STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING _____ B. WING _____	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

(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 NJ00157451, NJ00163644, NJ00161813, NJ00165308, NJ00165172 STANDARD SURVEY: 8/22/23 CENSUS: 111 SAMPLE SIZE: 26 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 5 of 24 residents reviewed (Residents #34, 49, 52, 48, and #84). The deficient practice was evidenced by the following: 1. On 08/10/23 at 10:10 AM, the surveyor observed Resident #34, eyes closed, NJ ex order 26.4b1 [redacted] in front of the nurses' station, talking	F 641	F□0641 MDS S/S = D The last plan of correction submitted had a typo - had reflected 43 when in fact it should have been 34. Good catch. How the corrective action will be accomplished for those found to have been affected by the deficient practice.	9/1/23

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

Electronically Signed | 09/05/2023

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

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F 641	Continued From page 1 to the other residents. The surveyor reviewed the medical records of Resident #34, which revealed the following: The Significant MDS (SMDS), dated NJ ex order 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, indicating that the resident's NJ ex order 26.4b1 The SMDS Section J Fall History on Admission/Entry/Reentry was coded NJ (zero) or No, which did not reflect the resident's NJ ex [redacted] The Care Plan initiated on NJ ex order 26.4b reflected, Focus: NJ ex order 26.4b1 [redacted] The Progress Notes on NJ ex order 26.4b1 stated that "While eating dinner resident thought someone took her cup and she followed the person and went to the bathroom where she NJ ex order 26. [redacted]. She screamed for help and when aide, who was with the resident 5 minutes before, went to room and found her NJ ex order 26.4b1 ." On 08/18/23 at 11:30 AM, the surveyor interviewed the MDS Coordinator, who worked in the facility for NJ Exec. Old years, and stated that the part-time MDS Coordinator, who had worked there for NJ Exec years, did not capture the fall incident. The MDS Coordinator stated that he will make a note to the part-time MDS Coordinator if there's any fall so that the part-time MDS will capture the fall moving forward."	F 641	All MDS assessments for Residents # 34, #49, #52, #48, and #84 were modified accurately, and submitted prior to survey team's exit. Education and in-service given to all MDS staff on accurate coding, to review the guidelines of the RAI manual. A review was done to all quarterly, annual, and significant change MDS to make sure they were coded accurately. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility acknowledges that all residents have the potential to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. A communication form between MDS coordinator and nursing team to ensure proper notification of resident changes, to improve nursing documentation to support the MDS and accurate coding. MDS coordinator or designee will audit assessment weekly to ensure proper coding, and report finding to the Director of Nursing (DON).	

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F 641	Continued From page 2 2. On 08/09/23 at 11:04 AM, the surveyor observed Resident #49 sitting in the chair with an [NJ Exec. Order 26:4.b] to his [NJ Exec. Order 26:4]. The surveyor reviewed the medical records of Resident #49, which revealed the following: The Quarterly MDS (QMDS), dated [NJ ex order 26.4b], reflected that the resident had a BIMS score of [NJ ex] out of 15, indicating that the resident's [NJ ex order 26.4b1] The QMDS Section N, Medications Received [NJ ex order 26.4b1] The Order Summary Report (OSR) in [NJ Exec. O] and [NJ Exec. Order 2] does not reflect [NJ Exec. Order 26:4.b.1] use in the facility. The Medication and Treatment Administration Record in [NJ Exec.] and [NJ Exec. Order 26] does not reflect [NJ Exec. Order 26:4.b.1]t use in the facility. The "[NJ ex order 26.4b1]" dated [NJ ex order 26.4b1] under [NJ ex order 26.4b1] On 08/18/23 at 12:05 PM, the surveyor interviewed the MDS Coordinator, who stated that he did not see the [NJ ex order 26.4b1] t the resident was taking in [NJ Exec.]. The MDS Coordinator added that the resident was going to the [NJ ex order 26.4b] and the [NJ ex order 26.4b] was given there. The MDS coordinator should capture the [NJ ex order 26.4b1] if provided in the facility. It should not be captured in the MDS	F 641	How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. The Director of Nursing or designee will review all audits monthly and corrective action will be taken as necessary. All results will be reported to the Quality Improvement Committee every 3 months for a year.	

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F 641	Continued From page 3	F 641		

assessment if given in the NJ ex order 26.4b1 [redacted]

3. On 08/10/23 at 11:20 AM, the surveyor observed Resident #52 sleeping in a bed covered with a blanket.

The surveyor reviewed the medical records of Resident #52, which revealed the following:

The SMDS dated [redacted], reflected that the resident had a BIMS score of [redacted] out of 15, indicating that the resident's NJ ex order 26.4b1 [redacted] The SMDS Section N, NJ ex order 26.4b1 [redacted] in the facility.

The OSR revealed that Resident #52 had a Physician's Order (PO) for NJ ex order 26.4b1 [redacted]

The Care Plan initiated on NJ ex order 26.4b1 reflected, Focus: NJ ex order 26.4b1 [redacted]

On 08/18/23 at 11:40 AM, the surveyor interviewed the MDS Coordinator and stated that the resident is taking NJ ex order 26.4b1 and it should be coded yes that the resident was receiving it during look back period.

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F 641	Continued From page 4	F 641		

4. The surveyor observed Resident #48 awake in bed on 8/9/23 at 12:03 PM.
The surveyor interviewed the unit Licensed Practical Nurse (LPN #1) on 8/18/23 at 11:32 AM. She stated the resident was admitted with an NJ ex order 26.4b1

The NJ ex order 26.4b Skilled Charting tool, documented by nursing, indicated the resident was NJ ex order 26.4b1 [redacted]

The NJ ex order 26.4b Admission MDS assessment tool indicated the resident was NJ ex order 26.4b1 [redacted] (Section H). The MDS did not indicate that the resident used an NJ ex order 26.4b1 [redacted]

On 8/18/23 at 12:55 PM the surveyor discussed with the Director of Nursing (DON) the Admission MDS coding error related to the use of an NJ ex order 26.4b1 .

On NJ ex order 26.4b the DON provided a modified (corrected) MDS to reflect the resident NJ ex order 26.4b [redacted]

5. On 8/10/23 at 12:22 PM, the surveyor observed Resident #84 in bed. The resident spoke another language but was able to understand English. The resident stated that he/she did not want to talk and was resting.

The surveyor reviewed the medical record for Resident #84.

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The Admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ ex order 26.4b1 [redacted]

The QMDS with an Assessment Review Date (ARD) of [redacted], reflected a BIMS score of [redacted] out of 15, indicating that the resident had a NJ ex order 26.4b1 [redacted] In addition, in NJ ex order 26.4b1 [redacted] Further review of Section N had conflicting information for the NJ ex order 26.4b1 [redacted]

A review of the Order Summary Report revealed a PO dated [redacted] for NJ ex order 26.4b1 [redacted] nd was currently an active PO and was being administered.

A review of the electronic medication administration record (EMAR) for NJ ex order 26.4b1 revealed a PO for NJ ex order 26.4b1 [redacted] with an administration time of 10 PM and nurse's signatures for administration for the month of NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted]

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NJ ex order 26.4b1

On 8/18/23 12:54 PM, the survey team met with the DON and Licensed Nursing Home Administrator (LNHA). The surveyor reviewed the MDS for Resident #84 and the DON stated that she would have to check with the MDS Coordinator.

On 8/21/23 at 9:30 AM, the survey team met with the DON and LNHA. The DON provided the surveyor with a modification to the MDS for Resident #84 completed by the MDS Coordinator.

On 8/21/23 at 10:25 AM, the surveyor interviewed the MDS Coordinator who stated that he had completed the modification of the MDS dated NJ ex order 26.4b for Resident #84 and confirmed that the MDS had inaccurate information for Section N. The MDS Coordinator stated that the nurse who completed the Section N was unaware that the electronic entries for psychiatrist consults had been changed and was no longer entered in progress notes and was being entered in the miscellaneous section. The MDS further explained that if the nurse had seen the psychiatrist consult notes then that would have helped the nurse to realize that they should have answered the following questions for the "NJ ex order 26.4b1 " correctly. The MDS Coordinator stated that he was responsible for the accuracy of the MDS.

