 last work date at the facility was NJ Exec Order 26.4b1. All Employees Health Records were reviewed for all new hired for the NJ Exec Order 26.4b1 findings was identified.	3/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/16/25

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S 140	Continued From page 1 10 randomly selected new employees (Staff #1). This deficient practice was evidenced by the following: The surveyor reviewed 10 randomly selected newly hired employee files. The review for [NJ Exec] screening upon hire for 1 of the 10 new employees revealed the following: Staff #1, a Registered Nurse hired on [NJ Exec Order 26.4b1], completed the first step of a [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b]. No additional documentation was in the file to indicate that the [NJ Exec Order 26.4b1] was completed. On 2/24/25 at 9:28 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) of the concern that the [NJ Exec Order 26.4b1] for Staff #1 had not been completed. On 2/24/25 at 10:51 AM, the surveyor interviewed the Human Resources Secretary (HRS), who stated that human resources instructed new hires that a medical exam was required and that they would have to go to their physicians or hospitals. The HRS further explained that the new hire should have their [NJ Exec Order 26.4b1] before starting; if not, the facility would provide it. On 2/24/25 at 11:47 AM, the surveyor met the LNHA and the Director of Nursing (DON), and the LNHA provided additional information for the [NJ Exec] of Staff #1. The LNHA stated that another [NJ Exec Or] was done on [NJ Exec Order 26.4b1] but [NJ Exec Order] was not provided for both dates. A review of the facility's policy, "Employee Health Records Policy Statement," with a review date of	S 140	All residents have the potential to be affected, however, no residents were affected. Human Resources Secretary (HRS) was in-serviced by the Director of Nursing (DON) regarding the importance of ensuring the 2 TB screening steps on file before employee start date. The DON/ Designee will monitor TB screening method weekly x4 then monthly x2. Findings will be reported at the next Quality Assurance and Performance Improvement (QAPI) meeting. Administrator/ Designee will analyze audits for patterns and trends, all findings of the audits will be presented during QAPI committee quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data.	

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S 140	Continued From page 2 January 2025, revealed under "Policy Interpretation and Implementation 1. c. associate TB screening method."	S 140		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00180085, NJ00168597, NJ00172899 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of	S 560	The Director of Nursing (DON) completed an audit of the Certified Nursing Assistant (C.N.A.) staffing schedule for the previous 30 days and rendered education to the Staffing Coordinator regarding the daily staffing requirements as indicated by the State of New Jersey. No negative outcomes were observed. All residents have the potential to be affected by the deficient practice, however, no residents were affected. DON/Designee will continue to review staffing needs with staffing coordinator daily to ensure adequate staffing on all shifts to assure mandatory staffing is maintained. Staffing Coordinator/Designee will continue to maintain a recruitment and hiring log, to track all C.N.A.s applicants and outcomes. Facility to continue utilizing agency contracts to increase staffing and solicit additional nursing agencies and	3/24/25

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S 560	Continued From page 3 P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	continue posting open C.N.A. position on job sites and host job fairs. Facility to continue to offer incentive referrals bonus to ensure positively attracting staff. DON/Designee will review staffing reports daily and perform weekly audits on C.N.A. staffing levels for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taking by the DON /Designee and reported to the Administrator. All findings of the audits will be presented to the facility QAPI committee monthly for three months, then quarterly thereafter for twelve months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30707	A. BUILDING: _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

(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 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week staffing prior to survey beginning 1/26/2025 and ending 2/8/2025 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 5 of 14 day shifts as follows: -01/27/25 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -01/29/25 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -02/02/25 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. -02/03/25 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -02/04/25 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. NJ complaint # NJ00180085 For the week of Complaint staffing from 11/10/2024 to 11/16/2024, the facility was	S 560		