NJAC 8:39-11.1, 11.2(e)(1)

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F 656	Continued From page 7	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		8/29/23

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F 656	Continued From page 8 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive, person-centered care plan addressing a resident's NJ Exec. Order 26:4.b.1 (Resident #48) and addressing a resident's NJ ex order 26.4b1 (Resident #52). The deficient practice was observed for 2 of 23 residents reviewed for comprehensive care plans and is evidenced by the following: 1. The surveyor observed Resident #48 awake in bed on 8/9/23 at 12:03 PM. The surveyor interviewed the unit Licensed Practical Nurse (LPN #1) on 8/18/23 at 11:32 AM. She stated the resident was admitted with an external NJ ex order 26.4b1 Additionally, the Certified Nursing Assistant (CNA #1) stated the resident NJ ex order 26.4b1 in the NJ Exec. Order 26:4.b.1 and called staff to be cleaned. A review of the hybrid medical record revealed the following information: The NJ ex order 26.4 Skilled Charting tool, documented by nursing, indicated the resident was NJ ex order 26.4b1	F 656	F- 0656 CARE PLAN POC SS = D How the corrective action will be accomplished for those found to have been affected by the deficient practice Resident # 48 NJ ex order 26.4b1 Resident # 52. NJ ex order 26.4b1 How the facility will identify other residents having the potential to be affected by the same deficient practice. It is the practice of Peace Care St. Joseph's to provide optimal care/services for the well-being. A review of the Comprehensive Care Plan policy was presented to	

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F 656	Continued From page 9 The [redacted] Admission Minimum Data Set (MDS) assessment tool indicated the resident was [redacted] (Section H). The comprehensive care plan did not include a Focus area for [redacted] or the use of an [redacted]. The care plan for [redacted] t on admission were noted to be related to [redacted]." Care plan interventions failed to address continence-related measures or interventions. 2. On 08/10/23 at 11:20 AM, the surveyor observed Resident #52 in bed, covered with a blanket. The surveyor reviewed the medical records of Resident #52, which revealed the following: The Significant MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] out of 15, indicating that the resident's [redacted] The SMDS Section O, [redacted] The Order Summary Report OSR revealed that Resident #52 had a Physician's Order (PO) [redacted] for [redacted]	F 656	the MDS coordinator and members of the interdisciplinary team. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Reviewing and updating Person centered -Care plans will be re-enforced with licensed staff and members of the interdisciplinary team, utilizing the RAI manual to initiate, revise or modify resident's care plan to reflect resident's current status. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. Unit managers will review all residents care plans three times weekly for the next 2 weeks using a care plan update tool. Then once a week for 4 weeks, once a month for two months then quarterly. Results will be reported to the nursing supervisor/designee/DON who will update the center's Quality Assurance Performance Improvement Committee monthly.	

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F 656	Continued From page 10 On 8/18/23 at 11:56 AM, the surveyor interviewed the LPN/UM and stated that the care plan upon admission to [NJ Exec. Order 26-4] was missed. On 8/18/23 at 12:55 PM, the surveyor discussed with the administrator and the Director of Nursing (DON) related to the missing care plan and did not provide further information. The facility policy titled "Comprehensive Care Plans" reviewed date on 2/2023 revealed under Policy Explanation and Compliance Guidelines: 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment."	F 656		
F 686 SS=G	NJAC 8:39-11.1 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		8/29/23

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F 686	Continued From page 11 This REQUIREMENT is not met as evidenced by: Complaint # NJ00161813 Based on interview and record review it was determined that the facility failed to provide effective care and services to promote [NJ ex order 26.4b1] [redacted] for 1 of 2 residents reviewed for [NJ Exec. Order 26:4.b.1]. Resident #105's [NJ ex order 26.4b1] was left untreated for more than a month. During this period the [NJ ex order 26.4b1]. The deficient practice was evidenced by the following: The surveyor reviewed Resident #105's closed hybrid medical record which revealed the following information. The Admission Record indicated the resident was admitted to the facility from the [NJ ex order 26.4b] on [NJ ex order 26.4b] The nurse documented in a [NJ ex order 26.4b] Admission Summary Progress Note that the resident had a [NJ ex order 26.4b1] [redacted] The nurse documented in a [NJ ex order 26.4b] Nursing Admission Screening/History report that the resident was [NJ ex order 26.4b1] [redacted] (not indicating whether left or right leg) and a [NJ ex order 26.4b1] [redacted]	F 686	F-0686 Treatment / Services to Prevent / Heal Pressure Ulcer S/S--G How the corrective action will be accomplished for those found to have been affected by the deficient practice. In this case Resident # 105, [NJ ex order 26.4b1] [redacted] All residents with wounds, with the assistance of the Wound Team, were reassessed to make sure that the care they are provided an affective treatment to promote improvement / healing of any and all wounds. Orders from the wound care provider are communicated to the Wound Team for immediate follow up. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents with wounds have the potential to be affected by this practice. The Wound	

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F 686	Continued From page 12 The resident's NJ ex order 26.4b1 initiated on NJ ex order 26.4b1 and revised on NJ ex order 26.4b1 listed a Focus area of "[resident] has potential for NJ ex order 26.4b1 An entry was added on NJ ex order 26.4b1 which read "noted with a NJ ex order 26.4b1 One intervention was added on NJ ex order 26.4b1 to apply an air mattress. All other care plan interventions were initiated on NJ ex order 26.4b1 consisting of general measures to prevent NJ ex order 26.4b1 . The NJ ex order 26.4b1 Admission Minimum Data Set assessment tool coded the resident as NJ ex order 26.4b1 Section C), having an NJ ex order 26.4b1 (Section I) and one NJ ex order 26.4b1 (Section M) present on admission. A NJ ex order 26.4b1 Report of Consultation written by the NJ ex order 26.4b1 A NJ ex order 26.4b1 Report of Consultation written by the same orthopedic physician indicated the NJ ex order 26.4b1 (NJ ex order 26.4b1 .) The orthopedic physician's NJ ex order 26.4b1 physical examination indicated the NJ ex order 26.4b1 The nurse documented in a NJ ex order 26.4b1 Wound-Weekly Observation Tool that a NJ ex order 26.4b1 and NJ ex order 26.4b1 " NJ ex order 26.4b1	F 686	Team will continue to round on a weekly basis. The change made to the current process (addressing the needs of the affected resident) are that all findings will be reported to the PeaceCare St. Joseph's team in real time for follow up treatment prior to the wound specialist exiting the facility for the day and ensuring that appropriate documentation / treatment of the wound has been provided. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. All nursing staff were in service regarding the facility policy on preventing pressure ulcers and promoting the healing process. All unit managers and nursing supervisors were in-service to reinforce the facility policy of pressure prevention to make sure proper treatment is done. Unit Manager will review treatment administration record daily for accuracy of wound treatment weekly in addition to skin assessment. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. Unit Manager / Designee will review treatment administration record daily for accuracy of wound treatment.	

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F 686	Continued From page 13 NJ ex order 26.4b1 A review of physician and nursing progress notes from NJ ex order 26.4b1 through NJ ex order 26.4 failed to reveal evidence of the development of a NJ ex order 26.4b1 A NJ ex order 26.4 Wound Consultation indicated the resident was observed with a NJ ex order 26.4b1 /upgrade to alternating pressure mattress. A review of NJ ex order 26.4b1 and NJ ex order 26.4b1 Treatment Administration Records failed to reveal a physician's order for a NJ ex order 26.4b1 There was a NJ ex order 26.4 physician's order t NJ ex order 26.4b1 A NJ ex order 26 Wound Consultation indicated the NJ ex order 26.4 A NJ ex order 26.4 Wound Consultation indicated the NJ ex order 2	F 686	Assistant Director of Nursing or designee will conduct weekly skin assessments which will be documented in the treatment administration records. All findings to be reported quarterly to the Quality Assurance committee for action. The Director of Nursing or designee will review these audit reports monthly (prior to the QA meetings) and take any / all appropriate action to prevent / facilitate healing as necessary. All findings will be reported quarterly to the Quality Assurance committee for action every quarter for a year.	

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F 686	Continued From page 14 A [redacted] Wound Consultation noted the [redacted] A review of the [redacted] TAR included a [redacted] physician's order for a [redacted] A second physician's [redacted] order was written on [redacted] for [redacted] A [redacted] (17:41) Health Status Note documented Resident #105 was [redacted] at 5:01 PM due to [redacted] The surveyor interviewed a unit Licensed Practical Nurse (LPN) on 8/17/23 at 11:47 AM. The LPN stated she did not remember Resident #105. She further stated the Wound Consultant discusses the proposed [redacted] with the unit nurse and the Consultant writes the order. The surveyor interviewed a unit Registered Nurse	F 686		

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F 686	Continued From page 15	F 686		

(RN) on 8/17/23 at 12:04 PM. The RN did not remember Resident #105. The RN stated the Wound Consultant discusses the recommended treatment with the unit nurses and the Consultant calls the physician who then writes the treatment order.

The surveyor interviewed the Director of Nursing (DON) and the Administrator on 8/17/23 at 12:30 PM. The DON stated the facility procedure is for the Wound Consultant to discuss the recommendations with the unit nurse. The unit nurse contacts the physician, who writes the order.
The DON stated Resident #105 was first observed with a NJ ex order 26.4b1 not on NJ ex order 26.4b1. She stated a NJ ex order 26.4b1 The DON was unable to provide evidence that a NJ Exec. Order 26:4.b.1 was initiated on NJ ex order 26.4b1. The DON stated that the nurse who first observed the NJ ex order 26.4b1 on NJ ex order 26.4b1 did not follow facility protocol by calling the primary physician with the Wound Consultant's recommendation. The nurse was terminated.

The surveyor interviewed the Wound Consultant on 8/18/23 at 11:47 AM. She stated that if the resident was receiving NJ ex order 26.4b1 she would have no way of knowing whether it was applied since the NJ ex order 26.4b1 She further stated she discusses NJ ex order 26.4b1 with the unit nurse. The unit nurse contacts the primary physician to write the order.

The Pressure Injury Prevention Guidelines, implemented 11/20/21 and reviewed/revised 2/20/23, was presented to the surveyor on

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F 686	Continued From page 16 8/16/23 by the DON. Step 9 stated that the effectiveness of interventions will be monitored through ongoing assessment of the resident NJ ex order 26.4b1. Considerations for needed modifications included development of a new NJ ex order 26.4b1 The Consulting Physician/Practitioner Orders policy, implemented 10/2021 and reviewed/revised 8/2023, was presented to the surveyor on 8/18/23 by the DON. Step 2 indicated the consulting physician/practitioner discusses the order recommendation with the nurse. The nurse contacts the primary physician to verify the order. NJAC 8:39-25.2(b)(c) NJAC 8:39-27.1(e)	F 686		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) assess for complications upon their return from the NJ Exec. Order 26:4.b.1 for 2 of 2 residents (Resident #61, and #49) and b.) consistently NJ Exec. Order 26:4.b.1 in accordance with the physician's order for 1 of 2 resident (Resident #49) reviewed for NJ Exec. Order 26:4.b.1.	F 698	F 0698 Dialysis s/s--E How the facility will identify other residents having the potential to be affected	8/29/23

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F 698	Continued From page 17 The deficient practice was evidenced by the following: 1. The surveyor observed Resident #61 awake in bed on 8/14/23 at 11:41 AM. At that time, the unit Licensed Practical Nurse (LPN #1) stated the resident went to the NJ ex order 26.4b1 on Tuesdays, Thursdays, and Saturdays. The LPN stated an assessment of vital signs and the [redacted] access site prior to leaving for the [redacted] and upon return from the [redacted] were documented in electronic nurse progress notes. A review of the hybrid medical record revealed the following information: The 6/15/23 Quarterly Minimum Data Assessment (MDS) tool indicated the resident [redacted] The Medication Review Report included an [redacted] physician order for [redacted] and [redacted] The RD Care Plan (initiated [redacted], revised [redacted] and [redacted]) instructed nursing staff to [redacted] The surveyor reviewed Nurse Progress Notes for 13 days in [redacted] and 6 days in [redacted] during which	F 698	by the same deficient practice. All Nurses were in-serviced and educated to monitor dialysis shunts and document in the resident's medical records as per facility policy on Pre and post dialysis days. Physician's orders were transcribed onto resident #61 and resident #49's medical records for nurses to [redacted] Resident #49 and resident #61 [redacted] in accordance with physician orders and documented as per facility policy. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The unit manager / nursing supervisor / or nursing designee will audit orders / check documentation for all residents receiving hemodialysis weekly for 4 weeks. The findings will be reported to the Dir of Nursing and the Quality Assurance team during these weekly audits and determinations will be reported to the QA Committee quarterly. The dialysis communication form between dialysis center and Peace care St. Joseph's have been revised and all nurses were in -serviced and educated before the form was implemented.	

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F 698	Continued From page 18 the resident went out for [NJ Exec]. Nursing documented a [NJ Exec. Order 26.4] assessment of the [NJ Exec] on 3 of 19 days. The surveyor interviewed the unit LPN #1 a second time on 8/15/23 at 9:35 AM. The LPN stated nursing should document vitals and access site assessments before and after the resident receives RD in the electronic progress notes. The surveyor discussed concerns with the Director of Nursing (DON) and the Administrator on 8/15/23 at 1:37 PM. During that discussion, no further information was provided by the DON or Administrator. On 8/16/23 at 1:38 PM the DON provided the surveyor with the facility policy and procedure for Hemodialysis, reviewed/revised 3/2023. Step 8 stated that "The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications." On 8/17/23 at 10:05 AM the DON stated to the survey team that the nurses were supposed to document the [NJ Exec. Order 26] assessments in the electronic progress notes. She further stated that this had been done inconsistently. 2. On 08/09/23 at 11:04 AM, the surveyor observed Resident #49 sitting in the chair with an NJ ex order 26.4b1 The resident stated	F 698	How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. Evening nursing supervisors to monitor post dialysis form documentation for compliance on dialysis days as per facility policy. Unit managers/designee to monitor post dialysis documentation daily for the next 30days and report findings to the DON. NJ ex order 26.4b1 resident #49 has been reviewed with nursing staff to ensure adherence. How the corrective action will be accomplished for those found to have been affected by the deficient practice. Residents medication administration and fluid restriction order was recalculated for all hemodialysis residents. How the facility will identify other residents having the potential to be affected by the same deficient practice. All nurses were in-serviced on Fluid Restriction orders, documentation and monitoring will be conducted as per physician's orders.	

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F 698	Continued From page 19 that NJ ex order 26.4b1 The surveyor reviewed the medical records of Resident #49, which revealed the following: The NJ ex order 26.4b1 Quarterly MDS tool indicated the resident had NJ ex order 26.4b1 Physician Orders for NJ ex order 26.4b1 at 2 PM" and "NJ ex order 26.4b1 " The care plan in NJ ex orde and NJ ex order 26 t does not reflect the order for NJ ex order 26.4b1 . The surveyor reviewed Progress Notes for 13 days in NJ Exec. O and 4 days in NJ Exec. Order 2, during which the resident went out for NJ Exec . There's no nursing documentation NJ Exec. Order 26.4 assessment of the NJ ex on 3 of those days. Seventeen days NJ Exec days did not have NJ Exec. Order 26.4 nursing assessments of the NJ ex order 26.4b1 On 08/15/23 at 11:04 AM, the surveyor interviewed the unit manager and stated there was no consistent documentation from the nurses/staff when the resident NJ ex order 26.4b1 On 8/15/23 at 1:37 PM, The surveyor discussed concerns with the DON; no further information was provided. On 8/16/23 at 1:38 PM, the DON provided the surveyor with the facility policy and procedure for Hemodialysis, reviewed/revised on 3/2023. Step 8 states, "The nurse will monitor and document the status of the resident's access site(s) upon	F 698	What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. All resident's on fluid restrictions will be monitored closely to ensure compliance as per facility policy. Residents and family members will be educated on the importance of following physician's orders and the need for compliance is being stressed. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. Registered dietician, unit manager, and nurse designee will audit twice a week for 4 weeks. The Registered Dietician/designee will review the results and report the findings to the Quality Assurance Improvement Committee monthly.	

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return from the dialysis treatment to observe for bleeding or other complications."