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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S 560	Continued From page 5 deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -11/16/24 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs. NJ complaint #NJ00168597 For the week of Complaint staffing from 10/22/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -10/22/23 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs. -10/23/23 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -10/24/23 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -10/27/23 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs. -10/28/23 had 6 CNAs for 71 residents on the day shift, required at least 9 CNAs NJ complaint #NJ00172899 For the week of Complaint staffing from 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -12/31/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs. -01/01/24 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -01/06/24 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs.	S 560		
S2120	8:39-31.1(c) Mandatory Physical Environment Fire safety maintenance and retrofit of long-term	S2120		3/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30707	A. BUILDING: _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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S2120	Continued From page 6 care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, PO Box 809, Trenton, New Jersey 08625-0809. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 02/19/2025 in the presences of the Director of Housekeeping and Maintenance (DOHM), it was determined that the facility failed to ensure that quarterly Uniform Fire Code inspections were conducted in accordance with N.J.A.C 5:70. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that the New Jersey Uniform Fire Code Certificate of Inspection that was provided was conducted on 01/15/2025. Documentation of quarterly inspections conducted in 2023 Q1-Q4 and 2024 Q1-Q4 could	S2120	No residents were affected by the deficient practice. The New Jersey Uniform Fire Code quarterly inspection documentation for 2023 Q1-Q4 and 2024 Q1-Q4 was re-requested from West Orange Fire Department and received. All Residents have the potential to be affected, however, no residents were affected. The Director of Housekeeping and Maintenance (DOHM) was in-serviced by the Administrator regarding the importance of ensuring the quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30707	A. BUILDING: _____ B. WING _____	C 02/24/2025

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S2120	Continued From page 7 not be produced. In an interview at the time, the DOHM confirmed the review and stated that the fire department does come out for inspections and the fire department informed them that they do not have enough people to provide reports of the inspections. The facility's Administrator was informed of the deficient practice at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM.	S2120	Uniform Fire Code inspections are conducted and quarterly report received in a timely manner. The Administrator will ensure that the plan of correction has been fully implemented and the inspection report will be audited 1 time per quarter for 2 quarters. The findings of these quality monitoring audits will be reported to the QAPI committee until 100% consistent substantial compliance has been met.	

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
315416 Y1	A. Building B. Wing Y2	5/15/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 03/24/2025	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 03/24/2025	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	
2/24/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315416 Y1	A. Building B. Wing Y2	5/15/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0640 Reg. # 483.20(f)(1)-(4) LSC	Correction Completed 03/24/2025	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 03/24/2025	ID Prefix F0655 Reg. # 483.21(a)(1)-(3) LSC	Correction Completed 03/24/2025
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 03/24/2025	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 03/24/2025	ID Prefix F0711 Reg. # 483.30(b)(1)-(3) LSC	Correction Completed 03/24/2025
ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 03/24/2025	ID Prefix F0806 Reg. # 483.60(d)(4)(5) LSC	Correction Completed 03/24/2025	ID Prefix F0809 Reg. # 483.60(f)(1)-(3) LSC	Correction Completed 03/24/2025
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 03/24/2025	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/24/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
30707 Y1	A. Building B. Wing Y2	5/15/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/24/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/24/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT Y3
30707		5/15/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0140 Reg. # 8:39-2.9(c)(7) LSC	Correction Completed 03/10/2025	ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/24/2025	ID Prefix S2120 Reg. # 8:39-31.1(c) LSC	Correction Completed 03/21/2025
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 2/24/2025	☐ 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
	315416	A. BUILDING **01** B. WING _____	**02/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	**103 PLEASANT VALLEY WAY** **WEST ORANGE, NJ 07052**

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E 000	Initial Comments This facility was in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1990's with no current major renovations or noted additions. It is a three- story building with Type II (000) construction and is fully sprinklered. The main facility consists of 3 buildings with residents: CPCH, AL, and SNF. 1. Barker 3-story W/full basement 2. Ripple Pavilion 2-story W/partial basement 3. Moorings 2-story W/partial basement There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The 250 KW generator outside the facility (Diesel), is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The generator powers approximately 40 % of the main building.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT	K 222		2/25/25