On 8/17/23 at 10:05 AM, the DON stated to the survey team that the nurses were supposed to document the [redacted] assessments in the electronic progress notes. She further stated that this was done inconsistently.

3. The Order Summary Report (OSR) for Resident #49 was revealed in the Physician's Order (PO) dated [redacted] for [redacted]

The Electronic Medication Administration Record (eMAR) in [redacted] reflected the above [redacted] order for [redacted]

The [redacted] eMAR reflected that nurses administered fluids 18 times outside the physician-ordered [redacted] for Nursing of [redacted]

[redacted]

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F 698	Continued From page 21 NJ ex order 26.4b1 [redacted]. On 8/14/23 at 11:36 AM, the surveyor interviewed the LPN/UM and stated that the resident goes out on pass with the son, who is both aware of the [redacted NJ Exec. Order 26:4.b.1]. The staff continued educating the resident and son on maintaining the [redacted NJ Exec.O] [redacted]. On 8/15/23 at 01:27 PM, the survey team met with the Licensed Nursing Home Director (LNHA) and Director of Nursing (DON) and did not comment further. The facility policy titled "Fluid Restriction" with the revised date of 08/14/2023 stated under "Policy: It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders."	F 698		
F 755 SS=D	NJAC 8:39-27.1(a) 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	F 755		8/29/23

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F 755	Continued From page 22 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to a.) accurately document the administration of medications in the electronic administration record and electronic treatment administration record, and b.) clarify duplicate physician's orders for an [redacted]	F 755	F 0755 PHARMACY SERVICES S/S- D Please clarify what AA Committee is (Findings from these audits will be presented to the Dir of Nursing for review.	

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F 755	Continued From page 23 document the NJ ex order 26.4b1 The deficient practice occurred for 5 of 9 residents, (Resident #34, #48, #49, #52 and #67) reviewed for medication management. 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: "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." This deficiency was evidenced by the following: 1. On 8/15/23 at 9:13 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN #1) preparing to administer four NJ ex order 26.4b1 [redacted]	F 755	These audits will also be brought before the AA committee). Good catch - typo - should have read Quality Assurance (QA) committee. How the corrective action will be accomplished for those found to have been affected by the deficient practice. Resident # 48 NJ ex order 26.4b1 All nurses were educated and re-in-serviced on medication administration with regards to how to clarify duplicate physician's orders before administration of medication. Nurse #1 was also monitored by the pharmacy consultant and will have weekly monitoring for 4 weeks during which time the findings will be reported to the Dir of Nursing and the QA committee. Licensed nursing staff were in-serviced regarding the need to call the doctor if a medication requires multiple tablets to obtain the required dosage and transcribe dosage onto the MAR to reflect what was administered. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving medications are at	

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F 755	Continued From page 24 #48. On 8/15/23 at 9:27 AM, the surveyor observed the RN #1 go into the room to administer medications to Resident #48. The surveyor with the RN #1 observed that there were already [redacted] oth with a date of [redacted] written in marker on the patches. Resident #48 stated that the other nurse NJ ex order 26.4b1 [redacted] On 8/15/23 at 9:30 AM, the surveyor observed the RN #1 NJ ex order 26.4b1 [redacted] On 8/15/23 at 9:32 AM, the surveyor, in the presence of the RN #1, interviewed the resident who stated that he/she thought the NJ ex order 26.4b1 [redacted] t was unsure. The resident then stated that he/she thought the NJ ex order 26.4b1 . The resident added that the nurses came in and NJ ex order 26.4b1 . Upon returning to the medication cart, the RN #1 electronically signed the physician's order (PO) for the NJ ex order 26.4b1 [redacted] The RN #1 stated that according to the electronic medication administration record (EMAR) the PO indicated only NJ ex order 26.4b1 [redacted] RN #1	F 755	potential risk for harm as a result of this deficient practice. Pharmacy consultant to audit all patch orders twice a week for 4 weeks to ensure proper ordering, placement for proper application and removal weekly for a 4 week periods. Findings to be reported to the Director of Nursing for appropriate corrective action as well as the QA committee. How the corrective action will be accomplished for those found to have been affected by the deficient practice. Pharmacy consultant to audit all patch orders twice a week for 4 weeks to ensure proper ordering, placement for proper application, and removal weekly for a 4 week periods. Findings to be reported to the Director of Nursing for appropriate corrective action as well as the QA committee. Pharmacy consultant to audit all patch orders twice a week for 4 weeks to ensure proper ordering, placement for proper application and removal weekly for a 4 week periods. Findings to be reported to the Director of Nursing for appropriate corrective action as well as the QA committee. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.	

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F 755	Continued From page 25 added that she thought there was a separate PO to remove th NJ ex order 26.4b1 on her shift. On 8/15/23 at 11:03 AM, the surveyor interviewed the RN #2 who stated that she was the acting unit manager. The surveyor, with the RN #2, reviewed electronically Resident #48's EMAR. The RN #2 stated that there was NJ ex order 26.4b1 both ordered for 8 AM. The RN #2 added that the 8 AM PO was the responsibility of the 12 midnight to 8 AM nurse's responsibility. The RN #2 also stated that there was a 9AM PO fo NJ ex order 26.4b1 hich was the responsibility of the 8 AM to 4 PM nurses' responsibility. The RN #2 stated she thought when the PO was changed that they forgot to discontinue the 9 AM PO. The RN #2 added that there was usually a PO to NJ ex order 26.4b1 On 8/15/23 at 12:40 PM, the surveyor interviewed the RN #2 who stated that she had spoken with Resident #48 and the resident NJ ex order 26.4b1 so she had discontinued the POs. The RN #2 also stated that there should be a removal PO for the NJ ex order 26.4b1 but was unable to find the documentation and was unable to speak to why there was no PO for the removal. The surveyor reviewed the medical record for Resident #48.	F 755	The Pharmacy consultant/designee will monitor RN #1 on medication administration. Dir of Nursing and pharmacy consultant to monitor MAR and TAR omissions for compliance weekly for the next 4 weeks and report to the QA committee All nurses will be re0inserviced on transcription of patch orders to include time of administration, time of removal, and site in which patch should be administered. Pharmacy consultant will audit all patch orders twice a week for 4 weeks to ensure proper entry, application, and removal for 4 weeks. Findings from these audits will be presented to the Dir. of Nursing for review. These audits will also be brought before the QA committee during the quarterly meetings. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. Pharmacy consultant to audit all patch orders twice a week for 4 weeks to ensure proper ordering, placement for proper application and removal weekly for a 4 week periods. Findings to be reported to	

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F 755	Continued From page 26 A review of the resident's Admission Record revealed diagnoses which included NJ ex order 26.4b1 [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care with a assessment reference date of [redacted], reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident NJ ex order 26.4b1 . A review of the NJ ex order 26.4b1 EMAR revealed a PO for 'NJ ex order 26.4b1 [redacted] Another PO was noted on the EMAR for 'NJ ex order 26.4b1 [redacted] with an administration time of 8 AM and was signed as administered by the nurses beginning from NJ ex order 26.4b1 . An additional PO was noted on the EMAR for 'NJ ex order 26.4b1 [redacted] with an administration time of 8 AM and was signed as administered by the nurses beginning from [redacted] and continued to [redacted]. The EMAR had no dates of when the above POs were started.	F 755	the Director of Nursing for appropriate corrective action as well as the QA committee. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Nursing supervisors / unit managers will monitor all MAR / TAR reports on a daily basis prior to nursing staff going off shift to obtain 100% compliance with MAR / TAR reporting. Any / all omissions will be reported to the Dir. of Nursing for the appropriate action. Pharmacy consultant to audit MAR / TAR for omissions two times per week for 4 weeks. Findings to be reported to the Dir. of Nursing and the QA committee at the next quarterly meeting Dir of Nursing and pharmacy consultant to monitor MAR and TAR omissions for compliance weekly for the next 4 weeks and report to the QA committee	

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F 755	Continued From page 27 A review of the Order Summary Report (OSR) revealed a PO dated NJ ex order 26.4b1 for "NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted] This PO was currently active. In addition, the OSR revealed a PO dated NJ ex order 26.4b1 for "NJ ex order 26.4b1 [redacted] Further review of the OSR revealed a PO dated NJ ex order 26.4b1 for NJ ex order 26.4b1 [redacted] his PO was currently active. In addition, the OSR revealed a PO dated NJ ex order 26.4b1 for NJ ex order 26.4b1 [redacted] There was no PO noted on the OSR that correlated with the EMAR for the 9 AM PO NJ ex order 26.4b1 [redacted] On 8/15/23 at 1:40 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor reviewed the duplicate PO for NJ ex order 26.4b1 [redacted] that had occurred on the medication administration observation and the NJ ex order 26.4b1 [redacted] Resident #48. The DON stated that she had reviewed the resident's	F 755		

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EMAR and saw that there were two (2) POs for a NJ ex order 26.4b1 to be applied at 8 AM and 9 AM. The DON also stated that the 9 AM NJ ex order 26.4b1 . The DON confirmed that the RN #1 should not have removed and replaced the NJ ex order 26.4b1 that had been applied at 8 AM.

On 8/16/23 at 10:12 AM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone. The CP stated that the facility had recently changed the provider pharmacy and had not met with the new provider pharmacy representative but was unable to speak to whether there were any issues with the change in provider pharmacy. The CP stated that the PO for a NJ ex order 26.4b1 would specify the site of application and would have to have a separate PO entered electronically to document the NJ ex order 26.4b1 .

On 8/18/23 at 9:30 AM, the DON provided the surveyor with the content of an inservice that was performed for the nurses after the medication observation on NJ ex order 26.4b1 to emphasize that for NJ ex order 26.4b1

A facility policy dated as implemented 2/15/23 and review/revised 8/14/23 for "Medication Administration" reflected that "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." In addition, the policy reflected to "Correct any discrepancies and report to nurse manager."

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A facility policy dated as implemented 2/15/23 and review/revised 8/14/23 for "Medication Transcription" reflected "To facilitate effective communication, documentation, and aid in prevention of medication errors, medication errors, medication orders should be clear and concise and free of potentially dangerous abbreviations. In addition, the policy indicates for "Order Clarification" that "The prescriber is contacted by nursing to verify or clarify an order (i.e., when the resident has allergies to the medication, there are contraindications to medications, significant drug interactions or presence, the directions are confusing." Further review of the policy reflected "If an Electronic Health Record (EHR) system is used, specific procedures should be followed and may differ slightly from the procedures for using paper physician order sheets, verbal telephone order sheets and MARs/TARs. Electronic systems also describe in the system user manuals procedures will vary between the various electronic systems available."

On 8/15/23 at 9:13 AM, during the medication administration observation, the surveyor observed the RN #1 preparing to administer four (4) medications, which included NJ ex order 26.4b1 [redacted] o Resident #48. The RN #1 stated that she did not have the NJ ex order 2 for Resident #48 in her medication cart.

At that time, the RN #1 reported to her supervisor at the nursing desk that she did not have the NJ ex order 26.4b1 for Resident #48.

On 8/15/23 at 9:32 AM, the surveyor observed the Infection Preventionist (IP) bring two NJ ex

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NJ ex order 26.4b1 to RN #1 at the medication cart. The IP stated that she had taken the NJ ex order 26.4b1 from the facility electronic back up supply.

On 8/15/23 at 9:38 AM, during the medication administration observation, the surveyor observed the RN #1 administer the NJ ex order 26.4b1 to Resident #48.

Upon returning to the medication cart, the surveyor observed the RN #1 electronically sign for the administration of the PO for NJ ex order 26.4b1 The RN #1 stated that the PO was for NJ ex order but all they had in the back up supply was NJ ex order 26.4b1 so she was administering NJ ex order 26.4b1 .

The surveyor reviewed the medical record for Resident #48.

A review of the resident's Admission Record revealed diagnoses which included NJ ex order 26.4b1

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care with a assessment reference date of NJ ex order 26.4b, reflected the resident had a brief interview for mental status (BIMS) score of NJ ex out of 15, indicating that the resident had an NJ ex order 26.4b1

A review of the NJ ex order 26.4b1 EMAR revealed a PO for NJ ex order 26.4b1

A review of the Order Summary Report revealed

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F 755	Continued From page 31 a PO dated [NJ ex order 26.4b] for NJ ex order 26.4b1 [redacted] give one tablet by mouth two times a day for [NJ Exec. O]." On 8/15/23 at 1:40 PM, the survey team met with the LNHA and the DON. The surveyor reviewed the [NJ Exec. Orde] administration for Resident #48. The DON verified that the facility backup supply had NJ ex order 26.4b1 [redacted] he DON acknowledged that the nurses should document what was administered on the EMAR. The DON stated that there should have been a PO for the NJ ex order 26.4b1 [redacted] The DON was unable to speak to why NJ ex order 26.4b1 was not available. On 8/16/23 at 10:12 AM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone. The CP stated that the EMAR must reflect what was being administered. The CP added that if the NJ ex order 26.4b1 was not available then the nurses should have documented that NJ ex order 26.4b1 [redacted] A facility policy dated as implemented 2/15/23 and review/revised 8/14/23 for "Medication Administration" reflected that "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." In addition, the policy reflected to "Administer medication as ordered in accordance with manufacturer specifications."	F 755		

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2. The surveyor reviewed the medical records for Resident #34 that revealed the following:

According to the OSR, Resident #34 had a PO for medications and treatments to be administered to the resident at different times of the day.

The [NJ ex order 26.4b1] eMAR revealed that the following medication that was due had no documentation of being administered:

- [NJ ex order 26.4b1].

The [NJ ex order 26.4b1] eTAR revealed that the following treatments that were due had no documentation of being administered:

[NJ ex order 26.4b1]

3. The surveyor reviewed the medical records for Resident #49 that revealed the following:

According to the OSR, Resident #49 had a PO for medications/treatments to be administered to the resident at different times of the day.

The [NJ ex order 26.4b1] eMAR revealed that the following medication that was due had no documentation of being administered:

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-NJ ex order 26.4b1 [redacted]

The NJ ex order 26.4b1 eTAR revealed that the following treatment that was due had no documentation of being administered:

NJ ex order 26.4b1 [redacted]

4. The surveyor reviewed the medical records for Resident #52 that revealed the following:

According to the OSR, Resident #52 had a PO for medications/treatments to be administered to the resident at different times of the day.

The NJ ex order 26.4b1 eMAR revealed that the following medication that was due had no documentation of being administered:

NJ ex order 26.4b1 [redacted]

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NJ ex order 26.4b1 [redacted]

The NJ ex order 26.4b1 eTAR revealed that the following treatments that was due had no documentation of being administered:

- NJ ex order 26.4b1 .
- NJ Exec. Order 26:4.b.1 [redacted] due.

5. The surveyor reviewed the medical records for Resident #67 that revealed the following:

According to the OSR, Resident #67 had a PO for treatments to be administered to the resident at different times of the day.

The NJ ex order 26.4b1 eTAR revealed that the following treatment that was due had no documentation of being administered:

NJ ex order 26.4b1 [redacted]

On 08/14/23 at 11:36, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) regarding the omitted medication and treatment administration signature in the eMAR/eTAR; she said she didn't know about it.

On 8/15/23 at 01:27 PM, the survey team met with the Licensed Nursing Home Director (LNHA) and Director of Nursing (DON) but did not comment further.