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

Electronically Signed | 03/14/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING **01** B. WING _____	**02/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 222	Continued From page 2 installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations, and interviews on 02/18/2025 in the presence of the[US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that doors provided with delayed egress locking arrangements were in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.4, 7.2.1.5.10.2 and 7.2.1.6. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:28 AM revealed that the door leading to the lawn in staircase # 4 was provided with a delayed egress locking arrangement but was not provided with a ready visible sign that read: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. An observation at 11:54 AM revealed that the emergency exit door in staircase #2 required more than one releasing operation to be opened. This door, equipped with a delayed egress locking system, did not trigger an irreversible process to release the lock in the direction of	K 222	On 02/19/2025, Door leading to the lawn in staircase # 4 was provided with a ready visible sign that read: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. Please see picture #1. On 2/22/2025, the vendor removed the button allowing the door to be released with only one motion of pushing. See picture# 1. All Residents have the potential to be affected, however, no residents were affected. An entire facility door audit was conducted on 2/25/2025 to ensure that were all in compliance. No other areas of concern were noted. The Maintenance Director/Designee will conduct audits to doors provided with delayed egress locking arrangements for compliance once per month, for the next 2 quarters. The findings of these quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING 01 B. WING _____	02/24/2025

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K 222	Continued From page 3 egress within 15 seconds. This only occurred when a separate manual release device on the door frame was pushed beforehand. In interviews at the time, the [US FOIA (b)(6)] confirmed the observations. The facility's [US FOIA (b)(6)] was informed of the deficient practices at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM.	K 222	audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee for the next 2 quarters.	
K 223 SS=F	N.J.A.C. 8:39-31.2 (e) Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 02/18/2025 in the presence of the [US FOIA (b)(6)] [redacted]), it was determined that the facility failed to ensure that doors in all exit stairway enclosures were equipped with smoke-resistant doors that were	K 223	On 02/22/2025, the door for stairway enclosed M1#5 panic bar repaired, basement stairway enclosure hinges were adjusted by the contractor to all now positively latching in their frames. Please see pictures #2.	2/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING 01 B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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K 223	Continued From page 4 positive latching and either self-closing or automatic-closing in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.7, 7.2.1.8.2 and NFPA 80, Section 5.2.4.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:10 AM revealed that the door for stairway enclosure M1#5 did not positively latch when tested by the US FOIA (b)(6) An observation at 2:21 PM revealed that the stairway enclosure in the basement near the maintenance storage room did not positively latch when tested by the US FOIA (b)(6) In interviews at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM. N.J.A.C. 8:39-31.2 (e) NFPA 80	K 223	All Residents have the potential to be affected, however, no residents were affected. An entire facility door with self-closing devices audit was conducted on 2/25/2025 to ensure that they were all in compliance. None were found. The Maintenance Director/Designee will conduct monthly audits to doors with self-closing devices for compliance for the next 2 quarters. The findings of these quality audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee for the next 2 quarters.	
K 321 SS=F	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 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing	K 321		2/25/25

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	315416	A. BUILDING 01 B. WING _____	02/24/2025

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K 321	Continued From page 5 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 02/18/2025 in the presence of the [redacted], it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 8.4, 8.7.1, 19.3.2.1, and 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 2:05 PM revealed that the elevator control room wall contained a 7-inch diameter penetration that compromised the smoke resistance of the room. In an interview at the time, the [redacted] confirmed the observation and stated that he would have someone repair the penetration right away.	K 321	On 2/20/2025, the elevator control room penetration in wall was addressed by closing the 7-inch diameter opening with concrete. See picture # 3. All Residents have the potential to be affected, however, no residents were affected. An audit of all hazardous areas was conducted on 2/25/2025 to ensure that they were all in compliance. No other areas of concern were noted. The Maintenance Director/Designee will conduct monthly audits of hazardous areas for compliance for the next 2 quarters. The findings of these quality	

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	315416	A. BUILDING 01 B. WING _____	02/24/2025