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F 755	Continued From page 35 The facility policy titled "Medication Administration" with the revised date on 08/14/2023 stated under Policy Explanation and Compliance Guidelines: 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR."	F 755		
F 812 SS=D	NJAC 8:39-11.2(b), 29.2(d) 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 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to sanitize and air dry steam table	F 812	F 812 Food Requirements Food Procurement, Store / Prepare /	9/8/23

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F 812	Continued From page 36 pans in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 8/9/23 at 11:48 AM, in the presence of the Food Service Director (FSD) and the Administrator, the surveyor observed the following: On a shelf near the wall of the kitchen, the surveyor observed eight quarter sized deep-set steam table pans stacked with water between them, 15 eighth sized steam table pans stacked with water between them, and 12 small square steam table pans stacked with water between them. The FSD stated that these should be air dried before stacking. The surveyor reviewed the ware washing policy and procedure dated 10/1/22, which revealed that once equipment or utensils onto a clean surface to air dry and once equipment and utensil are completely air dried, they can be returned to storage. NJAC 8:39-17.2(g)	F 812	Serve / - Sanitary SS = d How corrective action will be accomplished for this residents found to have been affected by the deficient practice (how team determined the root cause of each deficient practice and how they plan to address the underlying issues as well) #3 Revision - "Does not contain elements how the facility will correct the deficiency as it relates to the individual: 1. At the time of survey the surveyor observed the Dietary manager remove the nestled items from the drying rack and instruct the pot washer to rewash / sanitize and place the items in question back on the drying rack without stacking (nestling) the items. 2 "How did the facility correct the deficient practice immediately?" The surveyor observed the Dietary manager remove the damp items that were stacked. They were rewashed, sanitized, and placed in the rack separately for drying. 3 Measures that the facility will take or the systems it will alter to ensure that the problem does no recur? Aside from providing additional training to the pot washing staff as to the reasons why stacking wet items is potentially dangerous to the residents (as stated in the previous POC's listed below) an	

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additional drying rack was purchased to hold the wet items during the drying process.

4 How did the facility correct needed additional space?
No idea what that means - I believe there is adequate space available to accommodate the drying process.

5 Was additional drying rack purchased?
Yes

It was observed (at the conclusion of the noon meal) that a Dietary Pot Washer had washed and stacked clean pans that were damp without allowing sufficient time for them to completely dry creating a possible potential for microbial growth. The Dietary staff were counselled as to the potential hazards that could be created to our residents from storing damp pans. It was further noted at that time a large number of other items such as pots, pans and trays were awaiting to be washed. It was pointed out that space was limited so to prevent additional concerns it was noted that additional drying racks would assist from this sort of issue occurring in the future.

How the facility will identify other residents having the potential to be affected by the same deficient practice. (The POC must determine now the facility will determine the scope of the problem by identifying everyone who has the potential to be affected by the same practice that caused

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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F 812	Continued From page 38	F 812		

the deficiency to be cited).

The management team at PeaceCare St. Joseph's evaluated the washing / sanitation program and after observation it was determined that more space was needed to adequately space out pots, pans, and trays after washing to prevent the possibility of microbial growth. Based upon observation it was decided that proper space is need to allow for air drying before storage - this would be accomplished through the use of a new drying rack.

What measures will be put in place or systemic changes made to ensure that the deficient practice will no recur (The POC mu specify what will be done to ensure that the deficient practice is corrected and that the correction will be sustainable over time).

Based upon observation an additional dryer racks was implemented so that pots, pans, and trays can be properly spaced for drying prior to storage to prevent the possibility of microbial growth.

How will the facility monitor the corrective action to make sure that the deficient practice will not recur and what program will be put into place to monitor effectiveness of the systemic change.

The Dietary management team will, after each meal, check the drying and storage

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F 812	Continued From page 39	F 812	of all pots, pans, and trays to ensure items are not wet stored and that the items that we washed were properly separated so facilitate air drying. Date in which the corrective action will be completed 09/08/23	
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are	F 868		10/11/23

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F 868	Continued From page 40 necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to assure that the required staff attended the quarterly Quality Assurance (QA) meetings. This was identified for 2 of 2 quarterly QA meetings reviewed. This deficient practice was evidenced by the following: On 8/09/23 at 10:25 AM , the surveyor requested to review the QA meeting sign in sheets for the last 2 quarters dated April 26, 2023 and January 25, 2023 upon entrance. On 8/10/23 at 10:00 AM, the Administrator asked the surveyor for more time to locate the QA meeting sign in sheets. On 8/14/23 at 9:40 AM, the Administrator stated that he needed more time to find the QA meeting sign in sheets, as the person who was responsible for holding those documents is away on vacation and unable to be reached. He stated that he will look one more time in that person's office to locate the sign in sheets. On 8/15/23 at 9:24 AM, the Administrator stated that he cannot locate the QA meeting sign in	F 868	F 868 QAA Committee SS = E Please provide additional information regarding the 3rd Quarter QA meeting. The key project that the team had selected for the 3rd quarter was meal deliver. It was being reported by residents and families that the breakfast meal was being served cold. Upon investigation is was not that the breakfast meal was being served cold it was a matter of the meal being delivered at 7:30 A while many of the residents were still sleeping. The food was left at the resident's bedside so it was available to them when they woke up. By that time the meal was cold and many residents didn't ask staff to head it up. By move the meal delivery time from 7:30A to 8:30A a successful change of shift had occurred morning shift reported in at 8:00A) and meals were being eaten at the proper temperature. This will be an on-going monitoring going forward to ensure meals being served at the proper	

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F 868	Continued From page 41 sheets and that there were QA meetings held in January 2023 and April 2023. The Administrator stated that he does not know who attended these meetings and he cannot prove that the correct individuals were in attendance. The Administrator stated that he and the Director of Nursing are in the process of monitoring the April 2023 QA meeting concerns and that there will be another QA meeting this month after survey is over. The surveyor reviewed QA plan and QA monitoring policy and procedure with a revised date of 4/24/23, which revealed that the facility's QA committee meets quarterly to analyze data collected through planned and routine data collection activities and the committee shall consist of at a minimum of the Director of Nursing Services, Medical Director, Infection Preventionist, and at least three other members of the facility's staff. N.J.A.C. 8:39-33.1 (b)	F 868	temperature. How corrective action will be accomplished for these residents found to have been affected by the deficient practice (how team determined the root cause of each deficient practice and how they plan to address the underlying issues as well) At the time of the survey inspection, it was determined that the QAA sign in sheets, which identified members of the PeaceCare St. Joseph's team present at each Quarterly meeting, were not available. The team consists of the Dept Head conducting the QAA project, members of the Dept evaluating the issue, the Dir of Nursing, Infection Preventionist, Administrator, and the Medical Director. Since it was determined that the sign in sheets could not be located (but the projects were prevented for review) it was decided that going forward the attendance sheets should be scanned into a "share drive" where key management staff could access them upon request. How the facility will identify other residents having the potential to be affected by the same deficient practice. (The POC must determine now the facility will determine the scope of the problem by identifying everyone who has the potential to be affected by the same practice that caused the deficiency to be cited).	

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F 868	Continued From page 42	F 868		

The management team at PeaceCare St. Joseph's recognizes the need to have the QAA sign in sheets available for review and believe by scanning them into a "shared drive" after each meeting going forward will address the problem of presenting them to the survey team for inspection going forward.

What measures will be put in place or systemic changes made to ensure that the deficient practice will no recur (The POC mu specify what will be done to ensure that the deficient practice is corrected and that the correction will be sustainable over time).

It has ben determined that having a sole individual responsible for maintaining the educational materials and in-service documents for the entire facility is not in the best interests of PeaceCare St. Joseph's. By having this issue come to light the team decided that we needed to come up with a more user friendly plan and by having the QAA project, as well as the attendance sheets, scanned into a "shared drive" for management access our concern will no longer be an issue.

How will the facility monitor the corrective action to make sure that the deficient practice will not recur and what program will be put into place to monitor effectiveness of the systemic change.

PeaceCare management will monitor the

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F 868	Continued From page 43	F 868	minutes of each QAA meeting to ensure that they are properly scanned in and stored on a "shared drive" so that they will be available for inspection upon requests. Date in which the corrective action will be completed 10/11/23	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		8/29/23

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F 880	Continued From page 44 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 45 Based on observation, interview, and record review, it was determined that the facility failed to a.) adhere to accepted standards of infection control practices for the proper disposable of gloves, b.) implement hand hygiene between glove changes during care, and c.) perform proper hand washing to prevent the spread of infection during care and preparation of food. This deficient practice was evidenced by the following: On 8/10/23 at 12:15 PM, the surveyor observed meal service in the 3rd-floor dining room. The dietary aide (DA) doffs gloves and places them on the cart used for food preparation in front of her. The DA continued to prepare the food after removing the gloves and did not perform hand hygiene. The surveyor got the DA's attention, then went to the sink and washed her hands. The surveyor observed the DA performing hand washing. The aide washed her hands for 18 seconds and did not completely wipe off her hands with the paper towel, and the water dripped onto both hands. The dietary aide was asked how long they should be handwashing; she responded 20 seconds and did not comment further. On 8/10/23 at 12:44 PM, while passing in the hallway, the surveyor observed the certified nursing aide (CNA #1) going out of the resident's room wearing gloves, touching the soiled linen cart cover, and returning to the resident's room without doffing and performing hand hygiene. The surveyor interviewed the aide, stating that she left the resident's room to look for her co-worker to help her and didn't realize she was wearing gloves. CNA #1 added that the gloves should not wear out of the hallway and perform hand washing after removing the gloves. The aide did	F 880	F-0880 INFECTION CONTROL POC S/S---D How the corrective action will be accomplished for those found to have been affected by the deficient practice. Certified Nursing Assistant # 1 on the 3rd floor has been in-serviced on infection prevention and control practices. Including the facility policy regarding wearing gloves in the hallway. She was also in-serviced on proper use of PPE to decrease the possibility of the spread of infections. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Infection preventionist/designee provided in-service education to all staff regarding facility policy on standard precautions and proper doffing of PPEs. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Infection Preventionist will observe and document performance of the Certified Nursing Assistant # 1 regarding infection prevention and control practices weekly for the next 3 months. How the facility will monitor its corrective	

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F 880	Continued From page 46 not comment further on touching the soiled linen cover. On 8/10/23 at 01:15 PM, the surveyor interviewed the unit manager (UM). The UM stated that the aide should not wear gloves in the hallway, touch soiled linen cover and return to the resident's room wearing the same gloves they are supposed to wash their hands after removing the gloves. On 8/18/23 at 01:00 PM, the surveyor reviewed the above observations with the Administrator and the Director of Nursing (DON). The DON stated that she did the handwashing in-service for all the staff that day of 8/10/23, including weekends, but did not know about the dietary aide staff. The DON added that she would add the dietary/kitchen for the in-service in proper handwashing. The facility policy titled "Subject: Handwashing/Hand Hygiene," with the reviewed date of 5/23/23, stated under "Policy Interpretation and Implementation 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. continues on next. Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. 3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. Applying and Removing Gloves, 5. Perform hand	F 880	actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. Random observation audits initiated on all units on daily basis for compliance by IP nurse, unit managers, supervisors. The Infection Prevention Nurse will report findings of the random audit on monthly QAPI meetings for the three months. Infection Preventionist/ designee to re-in-service all staff on proper hand washing and to do random hand washing competencies on staff daily for the next 30 days.	

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F 880	Continued From page 47 hygiene." The facility policy titled "Handwashing Guidelines for Dietary Employees" with the reviewed date of 8/22/23, stated under "7. Handwashing Procedure: 4. Rub together vigorously for at least 20 seconds, 8. Thoroughly dry and turn water off with paper towels touching faucet handles." The facility policy titled "Personal Protective Equipment" with the reviewed date of 8/16/2023 stated under "Policy Explanation and Compliance Guidelines: 4 Indications/considerations for PPE use: a. Gloves: vii. Dispose of gloves in appropriate waste receptacle." NJAC 8:39-19.4(a)(1)	F 880		

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S 000	Initial Comments Complaint # NJ00163644 THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS. COMPLAINT INVESTIGATIONS WERE ALSO COMPLETED DURING THIS SURVEY.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00163644 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following:	S 560	S 0560 Staffing SS = Please include how the deficient practice	9/29/23

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

Electronically Signed | 09/05/23

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S 560	Continued From page 1 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 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	S 560	is resolved. PeaceCare St. Joseph's staff's in excess of the State standards. On the days of survey we had numerous call outs (no one wants to be here when the State is around). That said I do not believe any facility in the State of NJ is immune from the staffing crisis. When we know in advance we are not going to meet the required staffing ratios for the day we utilize our connections with the several staffing agencies we are contracted with. During survey we should have recorded the time of our unit secretaries (who are also CNA's) and brought in someone else to cover the desk for the day(s) but we do not know until the last minute that staff were not coming to work. It is no surprise to anyone that people just do not want to work anymore and they have no dedication to the facility or the residents who trust them for their care. We can only plan for that shift and hope that staff will come to work. How are you increasing CNA staffing. Include creative way to increase CNA staff. We have created a program to hire nurse aides (non-certified staff) to make beds, transport, and pass water pitchers freeing up the CNA staff to spend more time doing clinical functions. How corrective action will be accomplished for this residents found to have been affected by the deficient	

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(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 2 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. (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 ... 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 10/09/2022 to 10/15/2022 revealed the following: -10/09/2022 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. 2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 07/23/2023 to 08/05/2023 revealed the following: -07/24/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -07/30/23 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. The surveyor discussed the staffing ratios concerns with the Director of Nursing and the Administrator, who stated they were aware of the staffing ratio criteria.	S 560	practice (how team determined the root cause of each deficient practice and how they plan to address the underlying issues as well) As we all know staffing in the healthcare industry is a tremendous concern. No matter how well we think we have the shifts covered we can never anticipate the number of "call outs" that might occur and staff around them. The Management team at PeaceCare St. Joseph's meets on a daily basis to discuss staffing and makes every effort to ensure that we are compliant with the daily staffing requirements. We have gone as far as to open our facility to training schools for not only LPN's but CNA's. We offer sign on bonuses and referral fees and still can not attract / retain staff. Most recently we have begun looking into hiring non-certified staff to be "bedmakers" who, if they demonstrate any desire to join the nursing staff, are enrolled into a training program at our expense. We also contract with several staffing agencies and yet they can not always successfully staff our facility. How the facility will identify other residents having the potential to be affected by the same deficient practice. (The POC must determine now the facility will determine the scope of the problem by identifying everyone who has the potential to be affected by the same practice that caused the deficiency to be cited). All residents and co-workers are affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030905	A. BUILDING: _____ B. WING _____	C 08/22/2023

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S 560	Continued From page 3	S 560	by the lack of staffing and we are constantly looking for creative ways to attract new staff to our team. What measures will be put in place or systemic changes made to ensure that the deficient practice will no recur (The POC mu specify what will be done to ensure that the deficient practice is corrected and that the correction will be sustainable over time). Again we have contracted with outside agencies for supplemental staffing, we have partnered with certification / licensing programs to bring additional staff to our facility and as much as it is slowly coming to a place that staffing is meeting or exceeding State standards all it takes is a few "call outs" and we are back in a position where we risk failing to meet our daily staffing requirements. How will the facility monitor the corrective action to make sure that the deficient practice will not recur and what program will be put into place to monitor effectiveness of the systemic change. The Dir of Nursing, Staffing Coordinator, HR Director, and the Administrator meet on a daily basis to review staffing and discuss ways to creatively recruit staff. Date in which the corrective action will be completed 09/08/23	

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
315452 Y1	A. Building B. Wing Y2	10/16/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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 F0686	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/29/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
8/22/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030905 Y1	A. Building B. Wing Y2	10/16/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/29/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
8/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING _____ B. WING _____	R-C 10/16/2023

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PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 10/16/2023 to confirm the facility's POC compliance regarding teh 8/22/2023 Recertification survey. The facility was found to be in compliance.	{F 000}		

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

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
	315452	A. BUILDING **01** B. WING _____	**08/22/2023**

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K 000	INITIAL COMMENTS LIFE SAFETY CODE 101:2012 The facility is not in substantial compliance with the Minimum Life Safety Code requirements as surveyed under CMS-2786R.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/10/2023, in the presence of the Maintenance Director (MD) and Administrator (ADMIN), it was determined that the facility failed to provide a battery backup emergency light above the electric fire pump transfer switch independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 19.2.9.1.- 7.9.1 (general) This deficient practice was identified for 1 of 3 transfer switches observed and was evidenced by the following: At 11:48 AM, the surveyor, in the presence of the MD and ADMIN observed one (1) fire pump transfer switch in the ground floor fire pump room. The fire pump room observed was not provided with any emergency lighting independent of the building's electrical system and emergency generator. The MD and ADMIN confirmed the findings at the time of the observation.	K 291	K 0291 Emergency Lighting (LSC 2012 Health Existing) SS = F How corrective action will be accomplished for this residents found to have been affected by the deficient practice (how team determined the root cause of each deficient practice and how they plan to address the underlying issues as well) Once it was identified the Maintenance Director had the electrician install an Emergency Backup light in the boiler room. How the facility will identify other residents having the potential to be affected by the same deficient practice. (The POC must	8/29/23