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K 321	Continued From page 6 The facility's [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code Exit conference on 02/19/2025 at 3:30 PM. N.J.A.C 8:39-31.2 (e)	K 321	audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee for the next 2 quarters.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interviews on 02/19/2025 in the presence of the [US FOIA (b)(6)] [redacted]), it was determined that the facility failed to ensure that deficiencies, damaged parts, or impairments found while performing the inspection, testing and maintenance of the fire alarm system were promptly corrected in accordance with NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that the semi-annual fire alarm inspection that was conducted on 01/11/2024 identified that the fire alarm panel batteries failed the load test. The semi-annual fire alarm inspection that was conducted on 06/17/2024 identified that the fire	K 345	The vendor addressed the fire alarm batteries on 9/10/2024. The fire alarm system batteries will be inspected and changed annually. Please see vendor confirmation attached. All Residents have the potential to be affected, however, no residents were affected. An audit of the most recent Semi-annual fire alarm report was conducted and no deficiencies were noted. The Maintenance Director/Designee will conduct audits on fire panel batteries once per year and an analysis of all the reports will be done in-house to ensure	2/25/25

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	315416	A. BUILDING **01** B. WING _____	**02/24/2025**

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K 345	Continued From page 7 alarm panel batteries failed the load test. Service reports indicate that the fire alarm batteries were changed on 09/10/2024, nearly 8 months after the problem was initially identified. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM. N.J.A.C. 8:39-31.2 (e) NFPA 25	K 345	that all the deficiencies noted will be addressed in a reasonable time frame. to check for compliance for the next 2 quarters. The findings of these quality audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee for the year.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		2/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING 01 B. WING _____	02/24/2025

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K 351	Continued From page 8 by: Based on observations and interviews on 02/18/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that all sprinkler heads were provided with escutcheons in accordance with NFPA 101:2012 Edition, Sections 19.3.5.1, 9.7 and NFPA 13:2010 Edition, Sections 6.2.7- 6.2.7.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:28 PM revealed that the sprinkler head in the restroom and the one just outside the restroom in the second-floor dining room were both missing escutcheons. An observation at 2:24 PM revealed that 2 sprinkler heads were missing escutcheons in the dietary kitchen and 1 sprinkler head was missing an escutcheon in the dietary service hallway. In interviews at the time the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM. N.J.A.C. 8:39-31.2 (e) NFPA 13	K 351	On 2/20/2025, the sprinkler vendor replaced the sprinkler head escutcheon plates in the restroom located outside the second-floor dining room, dietary kitchen and dietary service hallway. See picture #4 and 5. All Residents have the potential to be affected, however, no residents were affected. Quarterly and Annually Inspections will be conducted by sprinkler vendors. The Director of Maintenance will complete a monthly audit to ensure compliance and provide a copy of the audit to the Administrator. Audit results will be reviewed at the QAPI committee quarterly up to 1 year.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		3/24/25

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	315416	A. BUILDING 01 B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 9 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interviews on 02/18/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed ensure that sprinkler systems deficiencies, damaged parts, or impairments found while performing the Inspection, Testing and Maintenance of the sprinkler systems were promptly corrected in accordance with NFPA 101: 2012 Edition, Sections 19.3.5, 9.7, 9.7.2.1, NFPA 13, NFPA 25:2011 Edition, Section 4.1.4, 4.1.4.1, 4.1.4.2 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 02/18/2025 revealed that the quarterly Combo Standpipe Sprinkler inspection that was conducted on 09/22/2023 identified the sprinkler system as "Partially Operational". Deficiencies Identified: "The monitoring company did not receive all supervisory signals and/or	K 353	The sprinkler system that was previously partially operational due to a break in the central monitoring system signals, was fully addressed prior to survey and has been fully functional. Daily checking with central monitoring is conducted by the facility Engineer to ensure that the facility is connecting and is sending a signal to the central monitoring location, this is documented in the fire alarm monitoring log book. All residents have the potential to be affected, however, no residents were affected. An audit of the most recent fire alarm report was conducted, and no deficiencies were noted. The Maintenance Director/Designee will conduct audits on the sprinkler system	

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	315416	A. BUILDING **01** B. WING _____	**02/24/2025**

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GREEN HILL	**103 PLEASANT VALLEY WAY** **WEST ORANGE, NJ 07052**

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K 353	Continued From page 10 alarms. The reinspection certificate of repair for the Combo Standpipe Sprinkler that was conducted on 10/30/2023 identified the sprinkler system as "Partially Operational". Deficiencies Identified: "The monitoring company did not receive all supervisory signals and/or alarms. The quarterly Combo Standpipe Sprinkler inspection that was conducted on 12/28/2023 identified the sprinkler system as "Operational". Deficiencies Identified: "The alarm system is not monitored by the central station and it is recommended reconnecting to Rapid Response". The quarterly Combo Standpipe Sprinkler inspection that was conducted on 07/23/2024 identified the sprinkler system as "Partially Operational". Deficiencies Identified: "The monitoring company did not receive all supervisory signals and/or alarms. In an interview at the time, the [redacted] confirmed that the facility knew of the ongoing issue with the monitoring company not receiving all signals and of not being monitored by the central station. The [redacted] stated: "We believe there was an issue with the dialer or telephone line". "The problem is sporadic and will last 1 to 3 days at a time". The surveyor asked the [redacted] what was done, and who was notified while there was no central station monitoring. The [redacted] stated, "The	K 353	monthly, and the associated fire sprinkler company will be at the facility once per quarter to conduct testing the entire system. All reports would be analyzed for deficiencies and addressed immediately. The results of the quarterly inspections completed by the vendor will be discussed in Quality Assurance Performance Improvement (QAPI) quarterly meetings X4.	

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	315416	A. BUILDING **01** B. WING _____	**02/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	**103 PLEASANT VALLEY WAY** **WEST ORANGE, NJ 07052**

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K 353	Continued From page 11 person at the front desk is informed to call the fire department in case of emergencies and a fire watch is conducted". The surveyor then requested to see the Fire Watch reports for when the central station monitoring was not working. The US FOIA (b)(6) stated "We do not have fire watch paperwork; we only notify the front desk to call the fire department". The US FOIA (b)(6) then stated that a different company just recently took over central station monitoring and is currently under contract. The contract that was provided was dated 1/31/2025, nearly 15 months after the problem was initially identified. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM. N.J.A.C. 8:39-31.2 (e) NFPA 13, 25, 72	K 353		
K 363 SS=F	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 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	K 363		2/25/25

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	315416	A. BUILDING 01 B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 12 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 observations and interviews on 02/18/2025 in the presence of the [redacted], it was determined that the facility failed to: A) ensure that resident room doors were not blocked open and B) ensure that when closed, doors in the corridor stayed closed if a force of 5 LBS is applied at the latch edge of the door in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.5 and 19.3.6.3.10. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 363	On 2/20/2025, the latching hardware on the corridor door near room 1054 was adjusted, the clean utility room door on the 2nd Floor, tissue was at once removed from the latch, 252 door adjusted hinges to stay closed, oxygen storage room, adjusted to stay closed. Rooms 2052, 2058, 2060, 2065, and 2066 trash cans were removed from holding doors open. see picture # 6 and 7. On 2/20/25, employees were in-serviced on keeping all resident room doors were	

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	315416	A. BUILDING 01 B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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K 363	Continued From page 13 An observation at 11:22 AM revealed that the latching hardware on the corridor door near room 1054 was not functioning which prevented the door from staying closed if a force of 5 LBS was applied to the latch edge of the door. An observation at 12:21 PM revealed that the door to the clean utility room, located near the nurse's station on the second floor, had tissue stuffed into the door frame latch. This obstruction prevented the door from staying closed when tested by US FOIA (b)(6) An observation at 12:21 PM revealed that the linen closet door in the corridor near room 252 failed to stay closed when tested by the US FOIA (b)(6) An observation at 12:25 PM revealed that the oxygen storage room door failed to stay closed when tested by the US FOIA (b)(6) Observations between 12:34 PM and 12:43 PM revealed that resident rooms: 2052, 2058, 2060, 2065 and 2066 where being held open by trash bins. An observation at 12:51 PM revealed that the Spa room door failed to stay closed when tested by the US FOIA (b)(6) In interviews at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM. N.J.A.C 8:39-31.2 (e)	K 363	not blocked open, and when closed doors in the corridor stayed closed if a force of 5 LBS is applied at the latch edge of the door to be complying. All Residents have the potential to be affected, however, no residents were affected. An entire facility door audit was conducted on 2/25/2025to ensure that they were all in compliance. No other areas of concern were noted. The Maintenance Director/Designee will conduct door audits for compliance monthly for the next 2 quarters. The findings of these quality audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee for the next 2 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING **01** B. WING _____	**02/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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 and interviews on 02/18/2025 in the presence of the [redacted]), it was determined that the facility failed ensure that smoke barrier doors were in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.7 and 19.2.2.2.8. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:10 PM revealed that the 1 of 2 fire/smoke barrier doors across from the dining room on the second floor were being held open by the carpet and not by the magnetic hold open device that would automatically close the door upon activation of the fire alarm system. In an interview at the time, the [redacted] confirmed that the door was being held open by the carpet. The [redacted] pushed the door back to engage the	K 374	On 2/22/2025, vendor addressed the door frame across from the dining room on the second floor and from the rehab gym door. The smoke barrier door being held open with carpet was fixed immediately. On 2/18/2025, the rehab gym doors were released from being held open and staff re-in serviced about holding doors open with unapproved devices that prevent the door from fully closing. All Residents have the potential to be affected, however, no residents were affected. An entire facility door in smoke barriers audit was conducted on 2/25/2025 to ensure that they were all in compliance. No other areas of concern were noted.	2/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING 01 B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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K 374	Continued From page 15 magnetic hold-open device. The US FOIA (b)(6) then disengaged the door from the magnetic device, but the door failed to close into its frame. The US FOIA (b)(6) stated that they would have someone adjust the door. An observation at 12:30 PM revealed that the rehab gym contained a pair of swinging doors that were being held open by a magnetic hold open device that would automatically close the doors upon activation of the fire alarm system. The doors failed to close when tested by the US FOIA (b)(6) Rehab gym equipment was discovered to be hooked over the door and prevented the door from fully closing. The US FOIA (b)(6) removed the rehab gym equipment (pulley) and attempted to test the doors again. The doors failed to close when released from the magnetic hold open device. In an interview at the time, the US FOIA (b)(6) confirmed that the door did not close and stated that they would have someone adjust it. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM.	K 374	The Maintenance Director/Designee will conduct monthly door audits of smoke barriers for compliance for the next 2 quarters. The findings of these quality audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee for the next 2 quarters.	
K 521 SS=D	N.J.A.C 8:39-31.2 (e) HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.	K 521		2/25/25

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K 521	Continued From page 16 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 02/18/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that ventilation and air conditioning complied with NFPA 101:2012 Edition, Sections 19.5.2.1 and 9.2. This deficient practice had the potential to affect up to 8 of 86 residents and was evidenced by the following: Observations on 02/18/2025 between 11:18 AM and 1:55 PM revealed that the ventilation in rooms 1050, 2050, 2058 and 217 were not functioning when tested by the US FOIA (b)(6) In interviews at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 02/19/2025 at 3:30 PM. N.J.A.C. 8:39-31.2 (e)	K 521	On 2/20/2025 the Heating, ventilation and air condition (HVAC) technician repaired the HVAC in rooms 1050, 2050, 2058 and 217. All exhaust throughout the building were tested and were noted to be fully functional on 2/25/2025. please see pictures attached. All Residents have the potential to be affected, however, no residents were affected. An entire facility audit was conducted on 2/25/2025 to ensure that there were no other nonfunctioning exhaust systems in the facility. No other areas of concern were noted. The Maintenance Director/Designee will conduct weekly audits of all bathroom exhaust for fully functionality 1X per month then monthly X2. The findings of these quality audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee for the next 2 quarters.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING	K 531		4/30/25

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K 531	Continued From page 17 Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews on 02/18/2025 and 02/19/2025 in the presences of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that elevators were inspected, tested and maintained in accordance with NFPA 101:2012 Edition, Sections 19.5.3, 9.4.2,9.4.3 and ASME A 17.1, and A 17.3. This deficient practice had the potential to affect all residents and is evidenced by the following: An observation on 02/18/2025 at 11:23 AM revealed that the annual elevator certificate located in the elevator room indicated that the last inspection was issued on 05/19/2013. A record review on 02/19/2025 revealed that annual elevator certificates of occupancy/compliance for 2023 or 2024 could not	K 531	The Director of Facility Management scheduled an annual elevator inspection with the elevator service company on 2/25/2025. The contractor came on site to conduct inspections on 04/26/2025 and has filed the report with the West Orange buildings department, please see elevator inspection certification reports attached that indicate the elevators are fully functional and is in good operating condition. All Residents have the potential to be affected, however, no residents were affected. The U.S. FOIA (b) (6) [redacted] was in-serviced by the administrator on how to set up the inspection with the elevator inspector of	

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	315416	A. BUILDING **01** B. WING _____	**02/24/2025**

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K 531	Continued From page 18 be located for the elevator. In an interview at the time, the US FOIA (b)(6) confirmed that they could not locate annual elevator certificates but they were able to locate an elevator service contract. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code Exit conference on 02/19/2025 at 3:30 PM. N.J.A.C 8:39-31.2 (e)	K 531	West Orange New Jersey, which is to call the facility elevator company who will set up a date and time with the inspector of West Orange New Jersey. An entire elevator audit and elevator Category 1 inspection was completed on 4/26/25 to ensure that the elevators are in compliance with the regulation, no other concerns were noted. The Maintenance Director/Designee will conduct Monthly elevator audits for compliance monthly for the next 2 quarters. The findings of these quality audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee for the next 2 quarters.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		5/6/25

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K 918	Continued From page 19 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews on 02/18/2025 and 02/19/2025 in the presences of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance of generators was in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 8.3.7.1, and 8.3.8. These deficient practices had the potential to affect all residents and was evidenced by the following: An observation on 02/18/2025 revealed that 1 of 2 emergency generator batteries was a lead acid battery. In an interview at the time, the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid battery. The US FOIA (b)(6) confirmed that 1 of 2 batteries was a	K 918	The specific gravity testing of the lead acid battery was first conducted on 2/21/25 and will be conducted on a monthly basis going forward. please see audit attached. The facility maintains in corroboration with the generator servicing company that the fuel quality test is required to be performed annually in accordance with NFPA 110 chapter 8.3.8 requirements have been done in accordance with the required code refenced above and that these testing are done in compliance with the approved ASTM standards. The Fuel sediment test which gives an indication of the quality of the generator fuel indicated that all levels were within the required ranges. (see attached) completed on 8/16/2024 and resampled on 4/30/2025, please see fuel sample report attached.	

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K 918	Continued From page 20 lead-acid battery and stated that monthly testing was not conducted. A record review on 02/19/2025 revealed that documentation regarding annual fuel quality test could not be located. A work order was provided that indicated "Oil Sample" under the Task Description in the "JOB TASK" section of the report. The provided report titled: "Lubricant Analysis Report" indicate that oil analysis was conducted on samples taken 17-Jul-2023 and 30-Jul-2024. Annual fuel quality test reports could not be produced. In an interview at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code Exit conference on 02/19/2025 at 3:30 PM. N.J.A.C 8:39-31.2 (e) NFPA 99, 110	K 918	All Residents have the potential to be affected, however, no residents were affected. A generator and generator lead acid battery audit was done on all generators by vendor, no other areas of concern were noted. The Maintenance Director/Designee will conduct weekly generator audit X4. Then monthly load testing and specific gravity testing on the lead acid battery for the generator on going on a consistent basis. These inspections and audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee each quarter for the next 4 quarters.	

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
315416 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/15/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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 K0222	02/25/2025	LSC K0223	02/25/2025	LSC K0321	02/25/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	02/25/2025	LSC K0351	02/25/2025	LSC K0353	03/24/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	02/25/2025	LSC K0374	02/25/2025	LSC K0521	02/25/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0531	04/30/2025	LSC K0918	05/06/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/24/2025	☐ YES ☐ NO