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

Electronically Signed | 09/01/2023

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

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K 291	Continued From page 1 The Administrator was informed of the findings at the Life Safety Code exit on 8/10/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	determine now the facility will determine the scope of the problem by identifying everyone who has the potential to be affected by the same practice that caused the deficiency to be cited). All residents have the potential to be effected by this deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will no recur (The POC must specify what will be done to ensure that the deficient practice is corrected and that the correction will be sustainable over time). This newly installed emergency back up light will be monitored on a weekly basis by the Maintenance Dir (or supervisor). The monitoring of the emergency back up light was added to the TELS system an the Maintenance Dir (supervisor / designee) was educated how to monitor this in the TELS system. The findings of the weekly monitoring will be report to the QAPI committee on a quarterly basis for one year Date in which the corrective action was completed 08/29/23	
K 531 SS=F	Elevators	K 531		9/8/23

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K 531	Continued From page 2 CFR(s): NFPA 101 Elevators 2012 EXISTING 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 observation, interview, and record review on 8/9/23 in the presence of the Maintenance Director (MD) and Administrator (ADMIN), A).it was determined that the facility failed to ensure that there was documented evidence that 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 conformed 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.19.5.3, 9.4.2, 9.4.3). B). it was determined that the facility failed to ensure 5 of 5	K 531	K 0531 NFPA 101 Elevators (LSC 2012 Health Existing) SS = F How corrective action will be accomplished for this residents found to have been affected by the deficient practice (how team determined the root cause of each deficient practice and how they plan to address the underlying issues as well)	

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K 531	Continued From page 3 elevator's as per the City of Jersey City elevator inspection report's dated: 3/3/21, were inspected annually. This deficient practice was evidenced by the following: A). At 10:30 AM, the surveyor reviewed all LSC documentation provided by the MD. The monthly testing of the firefighters 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 was not provided. An interview was conducted with the MD, during the record review. He confirmed there was no current firefighter's monthly service log for 5 of 5 elevator devices. B). At 10:45 AM, the surveyor reviewed all elevator documentation provided by the Maintenance Director dated 3/3/21. The annual elevator inspection was approved for use until: 3/31/22 and was not inspected in over 17 months. The Maintenance Director in an interview during document review indicated that he called the "Elevator Construction Code Division department" and was informed that the city was short one elevator inspector and they were currently behind doing elevator inspections. The Administrator was informed of the findings at the Life Safety Code exit conference on 8/10/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3 & 9.4.3 Fire Fighters Emergency Operations: 9.4.3.2	K 531	It was determined that the elevators at PeaceCare St. Joseph's had not been inspected in keeping with ASME A17.1 nor was the Fireman' Service documented / tested on a monthly basis. As evidenced by the documentation provided at the time of this survey the Administrator of PeaceCare St. Joseph's had continued to pay the annual licensing / inspection fees to the City of Jersey City during the entire Covid period and had the elevators routinely serviced by Otis Elevator since the City of Jersey City would not come to inspect the elevators. The City of Jersey City, even after numerous calls, failed to send inspectors to the facility. The Administrator of PeaceCare St. Joseph's was finally able to reach the Mayor of Jersey City as well as the Councilman for the ward and explain the problem . After placing the call to the Mayor and Councilman the Inspector arrived at PeaceCare St. Joseph's and the elevators were successfully certified as to be in proper working order. Going forward the director of maintenance and the maintenance supervisor will inspect and document, on a monthly basis, that the Fireman's Service Recall equipment is in proper working order (since it was stated by the State Inspector this does not need to be done by the city inspector). These findings were (and will be) recorded on a monthly basis for one year in the electronic TELS reporting system and the finding of this testing will be presented to the QA committee on a quarterly basis for one year.	

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K 531	Continued From page 4	K 531	How the facility will identify other residents having the potential to be affected by the same deficient practice. (The POC must determine now the facility will determine the scope of the problem by identifying everyone who has the potential to be affected by the same practice that caused the deficiency to be cited). All residents have the potential to be effected by this deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will no recur (The POC mu specify what will be done to ensure that the deficient practice is corrected and that the correction will be sustainable over time). The monitoring has been added to the TELS system and the Maintenance Dir / superior have been educated about the monitoring of the elevator in the TELS system. How will the facility monitor the corrective action to make sure that the deficient practice will not recur and what program will be put into place to monitor effectiveness of the systemic change. The results of the monitoring will be presented to the QAPI committee on a quarterly basis for one year.	

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 531	Continued From page 5	K 531	Date in which the corrective action was completed 09/08/23	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on observation and interview on 8/9/23 and 8/10/23, in the presence of the Maintenance Director (MD) and Administrator (ADMIN), it was determined that the facility failed to ensure A). the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. B). the seperation from the old building to the new building had doors that were labeled with the fire	K 761	K 0761 NFPA 101 Maintenance, Inspection, & Testing - Doors (LSC 2012 Health Existing) SS = F How corrective action will be accomplished for this residents found to have been affected by the deficient	9/22/23

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K 761	Continued From page 6 rating as per NFPA 80. This deficient practice was observed for 11 of 11 doors observed. This deficient practice was evidenced by the following: A). At 09:00 AM document review indicated that the fire door assemblies were not inspected and tested annually in accordance with NFPA 80 Standard for fire doors. The Maintenance Director was interviewed at the time of the document review and he confirmed the fire doors were not inspected annually and could not provide a log indicating so. B). While touring the building from 09:30 AM, to 12:15 PM, on 8/10/23 the surveyor, MD, and ADMIN observed 2 of 3 sets of fire doors seperating the old section to the new section of the building on all four floors were not labeled with 90 minute fire rating as per NFPA 80. The MD and ADMIN in an interview both confirmed the findings while touring the facility on 8/10/23. The Administrator was informed of the findings at the Life Safety Code exit conference on 8/10/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 761	practice (how team determined the root cause of each deficient practice and how they plan to address the underlying issues as well) At the time of the survey inspection it was determined PeaceCare St. Joseph's had not conducted annual tests on Fire Doors in keeping with NFPA 80 and that several fire rating tags on existing doors at the facility were not available (or had been painted over). PeaceCare St. Joseph's has contracted with a certified door technician who has the knowledge and understanding of door operations to comply with the NFPA 101 Life Safety Code. The report of his findings is available for the State inspector's review. How the facility will identify other residents having the potential to be affected by the same deficient practice. (The POC must determine now the facility will determine the scope of the problem by identifying everyone who has the potential to be affected by the same practice that caused the deficiency to be cited). The maintenance director and maintenance supervisor at PeaceCare St. Joseph's have contracted with a certified door technician who has the knowledge and understanding of door components in keeping with NFPA 101 Life Safety Code. The doors have been re-inspected and their report is available for the State Inspection upon request. Going forward the doors will be inspected on a monthly	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE** **JERSEY CITY, NJ 07306**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 7	K 761	basis and an annual report with be provided by the qualified individual. To insure proper operation of these doors the findings of these inspections will be reported to the QA committee on a quarterly basis. Any and all necessary repairs will be made to ensure compliance at the time of the occurrence. All residents have the potential to be effected by this deficient practice What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur (The POC must specify what will be done to ensure that the deficient practice is corrected and that the correction will be sustainable over time). Going forward all doors will be inspected on a monthly basis by the maintenance director / supervisor / designee and a reports will be provided identifying any issues / concerns that might have developed will be made at that time. Any concerns will be corrected at the time of the inspection. The doors will also be certified by the qualified technician on an annual basis going forward. Maintenance director will educate the supervisor on this process. How will the facility monitor the corrective action to make sure that the deficient practice will not recur and what program will be put into place to monitor effectiveness of the systemic change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING **01** B. WING _____	**08/22/2023**

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PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE** **JERSEY CITY, NJ 07306**

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K 761	Continued From page 8	K 761	Monthly reviews of this monitoring will be presented to the QAPI committee on a quarterly basis for a period of one year. Date in which the corrective action will be completed 09/22/23	

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
315452 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/20/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	08/29/2023	LSC K0531	09/08/2023	LSC K0761	09/22/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO