

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

PRINTED: 08/20/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/18/2025
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MEADOW LAKES EAST WINDSOR, NJ 08520		
(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 Survey Date: 3/18/25 Complaint: # NJ 177680 Census: 49 Sample: 13 + 2 Closed Records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		5/1/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/20/2025

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

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of documentation, it was determined that the facility failed to provide a dignified dining experience by failing to a) provide NJ Exec Order 26.4b1 care to a resident prior to providing the lunch meal, and b) appropriately provide dining assistance in a dignified manner, and ensure appropriate resident engagement during the lunch meal. This deficient practice occurred for 4 of 4 residents (Resident #13, #27, #29 and #46) reviewed for dining and was evidenced by the following: 1. On 3/12/25 at 12:06 PM, the surveyor observed Resident #13 in the day room next to a Certified Nursing Aide (CNA) #1 who was preparing to assist the resident with the lunch meal. The surveyor NJ Exec Order 26.4b1 and then observed Resident #13's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 . At that time, CNA #1 stated that the	F 550	Correction; The Director of Nursing (DON) reviewed the care plan for Resident #13 and confirmed that existing interventions remain appropriate. The Director of Nursing identified during a pre-lunch observation, the noted that the resident required assistance with NJ Exec Order 26.4b1 care one hour before the meal. The care plan was updated to reflect this specific need. The interdisciplinary team, including the unit nurse, certified nursing assistant, dietitian, NJ Exec Order 26.4b1 nurse and aide, DON, and Unit Manager, reviewed Resident #29's care plan. The team confirmed that the interventions are appropriate and address the resident's current needs.		

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F 550	<p>Continued From page 2</p> <p>resident required [redacted] and had been provided with [redacted] that morning. The surveyor then inquired if the resident had been provided with [redacted] prior to serving the meal. CNA #1 confirmed that they had not provide [redacted] prior to serving the resident the meal, and proceeded to assist Resident #13 with the meal without first [redacted] the resident's [redacted].</p> <p>On 3/12/25 at 12:37 PM, CNA #1 [redacted] the resident to bed with a [redacted]. Upon observation of the resident, the surveyor observed that Resident #13 was [redacted] with [redacted].</p> <p>A review of the Face Sheet for Resident #13 revealed diagnoses which included but were not limited to [redacted].</p> <p>[redacted]. A review of the individual comprehensive care plan (ICCP) dated [redacted] to present, included a focus area of at risk for [redacted] to being [redacted] with Activities of Daily Living (ADL)s and [redacted]. Interventions included to provide [redacted] and "maintain my dignity during episodes of [redacted]. A review of the Monthly Summary Evaluation completed [redacted], included but was not limited to; [redacted] requests, [redacted] and [redacted] and was [redacted] on the staff for ADLs.</p> <p>A review of the facility provided policy, "Incontinent Care" revised 4/3/24, included but was not limited to; Policy: to provide cleansing ... and to maintain skin integrity incontinent care will</p>	F 550	<p>Resident #27's care plan was reviewed by the interdisciplinary team and determined to be appropriate. The Director of Nursing and Administrator met with the resident and [redacted] to inform them of a surveyor's findings regarding CNA #2 cutting the resident's food without permission or communication. Both the [redacted] US FOIA (b)(6) issued an apology. The [redacted] accepted the apology and confirmed [redacted].</p> <p>The Administrator offered assistance with food cutting moving forward, but the resident declined.</p> <p>The care plan for Resident #46 was reviewed by the Director of Nursing and Unit Manager and confirmed to meet the resident's current needs. The [redacted] US FOIA (b)(6) met with the resident and [redacted] to discuss the surveyor's observations from 3/12/25, and both extended apologies.</p> <p>Identify</p> <p>All residents have the potential to be affected by this deficient practice. The DON and UM conducted observations before and during mealtimes and reviewed care plans to ensure all interventions align with resident needs. Care plans were updated as needed, including those for residents requiring toileting assistance prior to meals or modifications to meal consistency.</p> <p>Systemic Changes</p>		

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	<p>Continued From page 3</p> <p>be provided as needed and according to the resident's care plan.</p> <p>2. On 3/12/25 at 12:04 PM, the surveyor observed CNA #2, was assisting Resident #29 with the lunch meal, and while assisting the resident she conversed with another CNA who was also assisting another resident with the meal and was behind Resident #29. CNA #2 then spoke over Resident #29 and began complaining about the kitchen staff, and stated "NJ Ex Order 26.4(b)(1) [REDACTED]" CNA #2 then without saying anything to Resident #29, stood up in the middle of assisting Resident #29 and walked to the back table, and then picked up the utensil for Resident #46 and handed it to the resident and returned to assist Resident #29.</p> <p>On 3/12/25 at 12:14 PM, CNA #2 again stood up from assisting Resident #29 and began removing dirty dishes, and then went back to Resident #29 and offered a drink to Resident #29 and stated, "you gonna eat?"</p> <p>On 3/12/25 at 12:22 PM, CNA #2 again stood up from assisting Resident #29, walked to another table and picked up Resident #27's knife, and while standing at the opposite side of the table began to cut Resident #27's food with one hand. CNA #2 then again returned to sit next to Resident #29.</p> <p>On 3/12/25 at 12:38 PM, CNA #2 began to NJ Ex Order 26.4(b)(1) and Resident #29 NJ Ex Order 26.4(b)(1) and Resident #29 NJ Ex Order 26.4(b)(1) in front of the NJ Ex Order 26.4(b)(1) and CNA #2 stated, "NJ Exec Order 26.4(b)(1)?" and CNA #2 proceeded to give the resident the NJ Ex Order 26.4(b)(1).</p>		<p>The Director of Nursing provided in-service training to all licensed nurses and Certified Nurse Aides on F550 – Resident Rights / Exercise of Rights. The training emphasized residents' rights to dignity, respect, and self-determination, as well as individualized care that supports quality of life. Staff were also educated on the importance of updating care plans promptly to reflect changing needs and to ensure interdisciplinary team members, including Certified Nurse Aides, are informed of those updates.</p> <p>Dining Room responsibilities were added to the nurse aide assignments in order to ensure sufficient coverage to serve residents without interruption.</p> <p>An Observational Rounds form was developed to record outcomes of dining observation and added to the Quality Assurance and Performance Improvement Plan. Nurse Supervisors were assigned to observe the dining room as well as observe random assistance being provided in other areas where meal service is occurring.</p> <p>An Observational Rounds Form was developed to record observations of incontinence care and added to the Quality Assurance and Performance Improvement Plan.</p> <p>Monitoring: The Director of Nursing or designee will conduct an audit of the Dining Room and Dayrooms weekly for 4 weeks, monthly</p>		

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F 550	<p>Continued From page 4</p> <p>On 3/12/25 at 12:50 PM, the surveyor interviewed CNA #2 regarding speaking over Resident #29, and leaving, assisting other residents. CNA #2 stated, "no" we cannot talk over the resident, and the resident is a [redacted] CNA #2 stated there was supposed to be four people in the dining room and "I don't know what happened."</p> <p>On 3/12/25 at 1:30 PM, the surveyor reviewed the medical record for Resident #29 which revealed a Care Plan Problem, I have [redacted] and am [redacted] for my care needs due to [redacted] and [redacted] ... Interventions, undated, included "approach in a [redacted] and [redacted] Another Problem, revealed [redacted] under [redacted] Care, resident with [redacted] needs due to [redacted] requires [redacted] and [redacted] at meals</p> <p>On 3/14/25 at 12:58 PM, the survey team met with the facility to discuss the above concerns.</p> <p>On 3/18/25 at 10:05 AM, the [redacted] US FOIA (b)(6) and the [redacted] US FOIA (b)(6) met with the survey team. The [redacted] US FOIA (b)(6) stated the staff was educated to include [redacted] scheduling and that [redacted] care was to be done as soon as resident needs the care. The [redacted] US FOIA (b)(6) further stated that definitely no matter where and what, that if a resident needed [redacted] care, it should be done immediately. In referencing the dining room observations, the [redacted] US FOIA (b)(6) stated that there were not enough people in the dining room.</p> <p>The Resident Rights Policy, Revised 12/3/24, revealed the facility will treat its resident in a manner that promotes and enhances the quality of life of each resident, ensuring dignity, choice</p>	F 550	<p>for 3 months and quarterly for 2 quarters. An Observational Rounds form will be used to identify and record observations. The audit results will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly for two quarters and the Committee will determine if the audit requires continuation or is deemed completed in October 2025.</p> <p>The Director of Nursing or designee will conduct observations of 5 residents who have cognitive and functional impairment, weekly for 4 weeks, monthly for 3 months and quarterly for 2 quarters. An Observational Rounds form will be used to identify and record observations. The audit results will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly for two quarters and the Committee will determine if the audit requires continuation or is deemed completed in October 2025.</p>	

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F 550	Continued From page 5 and self determination.	F 550			
F 640 SS=F	<p>NJAC 8:39-4.1(a); 27.1(a)</p> <p>Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)</p> <p>§483.20(f) Automated data processing requirement-</p> <p>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. <p>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.</p> <p>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. 	F 640		4/18/25	

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F 640	<p>Continued From page 6</p> <p>(iv) Significant correction of prior full assessment.</p> <p>(v) Significant correction of prior quarterly assessment.</p> <p>(vi) Quarterly review.</p> <p>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.</p> <p>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.</p> <p>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review it was determined that the facility failed to consistently ensure Minimum Data Set (MDS) assessments were submitted within the required time frame. This deficient practice occurred for 8 of 8 system selected residents (Resident #4, #6, #19, #22, #36, #42, #48, and #53) reviewed for timely submission of MDS and was evidenced by the following:</p> <p>On 3/12/25 at 11:01 AM, the surveyor interviewed the US FOIA (b)(6) regarding the MDS'. The surveyor provided a list of MDS and requested a validation report regarding timeliness. The US FOIA (b)(6) stated she knew she had late MDS submission.</p> <p>On 3/12/25 at 1:24 PM the US FOIA (b)(6) provided the following validation reports:</p> <p>1. Resident #6; Target Date: NJ Exec Order 26; Message: Assessment Completed Late: Z0500B NJ Exec Order 26.4b1)</p>	F 640	<p>Correction;</p> <p>A new MDS Coordinator was hired NJ Exec Order 26. The MDS Coordinator involved submitted her resignation NJ Exec Order 26.4b1 to be effective NJ Exec Order 26.4b1. A per diem replacement MDS Coordinator is currently working to c complete late MDS.</p> <p>Resident # 6 completed 3/12 Resident #4 completed 3/12 Resident #19 completed 3/13 Resident # 33 completed 3/9 Resident # 36 completed 3/13 Resident # 42 completed 3/18 Resident #48 completed 3/13 Resident # 53 completed 11/15</p> <p>Identify:</p> <p>All residents have the potential to be effected by this deficient practice. Late MDS were identified and a schedule for completion of late MDS was developed.</p>		

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F 640	<p>Continued From page 7</p> <p>is more than 14 days after A2300 (Assessment Reference Date).</p> <p>2. Resident #4; Target Date: [redacted] Message: Assessment Completed Late: Z0500B [redacted] is more than 14 days after A2300 (Assessment Reference Date).</p> <p>3. Resident #19; Target Date: [redacted] Message: Assessment Completed Late: For this Admission assessment Z0500B [redacted] is more than 13 days after (Entry Date).</p> <p>4. Resident #33; Target Date: [redacted] Message: Assessment Completed Late: Z0500B [redacted] is more than 14 days after A2300 (Assessment Reference Date).</p> <p>5. Resident #36; Target Date: [redacted] Message: Assessment Completed Late: Z0500B [redacted] is more than 14 days after A2300 (Assessment Reference Date).</p> <p>6. Resident #42; Target Date: [redacted] Message: Assessment Completed Late: Z0500B [redacted] is more than 14 days after A2300 (Assessment Reference Date).</p> <p>7. Resident #48; Target Date: [redacted] Message: Assessment Completed Late: Z0500B [redacted] is more than 14 days after A2300 (Assessment Reference Date).</p> <p>8. Resident #53; Target Date: [redacted] Message: Assessment Completed Late: Z0500B [redacted] is more than 14 days after A2300 (Assessment Reference Date).</p> <p>On 03/18/25 at 10:05 AM, the survey team met</p>	F 640	<p>Systemic Changes: The completion of MDS was added to the Quality Assurance Program with a benchmark of 100% completion. The MDS Tracker on MyUnity was added to the dashboard of both the Administrator and Director of Nursing.</p> <p>Monitoring: The Administrator or designee will audit MDS completion using the MDS Tracker on MyUnity EMR weekly for 4 weeks, monthly for 3 months, then quarterly for two quarters. The results will be reported to the Quality Assurance and Performance Improvement Committee quarterly. The Quality Assurance Performance Improvement committee will determine if the audit requires continuation or is deemed completed at the October quarterly meeting.</p>		

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F 640	Continued From page 8 with the US FOIA (b)(6) and no additional information was provided.	F 640			
F 677 SS=D	<p>NJAC 8:39-11.1 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of documentation, it was determined that the facility failed to provide appropriate NJ Exec Order 26.4b1 care for a resident (Resident #13) who was NJ Ex Order 26.4(b)(1) on staff for Activities of Daily Living (ADL) for 1 of 1 residents reviewed for ADLs. This deficient practice was evidenced by the following:</p> <p>1. On 3/12/25 at 12:06 PM, the surveyor observed Resident #13 in the day room next to a Certified Nursing Aide (CNA) #1 who was preparing to assist the resident with the lunch meal. The surveyor NJ Ex Order 26.4(b)(1) and observed Resident #13's NJ Exec Order 26.4b1 was NJ Exec Order 26.4. At that time, CNA #1 stated that the resident NJ Exec Order 26.4b1 and had had NJ Exec Order 26.4b1 care that morning. The surveyor inquired about the resident requiring NJ Exec Order 26.4b1 care. CNA #1 did not provide NJ Exec Order 26.4b1 care and assisted Resident #13 with lunch.</p> <p>On 3/12/25 at 12:37 PM, CNA #1 NJ Exec Order 26.4b1 the resident to bed with a NJ Exec Order 26.4b1. Upon</p>	F 677	<p>Correction The Director of Nursing (DON) reviewed the care plan for Resident #13 and confirmed that existing interventions remain appropriate. However, during a pre-lunch observation, the DON noted that the resident required assistance with NJ Exec Order 26.4b1 care one hour before the meal. The care plan was updated to reflect this specific need.</p> <p>CNA #1 was in-serviced on the facility policy for NJ Exec Order 26.4b1 care and educated on the inappropriateness of applying NJ</p> <p>Identify</p> <p>All incontinent residents have the potential to be effected by this deficient practice.</p> <p>Systemic Changes: An Observational Rounds Form was</p>	4/18/25	

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F 677	<p>Continued From page 9</p> <p>assessment of the resident, it was observed that Resident #13 was [redacted] with [redacted] and was [redacted].</p> <p>A review of the Face Sheet revealed that Resident #13 had diagnoses which included but were not limited to [redacted].</p> <p>[redacted] Resident #13 was newly admitted and the Minimum Data Set (MDS) an assessment tool used to facilitate care, had not been completed yet.</p> <p>A review of the individual comprehensive care plan (ICCP) dated [redacted] to present, included a focus area of being [redacted] with ADLs due to [redacted] and [redacted]. Interventions included to anticipate needs and being [redacted] on staff for [redacted]. A review of the Monthly Summary Evaluation completed [redacted] included but was not limited to; [redacted], always [redacted] of [redacted] and [redacted] and was [redacted] on the staff for ADLs.</p> <p>On 3/12/25 at 12:40 PM, the CNA stated that the [redacted] usually wore [redacted] and that residents should be changed every 2 hours.</p> <p>A review of the facility provided policy, "Incontinent Care" revised 4/3/24, included but was not limited to; Policy: to provide cleansing ... and to maintain skin integrity incontinent care will be provided as needed and according to the resident's care plan.</p> <p>A review of the facility provided policy, "Incontinent Care" revised 4/3/24, included but</p>	F 677	<p>developed to record observations of incontinence care and added to the Quality Assurance and Performance Improvement Plan. Observational Rounds for incontinence care will be conducted by a nursing supervisor at least weekly.</p> <p>The DON provided in-service training to all licensed nurses and CNAs on F550 – Resident Rights / Exercise of Rights. The training emphasized residents' rights to dignity, respect, and self-determination, as well as individualized care that supports quality of life.</p> <p>Monitoring:</p> <p>The Director of Nursing or designee will conduct observations of 5 incontinent residents who have cognitive and functional impairment, weekly for 4 weeks, monthly for 3 months and quarterly for 2 quarters. An Observational Rounds form will be used to identify and record observations. The audit results will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly for two quarters and the Committee will determine if the audit requires continuation or is deemed completed in October 2025.</p>		

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

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F 677	Continued From page 10 was not limited to; Policy: to provide cleansing ... for a resident who has been incontinent and to maintain skin integrity incontinent care will be provided as needed during the delivery of personal care services. Equipment included "adult brief". On 3/14/25 at 12:58 PM, the survey team met with the facility to discuss concerns. On 3/18/25 at 10:05 AM, the [US FOIA (b)(6)] stated the staff was educated to include toileting scheduling and that [NJ Exec Order 26.4b1] care was to be done as soon as resident needs the care. The [US FOIA (b)(6)] further stated that, "definitely no matter where and what, that if a resident needed [NJ Ex Order 26.4(b)(1)] care, it should be done immediately." She stated that it was "unfortunate" that the CNA applied [NJ Exec Order 26.4b1] and that it was not the facility practice.	F 677			
F 678 SS=D	NJAC 8:39-4.1(a); 27.1(a) Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to a) consistently ensure physician orders for residents' wishes for [NJ Ex Order 26.4(b)(1)] were documented in the medical records. This	F 678	Correction; A [NJ Ex Order 26.4] audit of all active medical records was conducted by the director of nursing on [NJ Exec Order 26] and confirmed the physician order for [NJ Exec Ord] was in place in	5/1/25	

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F 678	<p>Continued From page 11</p> <p>deficient practice was identified for 1 of 1 closed record reviewed for [redacted]</p> <p>[redacted]</p> <p>and was evidenced by the following:</p> <p>A review of Resident #18's closed medical record revealed that Resident #18 was admitted to the facility for [redacted]. Review of the Physician Order Summary (POS) dated [redacted], did not include an order for [redacted].</p> <p>A nurses progress note dated [redacted] timed 6:00 PM, revealed that the resident was [redacted] in the [redacted] chair in the room at 6:00 PM. The note further revealed that the resident was [redacted] to bed and [redacted] care was rendered. Resident was a [redacted].</p> <p>The surveyor reviewed the Physician Order Summary dated [redacted] and could not identify a physician Order for [redacted].</p> <p>A Physical examination dictated and signed by the physician on [redacted] at 12:22 AM reflected the following: General; [redacted] and [redacted]. [redacted] to [redacted].</p> <p>Plan of care.</p> <p>Plan:</p> <p>[redacted].</p> <p>Continue with [redacted].</p> <p>Continue with present medications.</p> <p>Continue [redacted] and monitor [redacted].</p>	F 678	<p>the EMR as appropriate.</p> <p>Identify: All residents are at risk when the advance directive/DNR is not reflected and accessible in the EMR. The audit conducted identified that all residents with a POLST had a physician order in the EMR.</p> <p>Systemic Changes: Resident #18 was admitted with an existing [redacted] signed previously by [redacted] physician, the same physician attending in the facility. This caused the [redacted] to be added to the paper medical record under physician orders and not entered into the Electronic Medical Record as a physicians order. A new policy and procedure for POLST management was developed. The Social Worker will be responsible to educate new admissions on POLST, identify the presence of an existing POLST and be the point of contact for all new POLST. All POLST, new and existing (signed by a physician) will be placed in the Nursing Supervisor Physicians Binder. The Nursing Supervisor will review all POLST with the physician and enter the physicians order in the EMR.</p> <p>Monitoring: The Director of Nursing or designee will audit for the presence of the resident's code status as a physician order in the EMR for all new admissions, weekly for</p>	

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F 678	<p>Continued From page 12</p> <p>There was no [NJ Exec Order 26.4b1].</p> <p>On 3/13/25 at 10:30 AM, the surveyor shared the above concerns with the [US FOIA (b)(6)] and requested the entire closed record for Review.</p> <p>On 3/14/25 at 1:15 PM, the [US FOIA (b)(6)] provided the closed record along with the New Jersey [NJ Ex Order 26.4(b)(1)] dated [NJ Exec Order 26.4b1] which contained the following order: [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b1]. Use [NJ Exec Order 26.4b1] manual treatment to relieve [NJ Exec Order 26.4b1] medications for [NJ Exec Order 26.4b1].</p> <p>On 3/14/25 at 1:00 PM, during an interview with the surveyor, the [US FOIA (b)(6)] stated that Resident #18 was a [NJ Exec Order 26.4b1]. The surveyor reviewed the closed chart with the [US FOIA (b)(6)] and could not identify a physician order for [NJ Exec Order 26.4b1].</p> <p>On 3/18/25 at 11:20 AM, during an interview with a surveyor, a [US FOIA (b)(6)] who recently began working at the facility, stated that a resident's [NJ Ex Order 26.4b1] status would show up when the resident's record was displayed on the computer screen. The [US FOIA (b)(6)] pulled up a random resident and showed the surveyor two areas where the [NJ Exec Order 26.4b1] [NJ Ex Order 26.4b1] status would be easily identifiable.</p> <p>On 03/18/25 at 11:34 AM, during an interview with the [US FOIA (b)(6)] who [NJ Exec Order 26.4b1] Resident #18's [NJ Exec Order 26.4b1] she admitted that she did not administer [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated while the nurse went to check the [NJ Ex Order 26.4b1] status in the paper chart, she called the son immediately to verify the [NJ Exec Order 26.4b1]. She stated</p>	F 678	<p>four weeks, monthly for 3 months, then quarterly for two quarters. The benchmark for compliance is 100%. The Quality Assurance Performance Improvement committee will determine if the audit requires continuation or is deemed completed at the October Quality Assurance and Performance Improvement Committee meeting</p>	

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F 678	<p>Continued From page 13</p> <p>that the [NJ Ex Order 26.4(b)] was in the paper chart. She confirmed that the [NJ Exec Order 26.4b1] should have been easily identified in the electronic medical record.</p> <p>On 3/18/25 at 1:05 PM, the surveyor interviewed the physician in charge of the resident's care. He stated clearly that the [NJ Exec Order 26.4b1] should have been in the electronic medical record and easily accessible. He added, "Staff should not have to look and check for the order. The process is to initiate [NJ Exec Ord] and call [NJ Exec C]. That is not practical. The [US FOIA (b)(6)] should educate or continue to reeducate the staff".</p> <p>A review of the facility's policy titled, "Electronic Health Record" (EHR) last reviewed 11/30/2024 indicated the following: This policy establishes the expectation that every clinician will use the EHR to access and retrieve information, enter data, and respond to clinical decision support interventions at the point of care. Procedure: The EHR is designed to be used at the point of care to support timely access and retrieval of information, accurate and complete capture and documentation of information, clinical decision-making, and communication with all stakeholders in the care process.. As such: "1" All clinicians are expected to use the EHR as the primary means to access and retrieve information, capture data, and be guided by clinical decision.</p> <p>Review of the facility's Advanced Directive" policy last revised 7/19/23 the policy revealed under "#4 the following: "Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record".</p>	F 678			

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F 678	Continued From page 14 NJAC 8:39-9.6(b)	F 678			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide NJ Exec Order 26.4b1 for a resident who was identified at risk for NJ Exec Order 26.4b1 and sustained NJ Exec Order 26.4b1 . This deficient practice was identified for 1 of 2 residents (Resident #47) reviewed for NJ Exec Order 26.4b1 and was evidenced by the following: On 3/13/25 at 8:31 AM, the surveyor observed Resident #47 in their room and was being assisted by a US FOIA (b)(6) . The resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 upon approach. At the US FOIA (b)(6) then wheeled Resident #47 in into the dayroom, then shortly after returned the resident to their room and left the resident NJ Exec Order 26.4b1 in their room. On 03/13/25 at 8:45 AM, during an interview with the surveyor the US FOIA (b)(6) stated that she cared for Resident #47 and left the resident alone in their room. The surveyor then went to the room with the US FOIA (b)(6) and the resident was not there. The US FOIA (b)(6) and surveyor encountered another staff member that stated Resident #47 was escorted	F 689	4/18/25		
			Correction; The Director of Nursing (DON) and Unit Manager (UM) reviewed the medical records of Resident #47, who is currently receiving NJ Exec Order 26.4b1 services. The Director of Nursing and Unit Manager met with the resident and the hospice nurse to discuss the surveyor's findings and review the resident's care plan. It was reinforced that Resident #47 is a NJ Exec Order 26.4b1 and must not be NJ Exec Order 26.4b1 . The NJ Exec Order 26.4b1 nurse subsequently educated the NJ Exec Order 26.4b1 aides on the importance of ensuring NJ Exec Order 26.4b1 and the expectation that the resident is NJ Exec Order 26.4b1 . Identify All residents have the potential to be affected by this deficient practice. The Director of Nursing and Unit Manager reviewed the care plans and risk assessments for all residents identified as		

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F 689	<p>Continued From page 15 to [redacted] at the [redacted].</p> <p>On 3/14/25 at 9:15 AM, the surveyor interviewed the [redacted] (US FOIA (b)(6)) stated that Resident #47 was [redacted] and [redacted] manifested by [redacted] and [redacted]. The [redacted] also stated that Resident #47 had a history of [redacted].</p> <p>On 3/14/25 at 9:40 AM, the surveyor observed Resident #47 in bed. A [redacted] was noted on the right side of the bed and at that time. The surveyor reviewed the medical record for the resident. The Admission Record reflected that Resident #47 was admitted to the facility with medical diagnoses which included, but were not limited to; [redacted].</p> <p>[redacted] A review of the Quarterly Minimum Data Set (MDS) a comprehensive assessment tool, dated [redacted], indicated that Resident #47 was [redacted]. Resident #47 received a score of [redacted] out of 15 on the Brief Interview for Mental Status (BIMS). The assessment indicated that Resident #47 required [redacted] of 1 person for [redacted] and [redacted] and was [redacted] on staff for all activities of daily living, used the wheelchair as the [redacted] and was [redacted].</p> <p>A review of the progress notes revealed that Resident #47 [redacted] at the facility for the last 120 days. On [redacted] the facility provided the following [redacted] reports. On [redacted] at 4:03 PM, Resident #47 [redacted] next to the activity room. Resident #47 [redacted] a [redacted] to the [redacted] which [redacted].</p>	F 689	<p>[redacted]. An interdisciplinary team (IDT), consisting of certified nursing assistants (CNAs), the activities director (AD), social worker (SW), and [redacted] staff, convened to review and reinforce each relevant resident's care plan. For Resident #47 specifically, the IDT agreed that current interventions should remain in place, emphasizing the importance of [redacted] due to the resident's [redacted] to [redacted]. It was also established that when a [redacted] aide's shift ends, the aide must ensure Resident #47 [redacted] is handed off directly to the Unit Manager or unit nurse to prevent any lapse in [redacted].</p> <p>Systemic Changes</p> <p>The Director of Nursing and her designee provided in-service training to all licensed nurses, CNAs, activities staff, housekeeping, maintenance personnel, and the social worker on F689 – Free of Accident Hazards. The training emphasized the requirement that residents identified as not safe to be left alone must be supervised at all times. Staff were instructed that if a resident is found alone against their care plan directive, the staff member must stay with the resident until the individual can be safely accompanied to a supervised area of their choosing (e.g., an activity room).</p> <p>Activity aides are assigned day room supervision during morning care and nurse aides are assigned day room</p>	

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F 689	<p>Continued From page 16</p> <p>NJ Exec Order 26.4b1</p> <p>A review of the IDT (Interdisciplinary Team) note dated [redacted] timed 9:57 AM, indicated that the resident was [redacted]. The IDT recommended that Resident #47 be kept within staff [redacted] and to refer to NJ Exec Order 26.4b1.</p> <p>On [redacted] at 2:44 PM, Resident #47 [redacted] a [redacted] in the room. The IDT's recommendation were to refer to [redacted] for screen and keep personal belongings within resident reach.</p> <p>On [redacted] at 3:00 PM, Resident #47 [redacted] in the [redacted] while being [redacted] by the [redacted] and [redacted] a [redacted] to the [redacted] of their [redacted] with NJ Exec Order 26.4b1. The IDT recommendations were to refer Resident #47 to [redacted] for screen and anticipate needs.</p> <p>On [redacted] at 4:00 PM, Resident # 47 was [redacted] on the [redacted] in the room. Resident #47 [redacted] a [redacted] with NJ Exec Order 26.4b1 to the [redacted] of their [redacted] and [redacted] to the [redacted]. The IDT again recommended to refer the resident to [redacted] screen. Keep the resident within [redacted] during waking hours.</p> <p>On [redacted] at 11:AM, Resident #47 [redacted] another [redacted] in the room. Resident #47 was [redacted] on the [redacted] by the the [redacted] out for [redacted] NJ Exec Order 26.4b1. The recommendation was to continue to monitor.</p> <p>On [redacted] at 3:18 PM, the resident [redacted] to [redacted] from the [redacted] and [redacted]. According to the [redacted] report, staff was across the room and could not get in time to the resident. The recommendation was for staff to monitor closely</p>	F 689	<p>supervision on their assignment sheet during waking hours.</p> <p>Monitoring</p> <p>The Director of Nursing or designee will perform observation rounds across all shifts, five days a week, weekly for four weeks, monthly for three months, and quarterly for two quarters thereafter.- in order to ensure that residents who are high risk for falls require supervision and noted cannot be left alone, are not left unattended.</p> <p>Audit findings will be reported in Quality Assurance and Performance Improvement meetings quarterly. The Quality Assurance and Performance Improvement Committee will assess the need for ongoing monitoring based on audit results at the October 2025 Quarterly meeting.</p>		

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F 689	<p>Continued From page 17 while awake.</p> <p>On [redacted] at 6:20 AM, Resident #47 [redacted] next to the closet. Resident #47 did [redacted]. Resident #47 [redacted]. There was no recommendation made by the IDT regarding the [redacted].</p> <p>On [redacted] at 10:15 AM, Resident #47 was [redacted] next to the bed [redacted]. Recommendations: [redacted]. Involve in activities. Educate CNA to use [redacted] method.</p> <p>On [redacted] at 9:30 AM, Resident #47 was [redacted] in the bathroom. Recommendation: Continue all current [redacted] recommendation in care plan. Continue [redacted] of the resident, and anticipate needs.</p> <p>Further review of the medical record revealed that Resident #47 had a care plan for [redacted] initiated [redacted]. The goal was for Resident #47 will not have any [redacted] related [redacted] through the review date. The interventions were to place call bell within reach. Remind and encourage to call for assistance. Staff to [redacted] [redacted] to right side of bed. Frequent rounding during the day and night. Increase activity and [redacted] after family visits. Staff re-educated to increase rounding and check the resident every 1 hour.</p> <p>On 3/14/25 at 1:05 PM, the facility was made aware of the concerns regarding the [redacted] and surveyor observations.</p> <p>On 3/18/29 at 12:30 PM, the [redacted] US FOIA (b)(6)</p>	F 689			

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F 689	Continued From page 18 [U.S. FOIA (b)] informed the survey team that she agreed that Resident #47 should not be [NJ Exec Order 29.48], and she would formulate a plan to address Resident #47's [NJ Exec Order 29.48] and the [NJ Exec Order 29.48]. A review of the facility's titled, "Falls Management Program" last revised 1/27/24 revealed the following under policy and procedure: Residents at high risk for falls must have an appropriate intervention protocol established immediately upon admission documented on the baseline care plan, and continued onto the comprehensive care plan. Procedure #4 The resident's fall risk and appropriate interventions will be reflected on the baseline care plan to be completed within 48 hours and continue to the comprehensive care plan as appropriate. Procedure # 12 All falls are investigated and trended for possible causative factors utilizing the Risk Watch Analysis and reported to the community Improvement Committee along with appropriate action plans.	F 689			
F 697 SS=E	NJAC 8:39-27.1(a) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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, record review and review of other facility documentation, it was	F 697	Correction; Licensed nursing Staff were re-educated	4/18/25	

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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) COMPLETION DATE	
F 697	<p>Continued From page 19</p> <p>determined that the facility failed to administer [redacted] medication as ordered by the physician. This deficient practice was identified for 1 of 3 residents reviewed for [redacted] management (Resident # 33) and was evidenced by the following:</p> <p>On 3/12/25 at 9:30 AM, during the initial tour of the facility, Resident #33 reported to the surveyor that they were [redacted] NJ Exec Order 26.4b1 and did not receive their [redacted] medications for a few days.</p> <p>On 3/13/25 at 8:52 AM, the surveyor interviewed the resident in their room. The resident informed the surveyor that there was a lack of communication among staff and no teamwork. The resident stated that they did not receive their [redacted] NJ Exec Order 26.4b1 prescribed for [redacted] for 3 days, and they experienced [redacted] NJ Exec Order 26.4b1 on their [redacted] NJ Exec Order 26.4b1 at that time.</p> <p>On 3/14/25 at 9:26 AM, the surveyor again visited the resident and they revealed that about 4 weeks ago, the [redacted] NJ Exec Order 26.4b1 was not administered for 3 days. When asked if they [redacted] NJ Exec Order 26.4b1 at that time, Resident #33 stated, "I am always in [redacted] NJ Exec Order 26.4b1 I have [redacted] NJ Exec Order 26.4b1 on my [redacted] NJ Exec Order 26.4b1 I do not have any [redacted] NJ Exec Order 26.4b1 they are [redacted] NJ Exec Order 26.4b1 to [redacted] NJ Exec Order 26.4b1. The nurse stated that they run out of the medication. My doctor always has my scripts."</p> <p>On 3/14/25 at 9:21 AM, the surveyor interviewed the [redacted] US FOIA (b)(6) in charge of the resident's care. The [redacted] US FOIA stated that the resident informed her that morning of the missing medication as she just returned to work today. She was not made aware and could not comment on the omissions.</p>	F 697	<p>on the re-order process for [redacted] NJ Exec Order 26.4b1 to include to obtain a physician order and prescription to be sent to the pharmacy and/or to order a three day emergency supply allowed by telephone order. Resident #33 was assessed for [redacted] NJ Exec Order 26.4b1 on every shift or [redacted] NJ Exec Order 26.4b1 and forward to identify [redacted] NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Resident #33 has not reported [redacted] NJ Exec Order 26.4b1 NJ Exec Order 26.4b1</p> <p>[redacted] NJ Exec Order 26.4b1 was added to the emergency medication system safe located in the facility and added to emergency medication system safe medication List.</p> <p>The emergency medication system safe medication List was updated to include [redacted] NJ Exec Order 26.4b1</p> <p>Identify: All residents with orders for pain management medication are at risk for this deficient practice. An audit was conducted to ensure that all in-house residents had all pain medication supplied as per physician orders. No residents were identified to be lacking.</p> <p>Systemic Changes: The emergency medication system safe and emergency medication system safe medication List was updated to include Hydrocodone. The emergency medication system safe medication List was placed on medication carts on B and C wing.</p> <p>Nurse competencies for controlled</p>		

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F 697	<p>Continued From page 20</p> <p>On 3/14/25 at 10:00 AM, the surveyor interviewed the US FOIA (b)(6). She stated that she was aware of the missing medication and would provide the investigation.</p> <p>On 3/14/25 at 12:40 PM, the surveyor reviewed the Medication Administration Record (MAR) and confirmed that the NJ Exec Order 26.4b1 was not administered on the following dates: NJ Exec Order 26.4b1. The investigation was not provided and there was no documentation that the physician was notified.</p> <p>A review of the Face Sheet (an admission summary) reflected that Resident #33 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1.</p> <p>A review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec out of 15, indicative of NJ Exec Order 26.4b1. The assessment included that the resident was receiving scheduled and as needed NJ Exec O medication, and had NJ Exec O in the last five days that would occasionally interfere with day-to-day activities.</p> <p>A review of the resident's individualized comprehensive care plan dated NJ Exec Order 26.4b1, reflected a Focus: I have NJ Exec Order 26.4b1. I have NJ Exec O to my NJ Exec Order 26.4b1 especially my NJ Exec Order 26.4b1. The goal indicated that the resident will be NJ Exec Order 26.4b1 and If I have NJ Exec O it will be managed through the next review period. Interventions included the</p>	F 697	<p>medication orders and re-ordering controlled medication was added to the Facility Assessment and the orientation and annual education program for licensed nurses. The competency and education includes narcotic ordering, re-order timelines and facility specific Policy and Procedure for ordering.</p> <p>The facility Policy and Procedures were revised to include the facility specific process for re-ordering controlled medication.</p> <p>Monitoring: The Director of Nursing or Designee will audit the medication record and available controlled medications of 10 residents or fewer if 10 residents do not have controlled medication, weekly for four weeks, monthly for three months and quarterly for two quarters. The results of the audit will be reported to the Quality Assurance and Performance Improvement Committee quarterly. The Quality Assurance Performance Improvement committee will determine if the audit requires continuation or is deemed completed at the October 2025 quarterly meeting.</p> <p>The Director of Nursing or designee will audit the completion of competencies for controlled medication orders for all licensed nurses upon hire and annually. Completion will be monitored weekly for 4 weeks and then monthly for 3 months and quarterly for two quarters. The results will be reported to the Quality Assurance and</p>		

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F 697	<p>Continued From page 21</p> <p>following: My nurse will administer my [redacted] medication as ordered by my physician. [redacted] NJ Exec Order 26.4b1. Offer me PRN (as needed) medications when I complain of [redacted]. Monitor the effectiveness of my [redacted] medication.</p> <p>A review of the Physician's Orders sheet (POS) for [redacted] NJ Exec Order 26.4b1 reflected a physician's order (PO) dated [redacted] NJ Exec Order 26.4b1 for the [redacted] NJ Exec Order 26.4b1. The order specified to administer 1 tablet orally every 12 hours for [redacted] NJ Exec Order 26.4b1 as of [redacted] NJ Exec Order 26.4b1. The order also reflected an order to check for [redacted] NJ Exec Order 26.4b1 every shift..</p> <p>A review of the electronic Medication Administration Record (eMAR) for Resident #33 for [redacted] NJ Exec Order 26.4b1, revealed the [redacted] NJ Exec Order 26.4b1 medication with scheduled administration times of 0900 (9:00 AM) and 2100 (9:00 PM).</p> <p>On the following dates and times, there was no documentation to indicate that the medication was administered as ordered:</p> <p>[redacted] NJ Exec Order 26.4b1 at 0900 and 2100 [redacted] NJ Exec Order 26.4b1 at 0900 and 2100 [redacted] NJ Exec Order 26.4b1 at 0900 and 2100</p> <p>The resident did not receive 6 doses of the medication.</p> <p>The [redacted] NJ Exec Order 26.4b1 non PRN [as needed] medications notes for [redacted] NJ Exec Order 26.4b1 monitoring reflected that on [redacted] NJ Exec Order 26.4b1 the resident reported [redacted] NJ Exec Order 26.4b1 evening shift [redacted] NJ Exec Order 26.4b1 was [redacted] NJ Exec Order 26.4b1.</p> <p>On [redacted] NJ Exec Order 26.4b1 the resident reported [redacted] NJ Exec Order 26.4b1 to the [redacted] NJ Exec Order 26.4b1.</p>	F 697	Performance Improvement Committee at least Quarterly. The Quality Assurance and Performance Improvement Committee will determine if the audit requires continuation or is deemed completed at the October quarterly meeting.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 697	<p>Continued From page 22</p> <p>On ^{NJ Exec Order 26.4b1} the resident reported ^{NJ Exec Order 26.4b1}</p> <p>On 3/13/14 at 1:15 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) # 1, who worked on ^{NJ Exec Order 26}. She stated that the medication was not available and she informed the ^{US FOIA (b)(6)}.</p> <p>On 3/18/25 at 9:16 AM, the ^{US FOIA} confirmed again that she was made aware of ^{NJ Exec Order 26.4b1} she informed the ^{US FOIA (b)(6)} and a script for the medication was forwarded to the provider pharmacy. She could not provide documentation of any communication with the pharmacy.</p> <p>On 3/18/25 at 9:31 AM, the surveyor contacted the provider pharmacy and the pharmacist informed the surveyor that they received a script for the ^{NJ Exec Order 26.4b1} or ^{NJ Exec Order 26.4b1}.</p> <p>On 3/18/25 at 10:36 PM, LPN #2 who did not administered the medication or ^{NJ Exec Order 26.4b1} informed the surveyor that staff were to order the ^{NJ Exec Order 26.4b1} when at least 8 tablets were left on the Bingo card (medication delivery system). She informed the surveyor that she informed the ^{US FOIA} that the medication was not available at that time. She stated she did not contact the physician. The surveyor and LPN # 2 reviewed the ^{NJ Exec Order 26.4b1} MAR [medication administration record]. She confirmed that Resident #33 did not receive the ^{NJ Exec Order 26.4b1} as ordered by the physician.</p> <p>On 3/18/25 at 12:56 PM, the surveyor interviewed the physician and he confirmed that he was not made aware that Resident #33 did not receive/have the ^{NJ Exec Order 26.4b1} since ^{NJ Exec Order 26}. The physician added, had he been made aware, he</p>	F 697			

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F 697	Continued From page 23 would have contacted the provider pharmacy and ordered a 3 day supply. The physician confirmed that he was made aware on 2/20/25 and he sent the script to the pharmacy on 2/20/25. The facility was made aware of the above concerns on 3/14/25. On 3/18/25, the facility confirmed that the physician was contacted on 2/20/25 and ordered a stat (immediate) delivery. A review of a facility policy titled, "Administering Medications" with a revised date of 1/10/25 included: Policy: Medications will be administered in a timely manner and as prescribed by the resident's attending physician or the facility's medical director. The individual administering the medication must initial the resident's EMAR/MAR on the appropriate line and date for that specific day before administering the next resident's medication. A review of a facility policy titled Pain Management with a revised date of 6/19/23, included under policy: The resident will be provided with the most effective pain relief methods, and their response to the treatment plan will be monitored and adjusted as needed.	F 697			
F 698 SS=E	NJAC 8:39-27.1(a) 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	F 698			4/18/25

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F 698	<p>Continued From page 24</p> <p>the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a) consistently complete the [redacted] communication form (CF) for the residents on [redacted] NJ Exec Order 26.4b1 [redacted] and b) monitor, assess and document the care of a [redacted] NJ Exec Order 26.4b1 [redacted] treatment. This deficient practice was identified for 1 of 1 resident (Resident #15) and was evidenced by the following:</p> <p>On 3/12/25 at 12:56 PM, the surveyor did not observe Resident #15 in their room. The US FOIA (b)(6) [redacted] informed the surveyor that the resident was in the [redacted] NJ Exec Order [redacted]</p> <p>On 3/12/25 at 11:04 AM, the surveyor reviewed the hybrid medical records (combination of electronic medical record and physical chart) of Resident #15.</p> <p>A review of Resident #15's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] NJ Exec Order 26.4b1 [redacted]</p>	F 698	<p>Correction;</p> <p>Nurses were educated on the Process of [redacted] NJ Exec Order 26.4b1 on 3/14/25 immediately following the communication of the observation by the surveyor.</p> <p>The following scheduled and subsequent [redacted] NJ Exec Order 26.4b1 documentation for resident #15 were conducted by and recorded by newly in-serviced licensed nursing staff.</p> <p>Identify: Resident #15 is the [redacted] NJ Exec Order 26.4b1 [redacted] resident in the facility. No other residents were identified with orders to check for [redacted] NJ Exec Order [redacted]</p> <p>Systemic Changes: The Dialysis Communication Form was revised to include information required to be completed by the Dialysis Unit and consistent with the facility Policy and Procedure.</p> <p>The Facility Assessment was revised to include Dialysis competencies including Bruit and Thrill, and Dialysis competencies were added to the licensed nurse orientation and annual education program.</p> <p>Monitoring: The Director of Nursing or designee will audit the individual Resident Dialysis book to ensure completion of the Dialysis Communication Form weekly for four</p>		

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F 698	<p>Continued From page 25</p> <p>A review of Resident #15's most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #15's had [redacted]. Further review of the MDS indicated the resident received [redacted].</p> <p>A review of Resident #15's individualized comprehensive care plan (ICCP) created on [redacted] included a focus care area that the resident had a diagnosis of [redacted] and had elected to [redacted]. The interventions included to monitor [redacted] is a [redacted] check [redacted] and [redacted] every shift; Review [redacted] communication form (CF) for completion.</p> <p>A review of the physician's Order Summary Sheet revealed the following orders: [redacted] schedule Tuesday, Thursday and Saturday with a start date [redacted]; Check [redacted] check [redacted] and [redacted] every shift (three times daily) with a start date [redacted] collect [redacted] communication book every Tuesday, Thursday, and Saturday, post [redacted] Observe toleration [redacted] vitals, new orders sign/initial book and date that this has been done with a start date [redacted]. The above order to check [redacted] three times daily was transcribed in Treatment Administration Records (TARs) with a start date of [redacted].</p>	F 698	<p>weeks and monthly for three months and quarterly for two quarters. The results will be reported to Quality Assurance Performance Improvement Committee at least quarterly. The Quality Assurance Performance Improvement committee will determine if the audit requires continuation or is deemed completed at the October 2025 quarterly meeting.</p> <p>The Director of Nursing or designee will audit the completion of competencies for Hemodialysis for licensed nurses upon hire and annually. Completion will be monitored weekly for 4 weeks and then monthly for 3 months and quarterly for two quarters. The results will be reported to the Quality Assurance and Performance Improvement Committee at least Quarterly. The Quality Assurance and Performance Improvement Committee will determine if the audit requires continuation or is deemed completed at the October quarterly meeting.</p> <p>Completion Date: 4/18/25</p>		

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F 698	<p>Continued From page 26</p> <p>A review of the NJ Exec Order 26.4b1 Treatment Administration Record (TARs) reflected that NJ Exec Order 26.4b1 order was signed by the US FOIA (b) who worked per diem (as needed) at the facility, as completed who was not able to explain how to assess the NJ Exec Order 26.4b1. There were 2 entries in NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and 3 entries in NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p> <p>On 3/12/25 at 12:47 PM, the surveyor interviewed the US FOIA (b) regarding the process for a resident that received NJ Exec Order 26.4b1 services. The US FOIA (b) stated that Resident #15 was on NJ Exec Order 26.4b1. The US FOIA (b) stated the nurses check the resident's vital signs (VS; blood pressure, heart rate, respirations, temperature, etc) before and after the NJ Exec Order 26.4b1 assessed NJ Exec Order 26.4b1 for any signs of NJ Exec Order 26.4b1 checked NJ Exec Order 26.4b1. The US FOIA (b) further stated the nurses would write down the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 findings on the CF before the resident would leave for their NJ Exec Order 26.4b1.</p> <p>On 3/12/25 at 1:00 PM, the surveyor reviewed Resident #15's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) contained two separate areas to be filled out; the top section was to be completed by the facility nurse prior to the resident leaving the facility for the NJ Exec Order 26.4b1 treatment and the bottom section was to be completed by the NJ Exec Order 26.4b1 center staff after treatment and last line needed to be signed by the receiving nurse at the facility when the resident returned. The binder contained the NJ Exec Order 26.4b1 CF's which indicated the following:</p> <p>CFs dated NJ Exec Order 26.4b1,</p>	F 698		

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F 698	<p>Continued From page 27</p> <p>NJ Exec Order 26.4b1 and undated CF, did not have VS, NJ Exec Order 26.4b1 and facility nurse signature to acknowledge that this section was completed before the resident left the facility for their NJ Exec session. The CF dated NJ Exec Order 26.4b1 and an undated CF was missing receiving nurse's signature and date at the bottom. The CF did not have a section on the form for an assessment of VS and disposition of NJ Exec Order 26.4b1.</p> <p>On 3/12/25 at 1:35 PM, the US FOIA (b) reviewed the NJ Exec binder in the presence of the surveyor and the US FOIA (b) stated the nurses are responsible to complete the top part of the CF. The US FOIA (b) further stated the US FOIA (b)(6) checked the NJ Exec binder for completion after the resident returned to the facility. The US FOIA (b) stated and demonstrated that she checked resident's NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1) at the NJ Exec Order 26.4b1 before the resident left for their NJ Exec Order 26.4b1.</p> <p>On 3/14/25 at 9:29 AM, during an interview with the surveyor, the US FOIA (b)(6) stated the top portion on the CF was completed by the nurses at the facility before the resident left for NJ Exec and the NJ Exec binder would be taken with the resident, by the transport staff. The US FOIA (b)(6) stated that it was important to complete the top portion of the CF so that the NJ Exec center knows about resident's VS before the resident left the facility. The US FOIA (b)(6) further stated when the resident returned to the facility, the US FOIA (b)(6) had to sign the CF as a receiving nurse in charge. Then the US FOIA (b)(6) would check for any signs for NJ Exec Order 26.4b1 at the NJ Exec Order 26.4b1. The US FOIA (b)(6) further stated the US FOIA (b)(6) would check NJ Exec Order 26.4b1 was removed from the NJ Exec Order 26.4b1 after 4 hours. The US FOIA (b)(6)</p>	F 698		

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F 698	<p>Continued From page 28</p> <p>stated [redacted] would be checked by [redacted] at the [redacted]. The [redacted] reviewed the [redacted] binder in the presence of the surveyor and observed the incomplete CFs. The [redacted] acknowledged the information was missing on the forms and stated the CFs should be completed prior to the resident leaving the facility for [redacted]. The [redacted] further stated she would educate and provide in-service to the nurses.</p> <p>On 3/14/25 at 9:46 AM, during an interview with the surveyor, the [redacted] stated the process was to check resident's VS, [redacted], and if the resident received any [redacted] medication before they left, that would be written down on the CF. The [redacted] stated when the resident returned from [redacted] center, she would check the CF and sign it as a receiving nurse. The [redacted] further stated, "If I am not there then the assigned nurse can sign the CF." The [redacted] stated the [redacted] was responsible to make sure the CFs were completed. The [redacted] stated to check for [redacted], she would place her hand at the [redacted] and feel for the [redacted].</p> <p>On 3/14/25 at 12:58 PM, the survey team met with the administration team and notified the above-mentioned concerns regarding Resident #15.</p> <p>On 3/18/25 at 10:05 AM, the survey team met with the [redacted] and the [redacted]. The [redacted] presented an in-service meeting and training sign-in sheet for assessment of an [redacted] that was completed after surveyor inquiry.</p> <p>A review of the facility provided "Dialysis Treatment-Communication" policy revised on</p>	F 698			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/18/2025
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MEADOW LAKES EAST WINDSOR, NJ 08520		
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F 698	Continued From page 29 1/25 included a statement: To assure continuity of care and treatment for the resident receiving hemodialysis, the facility will communicate with the hemodialysis center and interdepartmentally. C. Education and training to include: a. Upon orientation the nurses will be taught the care of grafts and fistulas through assessment.	F 698			
F 755 SS=D	NJAC 8:39- 27.1(a) Pharmacy Srvc/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		4/18/25	

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F 755	<p>Continued From page 30 reconciliation; and</p> <p>§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:</p> <p>Based on observation, interview, record review, and review of documentation, it was determined that the facility failed to ensure a resident received their physician ordered medication. This deficient practice was identified for 1 of 5 residents (Resident #48) observed during medication administration. This deficient practice was evidenced by the following:</p> <p>On 3/12/25 at 8:20 AM, the surveyor observed the US FOIA (b)(6) prepare medications to administer to Resident #48. The US FOIA (b)(6) and surveyor observed that the container for the medication NJ Exec Order 26.4b1 was empty. The US FOIA (b)(6) stated that medications were to be reordered when there were 10 doses left.</p> <p>A review of the Admission Face Sheet revealed that Resident #48 had diagnoses which included, but were not limited to; NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 Physician Order Sheet documented an order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 to be administered at 9:00 AM and 9:00 PM. A review of the individual comprehensive care plan (ICCP) effective NJ Exec Order 26.4b1 to present, included a focus area of a diagnosis of NJ Exec Order 26.4b1 ... take medications to manage my symptoms. Interventions included but were not limited to; the nurse will administer medications as ordered by the physician.</p>	F 755	<p>Correction;</p> <p>Resident #48 received a late dose of NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 at 1:00pm. The physician was notified of the need for administration of a late dose of NJ Exec Order 26.4b1 and approved by the physician. The late dose was administered and nursing. The resident was monitored for side effects related to of the late dose, no effects were reported by the resident or observed by the nursing staff. The medication was re-ordered for resident #48 and received in the evening of NJ Exec Order 26.4b1. Staff were re-educated on the re-order process for medications.</p> <p>On 3/12/25 NJ Exec Order 26.4b1 was added to the emergency medication system safe located in the facility and NJ Exec Order 26.4b1 was added to emergency medication system safe medication List.</p> <p>Identify:</p> <p>All residents are at risk for this deficient practice. On 3/18/25, an audit of 49 residents was conducted to ensure that all in-house residents had all medication supplied as per physician orders. No residents were identified to be lacking.</p> <p>Systemic Changes:</p>		

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F 755	<p>Continued From page 31</p> <p>On 3/12/25 at 11:30 AM, the surveyor approached the [US FOIA (b)(6)] and inquired regarding the missing [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated that she had not called the pharmacy yet. When asked if she notified the [US FOIA (b)(6)], she stated no. The surveyor approached the [US FOIA (b)(6)] and inquired regarding the missing [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated that she was not made aware of the missing [NJ Exec Order 26.4b1] and that if she had been made aware, she would have checked to see if the medication was available in the facility back up supply. The [US FOIA (b)(6)] further stated that the protocol for reordering medications was for the staff to request the refill when 5 pills were remaining.</p> <p>At 11:35 AM, the [US FOIA (b)(6)] accompanied the surveyor to the backup medication supplies and retrieved the [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated all staff were aware that they should check for missing medications in the backup supply. The [US FOIA (b)(6)] further stated that medications could be reordered via computer.</p> <p>A review of the facility provided policy, "Administering Medications" revised 1/17/25, included but was not limited to: Policy: Medications will be administered on time and per physicians order. Should a drug be given other than the scheduled time, an explanatory note must be entered.</p> <p>On 3/14/25 at 12:58 PM, the facility was made aware of the above concern.</p> <p>On 3/18/25 at 10:05 AM, the [US FOIA (b)(6)] acknowledged that the [US FOIA (b)(6)] did not act at the time and that the [NJ Exec Order 26.4b1] was in the backup medication supply.</p> <p>NJAC 8:39-27.1(a); 29.2(d); 29.3(a)5</p>	F 755	<p>The emergency medication system safe medication list was placed on the medication cart so that nurses can access a list of available medications. All licensed nursing Staff were in-serviced on the emergency medication system safe medication List.</p> <p>Nurse competencies for medication orders and re-ordering medication was added to the Facility Assessment and to the orientation and annual education program for licensed nurses. The competency and education includes re-order timelines and facility specific Policy and Procedure for ordering.</p> <p>The facility Policy and Procedures were revised to include the facility specific process for re-ordering medication.</p> <p>Monitoring: The Director of Nursing or Designee will audit the medication record and available medications of 10 residents, weekly for four weeks, monthly for three months and quarterly for two quarters. The results of the audit will be reported to the Quality Assurance and Performance Improvement Committee quarterly. The Quality Assurance Performance Improvement committee will determine if the audit requires continuation or is deemed completed at the October 2025 quarterly meeting.</p> <p>The Director of Nursing or designee will audit the completion of competencies for</p>		

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F 755	Continued From page 32	F 755	medication orders and re-ordering medication for all licensed nurses upon hire and annually. Completion of competencies will be monitored weekly for 4 weeks and then monthly for 3 months and quarterly for two quarters. The results will be reported to the Quality Assurance and Performance Improvement Committee at least Quarterly. The Quality Assurance and Performance Improvement Committee will determine if the audit requires continuation or is deemed completed at the October quarterly meeting.		
F 838 SS=F	<p>Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5)</p> <p>§483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.</p> <p>§483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population,</p>	F 838		4/18/25	

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F 838	Continued From page 33 using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources,	F 838			

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F 838	<p>Continued From page 34</p> <p>such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).</p> <p>§ 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.</p> <p>§483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).</p> <p>§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.</p>	F 838			

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F 838	<p>Continued From page 35</p> <p>§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.</p> <p>§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.</p> <p>§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the Facility Assessment (FA) failed to identify and include the staff competencies and skill sets necessary to provide the type of care required for the resident population. This deficient practice had the potential to affect all residents and was evidence by the following:</p> <p>On 3/12/25 at 11:20 AM, the US FOIA (b)(6) provided a copy of the FA dated NJ Exec Order 26.4b1 which revealed an attendance sheet with an Agenda that included, but was not limited to; Data-Disease/Conditions/Physical Behaviors needs/ Cognitive disabilities/Acuity and Staff Competencies and Skill Sets. The body of the document included Staff Competencies/Skill NJ Exec Order 26.4b1</p>	F 838	<p>Correction;</p> <p>The Administrator conducted a Facility Wide Assessment consistent with and informed by individual resident assessments with key personnel on Thursday 4/4/25. The 2025 Facility Assessment was revised to address required competencies and skill sets necessary to provide the level and types of care needed for the resident population.</p> <p>The revised Facility Assessment was reviewed by the Quality Assurance Committee on 4/5/25 and approved.</p> <p>Competencies were developed for Hemodialysis and Wound Care and added to the facility assessment.</p> <p>Identify:</p>		

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F 838	<p>Continued From page 36</p> <p>NJ Exec Order 26.4b1 [REDACTED] ... Staffing Plans: ...Staff competencies are conducted annually and when new skill sets are required based on resident care needs ... The [facility name redacted] can provide services for the following diagnosis/care categories: Common Diagnosis, NJ Exec Order 26.4b1 [REDACTED]</p> <p>[REDACTED] Specific Care or Practices: NJ Exec Order 26.4b1 [REDACTED] prevention and NJ Exec Order 26.4b1 [REDACTED]</p> <p>NJ Exec Order 26.4b1 [REDACTED] Other special care needs included [REDACTED] The document failed to include any staff competencies related to the specific care identified for the resident population.</p> <p>On 03/18/25 at 9:57 AM, the surveyor interviewed the [REDACTED] US FOIA (b)(6) regarding the FA and asked the [REDACTED] US FOIA (b)(6) if she was aware of the revised regulations related to the FA. The [REDACTED] US FOIA (b)(6) confirmed she was aware and stated the FA was in compliance, and was also reviewed by the corporation. The surveyor reviewed the FA in the presence of the [REDACTED] US FOIA (b)(6) and asked if the FA identified the specific staff competencies that were needed to care for the resident population. The surveyor asked specifically about any competencies related to care, including NJ Exec Order 26.4b1 [REDACTED] and NJ Ex Order 26.4b1 [REDACTED] care. The [REDACTED] US FOIA (b)(6) looked through the FA and stated, "I don't see it there."</p> <p>On 03/18/25 at 10:05 AM, the survey team met with the [REDACTED] US FOIA (b)(6) and no additional information was provided.</p>	F 838	<p>All residents receiving hemodialysis and wound care services were identified. All residents receiving hemodialysis and wound care services have the potential to be affected when competencies are not established in these areas of care.</p> <p>Systemic Changes: Hemodialysis and wound care services were added to the competencies required for completion for licensed nurses(RN,LPN)upon hire and annually.</p> <p>The Facility Assessment was revised to include a spread sheet that specifically addresses the required competencies and resources used to complete the competency.</p> <p>Monitoring: The Administrator or designee will audit the Facility Assessment for compliance using the Pathway Health Facility Assessment Quality Audit Tool monthly for three months and quarterly for 2 quarters. The audit will utilize data from the EMR report of resident diagnosis in order to identify service areas that would require a substantial modification of the Facility Assessment, or any part of it. The results of the audit will be reported to the Quality Assurance and Performance Improvement Committee quarterly. The Quality Assurance Performance Improvement committee will determine if the audit requires continuation or is deemed completed at the October Quality Assurance and Performance Improvement Committee meeting</p>		

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F 838	Continued From page 37	F 838			
F 865 SS=F	<p>NJAC 8:39-13.4(b) QAPI Prgm/Plan, Disclosure/Good Faith Atmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)</p> <p>§483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:</p> <p>§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;</p> <p>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;</p> <p>§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and</p> <p>§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with</p>	F 865		5/1/25	

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F 865	<p>Continued From page 38 requirements to a State Survey Agency, Federal surveyor or CMS upon request.</p> <p>§483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:</p> <p>§483.75(b)(1) Address all systems of care and management practices;</p> <p>§483.75(b)(2) Include clinical care, quality of life, and resident choice;</p> <p>§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.</p> <p>§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.</p> <p>§483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:</p> <p>§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.</p> <p>§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;</p>	F 865			

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F 865	<p>Continued From page 39</p> <p>§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;</p> <p>§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.</p> <p>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and</p> <p>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.</p> <p>§483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>§483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to self-identify all areas for improvement, then develop, implement and maintain a comprehensive, measurable, data driven Quality Assurance and Performance improvement (QAPI) program to address all systems and review significant events at QAPI. The deficient practice had the potential to affect all residents and was evidenced by the following:</p>	F 865	<p>Correction;</p> <p>All current QAPI reviewed by the surveyor were revised using an updated QAPI Tool with measurable SMART goals included.</p> <p>The administrator initiated a QAPI for all observed concerns identified during survey.</p>		

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F 865	<p>Continued From page 40</p> <p>Refer to F550, F677, F678</p> <p>On 3/18/25 at 9:22 AM, the surveyor interviewed the US FOIA (b)(6) regarding the QAPI program. The surveyor asked the US FOIA (b)(6) to identify all the current QAPI plans. The US FOIA (b)(6) stated that call bell response was identified from the resident council, and from grievances and the US FOIA (b)(6) provided the surveyor with the QAPI plan which was reviewed in the presence of the US FOIA (b)(6). The Problem Statement revealed: "Staff are to answer call lights."; The SMART Goal revealed: To respond residents need and request expeditiously and appropriately at all times."; The Root Cause/s: What are the contributing factors that cause the problem? "Staff not mindful of the call lights" and "Staff forget to turn off the call lights after answering their needs."; What is the importance of this goal? "To respond resident's needs appropriately in a timely manner."; Barrier/s: What difficulties will you encounter implementing your goal?</p> <p>The surveyor asked the US FOIA (b)(6) since the date of the goal is NJ Exec Order 28748, where is the measurable progress documented. The US FOIA (b)(6) reviewed the QAPI in the presence of the surveyor and stated, "I don't see the SMART goal is measurable." When asked what SMART meant the US FOIA (b)(6) stated, "we are not making it measurable."</p> <p>When asked what the remaining QAPI plans were, the US FOIA (b)(6) stated, that the facility identified that the staff were not all completing the online education system. When asked to provide the QAPI, the US FOIA (b)(6) stated they were in the "middle of it". When asked about a specific and</p>	F 865	<p>Nurse aides were in-serviced on Resident Rights and the treatment of residents with dignity and respect.</p> <p>Certified Nurse Aides were in-serviced on ADL Care for Dependent Residents.</p> <p>The Administrator identified all nurses and nurse aides who required renewal of BLS and CPR certification The VP of Health Service re-educated the Administrator and Director of Nursing on QAPI process</p> <p>Identify:</p> <p>All resident have the potential to be affected when the facility fails to self-identify all areas for improvement, then develop, implement and maintain a comprehensive, measurable, data driven Quality Assurance and Performance improvement (QAPI) program to address all systems and review significant events at QAPI.</p> <p>Systemic Changes:</p> <p>An audit requirement for POLST with corresponding EMR Physician Orders was added to the QAPI Plan to be measured quarterly by the Social Worker with a benchmark of 100% compliance.</p> <p>The policy and procedure for CPR was revised to include staff competency upon hire and annually.</p>		

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F 865	<p>Continued From page 41</p> <p>measurable goal, the [US FOIA (b)(6)] stated she did not have a document to show the surveyor, but the performance had improved from [NJ Exec Order 26.4b1]</p> <p>The [US FOIA (b)(6)] stated the facility had a QAPI on the inconsistent availability of the resident weights. The surveyor asked if the goal was specific and measurable and the [US FOIA (b)(6)] stated, "I don't have it, maybe the [US FOIA (b)(6)] had it?"</p> <p>The [US FOIA (b)(6)] stated there was a QAPI with [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1]. The surveyor asked if [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] was an adverse event? The [US FOIA (b)(6)] stated, yes, and it went into the internal "risk management system." The surveyor asked if adverse events were reviewed in QAPI and she stated, "no, I don't see it here, I cannot show it to you."</p> <p>The surveyor asked the [US FOIA (b)(6)] if hand hygiene during meals and standing and cutting resident meals has been identified as a concern per surveyor observations. The [US FOIA (b)(6)] stated, "that has not been identified as an issue" or had any concerns regarding that brought to her attention.</p> <p>The surveyor then asked if the [US FOIA (b)(6)] was aware of staff placing [NJ Exec Order 26.4b1] residents as observed during the survey. The [US FOIA (b)(6)] stated, "no", the Aides (Certified Nurse Aides) never brought it to my attention. The surveyor asked was placing a [NJ Exec Order 26.4b1] on a resident, okay? The [US FOIA (b)(6)] stated, "no, I expect the primary nurses to be checking from time to time." The surveyor asked the [US FOIA (b)(6)] if there were any audits or documents to show that care was monitored, and she stated, "No."</p> <p>On 3/18/25 at 12:07 PM, the survey team</p>	F 865	<p>The Quality Assurance and Performance Reporting Tool was revised to identify that the goal recorded must be specific, measurable, attainable, relevant and time bound(smart). Current/On-going Quality Assurance audits were reviewed and revised to record a "smart" goal.</p> <p>An Observational Rounds Tool was developed for audits in the areas of service which include wound care, hand hygiene, ADL care for functionally and cognitively impaired residents, dining infection control and resident dignity. The Observational Tool has been added to the Quality Assurance and Performance Improvement Plan with a benchmark of 100% compliance.</p> <p>The Monitoring Form for nursing staff license expiration was revised to include a column for BLS and CPR certification expiration dates. Expirations and presence of copies will be monitored monthly as part of the Quality Assurance and Performance Improvement Plan. The benchmark for this was set 100%</p> <p>Monitoring:</p> <p>The Administrator, and/or designee, will conduct an audit on all revised QAPI Plan. These audits will be conducted weekly for four weeks, monthly for three months and quarterly of two quarters. The Administrator will report to the QAPI Committee. The Quality Assurance Performance Improvement committee will</p>		

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F 865	Continued From page 42 interviewed a US FOIA (b)(6) regarding when on NJ Exec Order 26.4b1 6:00 PM, staff observed Resident #18 sitting in NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 ... Resident NJ Exec Order 26.4b1 at 6:00 PM. The US FOIA (b)(6) stated that the resident NJ Exec Order 26.4b1 and she had confirmed that she was the US FOIA (b)(6) supervisor that day. The surveyor asked the US FOIA (b)(6) if her NJ Exec Order 26.4b1 training was up to date. The US FOIA (b)(6) proceeded to look at her phone and looked up her NJ Exec Order 26.4b1 certification and stated, "it is expired, I thought it was due in NJ Exec Order 26.4b1 ". The surveyor requested all the NJ Exec Order 26.4b1 education for the nursing staff. On 3/18/25 at 1:56 PM, during an interview with the US FOIA (b)(6) the surveyor asked if she had been aware that the RN's NJ Exec Order 26.4b1 certification was expired. The US FOIA (b)(6) confirmed the US FOIA (b)(6) certification was expired and was unable to provide a list of all the NJ Exec Order 26.4b1 certifications of the nurses because only the former US FOIA (b)(6) had access to it. On 3/18/25 at 1:59 PM, the surveyor asked the US FOIA (b)(6) how the facility would ensure that there was a NJ Exec Order 26.4b1 certified staff member on each shift. The US FOIA (b)(6) stated that the US FOIA (b)(6) was incorrectly listed as having a current NJ Exec Order 26.4b1 certification.	F 865	determine if the audits requires continuation or is deemed completed at the October Quality Assurance and Performance Improvement meeting.		
F 880 SS=E	NJAC 8:39-33.1-4 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	F 880		4/18/25	

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F 880	<p>Continued From page 43</p> <p>designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§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:</p> <p>§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 §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the</p>	F 880			

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F 880	<p>Continued From page 44</p> <p>least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, it was determined that the facility failed to a.) follow appropriate infection control protocols during a [redacted] treatment observation. This deficient practice was identified for 1 of 2 residents (Resident # 54) reviewed with [redacted] b.) perform hand hygiene (HH) between serving food, removing dirty dishes, and when assisting residents. The deficient practice was identified in 1 of 1 dining room meal observation, for 3 of 4 residents (Resident #27, #29 and #46) reviewed for dining and was evidenced by the following:</p> <p>1. On 3/14/25 at 10:30 AM, the surveyor</p>	F 880	<p>Correction;</p> <p>The hand sanitizer(HH) dispenser was immediately replaced in the "remote kitchen".</p> <p>The Dining Server (DS) received immediate education on proper hand hygiene.</p> <p>CNA #2 received immediate education on proper hand hygiene as well as in-servicing on resident rights and dignity.</p> <p>Resident #54 [redacted] was observed for [redacted] by the [redacted] care consultant</p>		

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F 880	<p>Continued From page 45</p> <p>observed the US FOIA (b)(6)) perform a NJ Exec Order 26.4b1 treatment to the NJ Exec Order 26.4b1 of Resident #54, two certified Nursing Aides (CNA) assisted the US FOIA (b) during the NJ Exec Order 26.4b1 treatment.</p> <p>The US FOIA (b) prepared the over bed table and gather the needed supplies to complete the treatment. The US FOIA (b) placed the supplies on the overbed table.</p> <p>At 10:45 AM, the surveyor observed the US FOIA (b) removed the NJ Exec Order 26.4b1, dispose of the NJ Exec Order 26.4b1, removed the soiled gloves and placed them in the trash can inside the room. The US FOIA (b) then, without first performing HH, donned (put on) a clean pair of gloves and cleaned the NJ Exec Order 26.4b1 with [name redacted] NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 and patted the NJ Exec Order 26.4b1. The US FOIA (b) did not wash her hands or used Alcohol Based Hand Rub (ABHR) to cleanse her hands after removing the NJ Exec Order 26.4b1. The US FOIA (b) then donned gloves, applied the treatment NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 then attempted to NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 that was not NJ Exec Order 26.4b1. With the gloved hand the US FOIA (b) attempted to retrieve a pair of scissors from her pants pocket. The US FOIA (b) then could not reach the scissors and asked the US FOIA (b) to assist. The US FOIA (b) with her gloved hand reached for the scissors and gave them to the US FOIA (b). The US FOIA (b) picked up the scissors and cut the NJ Exec Order 26.4b1. The US FOIA (b) was about to insert the NJ Exec Order 26.4b1 to pack the NJ Exec Order 26.4b1 when the surveyor asked the US FOIA (b) if the scissors were clean or had they been disinfected. The US FOIA (b) then, donned a clean pair of gloves, disinfected the scissors, cut the NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1. The US FOIA (b)</p>	F 880	<p>through NJ Exec Order 26.4b1. The Licensed practical nurse was removed from the work schedule on 3/14/25 for re-training by the Infection Preventionist, The Licensed Practical Nurse was educated on the facility Policy and Procedure for NJ Exec Order 26.4b1 and observed for clean NJ Exec Order 26.4b1 which includes donning and doffing gloves, hand sanitation intervals and sanitation of equipment and supplies.</p> <p>Residents #46,#29 and #27 NJ Exec Order 26.4b1 were observed through NJ Exec Order 26.4b1 by the Infection Preventionist in order to identify and NJ Exec Order 26.4b1 concerns.</p> <p>Identify: All residents have the potential to be affected by improper hand hygiene.</p> <p>All residents receiving wound treatments have the potential to be affected by improper wound treatment(or Clean Dressing)technique.</p> <p>Systemic Changes: The Facility Clean Dressing Policy was changed to include the steps to follow while packing a wound.</p> <p>A Competency on Wound Care including clean dressings was added to the Facility Assessment to be completed by the Director of Nursing or designee upon hire, annually and when monitoring identifies the need for an updated competency.</p>	

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F 880	<p>Continued From page 46</p> <p>then applied a [redacted] for [redacted]. The [redacted] did not disinfect the overbed table after disposing of the unused supplies into the trash can. The [redacted] then signed the resident's Treatment Administration Record (TAR) for completion of the [redacted] treatment.</p> <p>On 3/14/25 at 11:30 AM, the surveyor reviewed the observed treatment with the [redacted]. The [redacted] confirmed that she missed some steps during the [redacted] care. The [redacted] stated that she should have washed her hands after removing the [redacted] prior to applying a clean pair of gloves.</p> <p>The surveyor reviewed Resident #54's electronic medical record. The admission Face Sheet reflected that Resident #54 had diagnoses which included but were not limited to; [redacted].</p> <p>[redacted]. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident was at [redacted] for developing [redacted] and had a [redacted].</p> <p>A review of the Care Plan initiated [redacted] reflected a problem for alteration in [redacted] related to [redacted]. The goals were the resident's [redacted] will continue to improve [redacted]. The interventions included: [redacted] as ordered, monitor for [redacted] and provide [redacted] care as needed. A review of Physician's Orders sheet (POS) for [redacted], reflected an order dated [redacted] for the [redacted] to be [redacted] with [name redacted]</p>	F 880	<p>Signage was added to the remote kitchen to remind food service staff to change gloves and perform hand hygiene based on protocols.</p> <p>The Hand Hygiene Competency was changed to add Infection Preventionist observation of staff serving residents in dining rooms and day rooms.</p> <p>The Dining Room was added to the observation tasks for the Infection Preventionist at least weekly</p> <p>Monitoring: The Director of Nursing or designee will audit wound treatments using the Observational Rounds/Wound Care tool on 3 residents weekly for four weeks, monthly for three months and quarterly for two quarters, ensuring that each staff nurse is observed over that time for Competency. The results will be reported to the Quality Assurance and Performance Improvement Committee quarterly. The Quality Assurance Performance Improvement committee will determine if the audit requires continuation or is deemed completed at the October Quality Assurance and Performance Improvement quarterly meeting.</p> <p>The Director of Nursing or designee will audit hand hygiene using the Observational Rounds/Dining tool weekly for four weeks, monthly for three months and quarterly for two quarters. The results will be reported to the Quality Assurance</p>		

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F 880	<p>Continued From page 47</p> <p>NJ Exec Order 26.4b1 -Remove with NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 -apply to NJ Exec Order 26.4b1 and with NJ Exec Order 26.4b1 every day and as needed.</p> <p>A review of the facility's policy titled, "Clean Dressing" last revised 1/28/25, revealed the following:</p> <p>Policy: The licensed nurse will use clean techniques for all dressing changes unless otherwise ordered by the physician. The policy did not address the steps to follow for packing a wound. A review of the treatment observation document attached to the facility policy reflected that staff were to wash their hands, after setting the clean field, after disinfecting the over bed table and after removal of the soiled dressing.</p> <p>2. On 3/12/25 at 11:49 AM, two surveyors observed the lunch meal in the dining room and observed the following:</p> <p>The remote kitchen was adjacent to the dining room and the surveyors observed through an open door that there was one dietary staff (DS) serving food in the kitchen and two CNAs were assisting residents in the dining room.</p> <p>On 3/12/25 at 12:04 PM, the DS entered the dining room wearing gloves and served soup to the residents. The DS returned to the kitchen and failed to remove her gloves or perform HH. The surveyor then observed CNA #2, was assisting Resident #29 at the lunch meal, CNA #2 then Resident #29 got up in the middle of assisting</p>	F 880	and Performance Improvement Committee quarterly. The Quality Assurance Performance Improvement committee will determine if the audit requires continuation or is deemed completed at the October Quality Assurance and Performance Improvement quarterly meeting.		

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F 880	<p>Continued From page 48</p> <p>Resident #29 and without first performing HH, walked to the back table and picked up the utensil for Resident #46 and handed it to the resident. CNA #2, without first performing HH, then returned to assist Resident #29.</p> <p>On 3/12/25 at 12:13 PM, the DS plated lunch plates and entered the dining room wearing the same gloves and served residents their lunch meal. At that time the surveyor observed that the HH dispenser adjacent to the dining room party entrance was empty. The surveyor informed the US FOIA (b)(6) who was also present and the US FOIA (b)(6) placed her hand under the dispenser and confirmed that the HH did not work.</p> <p>She reentered the kitchen at 12:17 PM, failed to remove gloves or perform HH and plated meals for the residents.</p> <p>On 3/12/25 at 12:13 PM, On 3/12/25 at 12:23 PM, CNA #2 who was assisting a resident with NJ Exec Order 26-41 stopped NJ Exec Order 26 the resident and walked over to a table with three residents and was handling their cups and utensils (Resident #46 and #27) and used a knife cut Resident #27's food, then without first performing HH returned to assist Resident #29 with their meal.</p> <p>On 3/12/25 at 12:14 PM, CNA #2 again got up from assisting Resident #29 and began removing dirty dishes from Resident #46 and without first performing HH went back to Resident #29 and used the resident's cup to offer a drink to Resident #29.</p> <p>On 3/12/25 at 12:19 PM, the DS delivered three more meals, and then removed two dirty soup bowls. The DS then returned to the kitchen still</p>	F 880			

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F 880	<p>Continued From page 49</p> <p>wearing the same gloves and without performing HH after removing the soiled dishes. At 12:22 PM, the DS delivered two more meals while still wearing the same gloves that were used to remove dirty dishes and plate up other meals.</p> <p>On 3/12/25 at 12:24 PM, CNA #2 walked over to Resident #27 and held that resident's hand while asking that resident if they wanted ice cream. CNA #2 then, without first performing HH, returned to resident #29 and continued to assist with feeding.</p> <p>On 3/12/25 at 12:26 PM, the DS was observed wearing the same gloves, delivered one meal to a resident, returned to the kitchen and began placing desserts on a cart. She did not change remove her gloves or perform HH. At 12:28 PM, the DS removed her gloves and put on new gloves without first performing HH, and then passed desserts from a cart to the resident in the dining room.</p> <p>On 3/12/25 at 12:32 PM, the DS returned to the pantry wearing the same gloves, proceeded to open up packages of crackers, placed the non-sealed crackers on a saucer, and served soup with the crackers to a resident in the dining room.</p> <p>On 3/12/25 at 12:33 PM, CNA #2 stopped assisting Resident #29 when another resident entered the dining room, and without first performing HH she assisted the newly arrived resident to sit, and then handed them their utensils.</p> <p>On 3/12/25 at 12:36 PM, the DS while wearing gloves, pushing the cart into the dining room,</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/18/2025
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MEADOW LAKES EAST WINDSOR, NJ 08520		
(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 880	<p>Continued From page 50</p> <p>then simultaneously provided residents with desserts while removing dirty dishes and placed on the same cart, then placed a tea bag in water opened and then used the same gloved hands to open [REDACTED] for a resident. There was no HH performed between providing food items and removing soiled items and at 12:42 PM, the DS then walked into the kitchen while pulling up her pants wearing the same gloves. The DS did not remove her gloves or perform HH and obtained a meal for a resident, and then delivered the meal, removed more dirty dishes while wearing the same gloves.</p> <p>On 3/12/25 at 12:46 PM, upon interview the DS stated she did not change the gloves because "I go fast." She further stated that she did not need to perform HH because it was only her, and she was not leaving the dining room. When asked about performing HH between delivering meals and removing dirty dishes, the DS stated she did not need to change her gloves just to deliver food and that there was usually another staff member there to assist her.</p> <p>On 3/12/25 at 1:08 PM, the [REDACTED] US FOIA (b)(6) stated that the kitchen staff should not be using the same gloves and should use HH between tasks. The [REDACTED] US FOIA (b)(6) further stated that the DS had been educated and usually would have others to help in the dining room.</p> <p>A review of the facility provided policy, "Hand Hygiene" revised 1/22, included but was not limited to; Policy: all associates handling food shall wash hands with soap and water at the following times (included) before handling good or clean utensils/dishes/equipment; before putting on gloves; after touching clothing; after handling</p>	F 880			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 880	<p>Continued From page 51</p> <p>soiled silverware/utensils; after handling garbage; after removing gloves; and after activities that may contaminate the hands.</p> <p>On 3/14/25 at 12:58 PM, the above concerns were presented to the facility.</p> <p>On 3/18/25 at 10:05 AM, the [REDACTED] presented documentation that the DS had been in serviced on hand hygiene on 2/13/25.</p> <p>NJAC 8:39 -19.4 (a)</p> <p>Surveyor: [REDACTED] NJ Exec Order 26.4b1</p> <p>Surveyor: [REDACTED] NJ Exec Order 26.4b1</p>	F 880			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/18/2025
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NAME OF PROVIDER OR SUPPLIER MEADOW LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 300 MEADOW LAKES EAST WINDSOR, NJ 08520
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S 000	<p>Initial Comments</p> <p>Survey Date: 3/18/25</p> <p>Complaint: # NJ 177680</p> <p>Census: 49</p> <p>Sample: 13 + 2 Closed Records</p> <p>The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/20/25

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315022	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 5/20/2025	Y3
NAME OF FACILITY MEADOW LAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MEADOW LAKES EAST WINDSOR, NJ 08520		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0640	Correction	ID Prefix F0677	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	05/01/2025	LSC	04/18/2025	LSC	04/18/2025
ID Prefix F0678	Correction	ID Prefix F0689	Correction	ID Prefix F0697	Correction
Reg. # 483.24(a)(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(k)	Completed
LSC	05/01/2025	LSC	04/18/2025	LSC	04/18/2025
ID Prefix F0698	Correction	ID Prefix F0755	Correction	ID Prefix F0838	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.71(a)(1)(3)(b)(1)(c)(1)-(5)	Completed
LSC	04/18/2025	LSC	04/18/2025	LSC	04/18/2025
ID Prefix F0865	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	05/01/2025	LSC	04/18/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/18/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315022	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MEADOW LAKES EAST WINDSOR, NJ 08520		
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E 000	Initial Comments	E 000			
K 000	<p>An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facilities Survey and Field Operations on 3/13/25 and 3/14/25. The facility was found to be in compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance, 42 CFR 483.73, Requirements for Long Term Care Facilities.</p> <p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 3/13/25 and 3/14/25, and the facility was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy.</p> <p>The facility is one story first occupied in 1965. The facility has concrete flooring, multiple roofing materials including fiberglass and wood sheathing and block bearing walls. The facility is noted to be a type III (211) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has two generators. One 2250 KW (kilowatt) diesel generator generates power for the entire campus and a back-up 60 KW for the health center. The facility has three smoke compartments in the certified area. The facility had a census of 49 at the time of survey.</p>	K 000			
K 222 SS=D	Egress Doors CFR(s): NFPA 101	K 222		3/27/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/01/2025

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

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K 222	Continued From page 1 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222			

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K 222	<p>Continued From page 2</p> <p>ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/14/25 in the presence of the US FOIA (b)(6) [REDACTED], it was determined the facility failed to provide a delayed egress locking system in the path of egress with a readily visible, durable sign in letters not less than 1 inch (in.) high and not less than 1/8 in. in stroke width on contrasting background that reads as follows located on on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, in accordance with NFPA 101: 2012 Edition, Section 7.2.1.6, 7.2.1.6.1.1 (4), and 19.2.2.2.1. This deficient practice had the potential to affect 12 of 49 residents and was evidenced by the following:</p>	K 222	<p>Plan of Correction</p> <p>Correction; A "Push Until Alarm Sounds, Door can be opened in 15 Seconds" sign was applied to the corridor double doors at the end of B-wing on 3/27/25.</p> <p>Identify: All secured/alarmed doors exiting the long term care unit to the interior or exterior were inspected by the Director of Security to ensure the required notice is in place. No other doors were identified to be without the notice. All residents have the potential to be affected by this deficient practice.</p>		

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K 222	Continued From page 3 An observation at 10:49 AM of the corridor double doors at the end of B- wing by room B-23, revealed the doors were equipped with delayed egress hardware and had an instructional sign to operate the doors that was not legible. The sign was scratched and faded. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 3:58 PM. N.J.A.C. 8:39-31.2(e)	K 222	Systemic Changes: The faded sign was not identified by the Maintenance Director or designee or Administrator or designee during monthly visual audits of the unit. The requirement to observe for the presence of a delayed egress sign, readily visible, has been added to the Monthly Life Safety Program Audit checklist. This monthly audit is conducted by the Maintenance Director or Designee and Administrator or Designee. Monitoring: The Maintenance Director or designee will conduct inspections for the presence of the signage weekly for four weeks and then monthly for 2 months and quarterly for 2 quarters. The benchmark will be 100% compliance. The findings of the inspection will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly.		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 293		3/20/25	

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K 293	<p>Continued From page 4</p> <p>Based on observations and interviews on 3/14/25 in the presence of the US FOIA (b)(6), it was determined the facility failed to ensure exits were marked by an approved sign that were readily visible from any direction of exit access for 2 of 2 enclosed court yard exit access areas in accordance with NFPA 101: 2012 Edition, Sections 19.2.10.1, 7.10, 7.10.1.2, and 7.10.1.5. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation of the B-wing court yard at 10:46 AM revealed there were no exit signs provided for exit access, path of egress travel out of the court yard area.</p> <p>An observation of the C-wing court yard at 11:25 AM revealed there were no exit signs provided for exit access, path of egress travel out of the court yard area.</p> <p>In interviews at the times, the US FOIA (b)(6) confirmed the observations.</p> <p>The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 3/14/25 at 3:58 PM.</p> <p>N.J.A.C. 8:39-31.2(e)</p>	K 293	<p>Plan of Correction</p> <p>Correction Lighted exit signs were installed over 2 doors on courtyard B and 2 doors in Courtyard C on 3/20/25.</p> <p>Identify: All residents have the potential to be affected by this deficient practice. Systemic Changes: A process to use the test button to test battery back-up for the exit signs was added to the Fire Inspection for testing once per month. These 4 new exit signs were added to the existing list for monthly inspection.</p> <p>Systemic Changes: A process to use the test button to test battery back-up was added to the Fire Inspection for testing once per month. These 4 new exit signs were added to the existing list for monthly inspection to be conducted by the Maintenance Director or Designee.</p> <p>Monitoring: The monthly test of exit signs was added to quality assurance rounds. The exit signs will be monitored monthly by the Maintenance Director or designee with a benchmark of compliance at 100%. The completion of the tests will be submitted to the Quality Assurance and Performance Improvement Committee at least quarterly.</p>		
K 324 SS=F	Cooking Facilities	K 324		3/18/25	

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K 324	<p>Continued From page 5 CFR(s): NFPA 101</p> <p>Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews on 3/14/25 in the presence of the US FOIA (b)(6) [REDACTED] it was determined the facility failed to perform monthly owners inspections of the range-hood fire wet chemical suppression systems in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and</p>	K 324	<p>Plan of Correction</p> <p>Completion: The March monthly owners Inspection was completed and was recorded on the kitchen range hood fire wet chemical suppression system on 3/18/25.</p> <p>Identify:</p>		

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K 324	<p>Continued From page 6</p> <p>NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 2:50 PM of the kitchen range-hood fire suppression system wet chemical inspection tag revealed the semi-annual inspection was performed February 2025 and there were no monthly inspections listed. The facility did not have monthly inspection documentation indicating the monthly owners inspection had been performed for the previous 12 months. No further documentation was provided.</p> <p>In an interview at the time, the [US FOIA (b)(6)] confirmed the observation and the [US FOIA (b)(6)] stated they did not perform an owners inspection.</p> <p>The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life Safety Code exit conference at 3:58 PM.</p> <p>N.J.A.C. 8:39-31.2(e) NFPA 17A, 96</p>	K 324	<p>There is one additional kitchen range food fire wet chemical suppression system located in the Independent Living Caf₂ which is not a apart of the Skilled Nursing Facility. This was also missing proof of monthly Inspections. This suppression system was also inspected on 3/18/25and recorded on the inspection tag. All resident have the potential for to be affected by this deficient practice.</p> <p>Systemic Changes: The monthly owner's inspection of the inspection of the kitchen range hood fire wet chemical suppression system was added to the Quality Assurance Facility Inspection list for monthly inspection.</p> <p>Monitoring: The Maintenance Director or designee will complete the monthly inspection and record it on the inspection tag. The Administrator or designee will inspect the tags monthly for 2 months to ensure compliance with recording the inspection on the tag. The benchmark was set at 100% compliance. The results will be reported to the Quality Assurance and Performance Improvement Committee at the next quarterly meeting.</p>		
K 343 SS=F	<p>Fire Alarm System - Notification CFR(s): NFPA 101</p> <p>Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant</p>	K 343		5/20/25	

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K 343	<p>Continued From page 7</p> <p>notification is provided automatically in accordance with 9.6.3 by audible and visual signals.</p> <p>In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire.</p> <p>19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews on 3/14/25 in the presence of the US FOIA (b)(6), it was determined the facility failed to ensure fire alarm occupant notification was provided automatically by audible and visual signals in accordance with NFPA 101: 2012 Edition Sections 19.3.4, 19.3.4.3.1, 9.6.3 and NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation of the B-wing court yard at 10:46 AM revealed there were no fire alarm horn/strobe notification devices provided for the court yard area.</p> <p>An observation of the C-wing court yard at 11:25 AM revealed there were no fire alarm horn/strobe notification devices provided for the court yard area.</p> <p>In interviews at the times, the US FOIA (b)(6) confirmed the observations.</p> <p>The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 3/14/25 at 3:58</p>	K 343	<p>Plan of Correction</p> <p>Correction</p> <p>A quote was obtained from a qualified vendor for the purchase and installation of 2 Horn Strobes in both B and C wing courtyards. The agreement for installation was signed on 3/31/25. The work has received the approval by the municipal inspector office on 4/30/25. The installation of horns and strobes is scheduled for 5/20/25 .</p> <p>This deficient practice was not previously identified during annual municipal fire inspections and the municipal inspector has been advised on 4/30/25 to observe this areas and other like it upon annual inspection.</p> <p>All nursing supervisors and managers on duty were notified to observe courtyard areas in the event of a fire alarm to ensure visitors or residents present in courtyards are notified of the alarm pending installation.</p> <p>Identify: B and C wing are the only interior</p>		

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K 343	Continued From page 8 PM. N.J.A.C. 8:39-31.2(e) NFPA 72	K 343	<p>courtyards in long term care. There are no other interior courtyards in the long term care area that require fire alarm notification. All residents and visitors who use the B and C wing interior courtyards have the potential to be effected by this deficient practice.</p> <p>Systemic Changes: Testing of the horn strobes were added to the monthly in-house fire alarm testing inspection which recorded and conducted by the Maintenance Director or Designee.</p> <p>Monitoring: Fire alarm testing is completed monthly by the Maintenance Director or designee. Upon installation, these horn strobes will be added to the testing and tested monthly with a benchmark of 100% and any variance in results of testing will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly.</p>		
K 353 SS=F	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p>	K 353		4/4/25	

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K 353	<p>Continued From page 9</p> <p>b) Who provided system test</p> <hr/> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews on 3/13/25 and 3/14/25 in the presence of the US FOIA (b)(6) [REDACTED], it was determined the facility failed to ensure 1. the dry pipe sprinkler system was air leak tested every 3 years, and 2. sprinkler heads and their escutcheons were maintained, in accordance with NFPA 101:2012 Edition, Sections 9.7 and NFPA 25:2011 Edition, Sections 13.4.4.2.9, 5.2.1.1.1 to 5.2.1.1.4, 5.2.3.2 and 5.4.1.8. This deficient practice had the potential to affect all residents and was evidence by the following:</p> <p>1. A record review on 3/13/25 revealed there was a dry pipe sprinkler system protecting the Long Term Care (LTC) area of the building and there was no record of an Air Leak Test being performed every 3 years as required. No document of an Air Leak Test was provided.</p> <p>In an interview on 3/14/25 at 12:00 PM, the US FOIA [REDACTED] stated that the facility's sprinkler service told him that the full trip test is the same thing and they did not have to do the Air Leak Test, they only had to do the Air Leak Test if they had a problem.</p> <p>2. Observations during a facility tour on 3/14/25</p>	K 353	<p>Plan of Correction</p> <p>Correction: The Dry Pipe Sprinkler System was air leak tested by the facility's qualified vendor on 3/18/2025. The inspection was successful and recorded on 3/18/25.</p> <p>Sprinkler Heads escutcheons were repaired or replaced to remove exposures and openings by the facility's qualified vendor on 3/19/25 in the drop ceiling over the double doors near the Director of Nursing Office, the B wing janitor closet, the B wing electrical closet, the B wing soiled utility room, the B wing day room, and the B wing corridor ceiling by the nurses station.</p> <p>Identify: The 3 years air leak test was not identified on the Quality Assurance and Performance Improvement Maintenance Schedule which resulted in the facility's failure to test. The Maintenance Schedule was reviewed to identify any other missing test or inspection requirements and the Dry Pipe Sprinkler System air leak test was added to the Schedule.</p>		

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K 353	<p>Continued From page 10 from 10:00 AM to 11:47 AM revealed the following:</p> <p>a. In the drop ceiling on the LTC side of the double smoke doors by the [US FOIA (b)(6)] office, there was a sprinkler head that had its escutcheon coming down 1/2-inch exposing a 1/2-inch by 2-inch opening through the ceiling on the side of the escutcheon.</p> <p>b. In the B-wing janitors closet, the escutcheon was coming down 3/4-inch on the sprinkler head exposing an open space in the dry wall ceiling.</p> <p>c. In the B-wing electrical closet by room B22, the sprinkler head was missing its escutcheon.</p> <p>d. In the B-wing soiled utility room, the escutcheon was coming down 5/8-inch.</p> <p>e. In the B-wing day room, one of 9 sprinkler escutcheons was coming down 1-1/4 inch.</p> <p>f. In the B-wing corridor ceiling by the nurses station office and day room, a sprinkler head was missing its escutcheon.</p> <p>In an interviews at the times, the [US FOIA (b)(6)] [US FOIA (b)(6)] [US FOIA (b)(6)] and Administrator confirmed the observations.</p> <p>The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life Safety Code exit conference at 3:58 PM.</p> <p>N.J.A.C. 8:39-31.2(e) NFPA 25</p>	K 353	<p>The Monthly Life Safety Program Audit was not specific to identify the deficient condition of exposure or openings to be observed. An inspection of the sprinkler head escutcheons was conducted by the facility's qualified vendor on 3/19/25 and no other sprinkler head escutcheons were found to cause exposures or openings.</p> <p>All residents have the potential to be affected by this deficiency.</p> <p>Systemic Changes:</p> <p>The Dry Pipe Sprinkler System Test was added to the Quality Assurance and Performance Improvement Maintenance Schedule of required tests with inspection to be conducted by a qualified vendor and to occur every 3 years.</p> <p>Inspections of the sprinkler head escutcheons to observe exposures and/or openings was added to the Monthly Life Safety Program Audit process for monthly inspection by the Maintenance Director or Designee.</p> <p>Monitoring:</p> <p>The presence of the Dry Pipe Sprinkler System test will be observed by the Administrator or designee every 3 years and variances reported to the Quality Assurance and Performance Improvement Committee quarterly.</p> <p>The Maintenance Director or designee will</p>		

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K 353	Continued From page 11	K 353	inspect sprinkler heads escutcheons weekly for 4 weeks and then monthly for two months and quarterly for 2 quarters. The benchmark for the inspection is 100% compliance, any variance in the benchmark will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly.		
K 355 SS=F	<p>Portable Fire Extinguishers CFR(s): NFPA 101</p> <p>Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews 3/14/25 in the presence of the US FOIA (b)(6) [REDACTED], it was determined the facility failed to ensure that Class K portable fire extinguishers were provided with the required instructional placard in accordance with NFPA 101:2012 Edition, Sections 9.7.4 and NFPA 10:2010 Edition, Sections 5.5.5.3, A 5.5.5.3. This deficient practice had the potential to affect all residents and was evidence by the following:</p> <p>An observation at 2:55 PM revealed that the Class K fire extinguisher in the kitchen was not provided with the required instructional placard stating that the fire protection system shall be actuated prior to using the class K portable fire</p>	K 355	<p>Plan of Correction</p> <p>Completion The Class K Fire Extinguisher sign stating that the fire protection system shall be actuated prior to using the Class K portable fire extinguisher. was installed at the location of the extinguisher in the main kitchen</p> <p>Identify: There are no other Class K extinguishers in the main kitchen or skilled nursing unit ancillary kitchen. All residents have the potential to be affected by this deficiency.</p> <p>Systemic Changes: The observation of the presence of the</p>	3/21/25	

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K 355	Continued From page 12 extinguisher. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 3:58 PM. N.J.A.C. 8:39-31.2(e) NFPA 10, 96	K 355	Class K extinguisher sign has been added to the monthly facility inspection list. Monitoring: The observation of the presence of the sign will be conducted by the Maintenance Director or his designee weekly for 4 weeks and monthly for 2 months. This has been set with a benchmark of 100%. The results of these inspections will be reported to the Quality Assurance and Performance Improvement Committee upon the next Quarter.		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		4/18/25	

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K 363	<p>Continued From page 13</p> <p>of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews on 3/14/25 in the presence of the US FOIA (b)(6) [REDACTED], it was determined the facility failed to ensure corridor doors positively latched and resisted the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect 6 of 49 residents and was evidenced by the following:</p> <p>An observation at 10:54 AM revealed the resident room B23 corridor door did not positive latch when tested.</p> <p>An observation at 10:57 AM revealed the resident room B20 corridor door did not positive latch when tested.</p> <p>An observation at 11:36 AM revealed the resident room B3 corridor door had a 5/8-inch space at the bottom quarter of the latching side of the door</p>	K 363	<p>Plan of Correction</p> <p>Completion</p> <p>On 3/25/25, a qualified vendor added rotund hinges to B-3 creating a positive latching and resolving gap.</p> <p>On 3/25/25, a qualified vendor added rotund hinges to B-20 creating a positive latching and resolving gap.</p> <p>On 3/25/25, a qualified vendor added rotund hinges to B-23, creating a positive latching and resolving gap.</p> <p>Identify:</p> <p>All corridor doors were tested by the Maintenance Director to identify any doors that did not positively latch or for gapping and warping. 13 doors were identified with concerns for latching, gaps and warping. 6 doors, B-17, C-19,C-4,C-1,B-12,B-13 were repaired by the qualified vendor with rotund hinge. 7</p>		

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K 363	Continued From page 14 leaf when it was closed into its frame allowing the passage of smoke. The open space traveled upwards between the door leaf and door frame tapering off at the door handle. In interviews at the times, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 3:58 PM. N.J.A.C. 8:39-31.2(e)	K 363	doors required replacement rooms B-2,B-6, B-8, B-23, C-3,C-13,C14 and replacement completed on 4/18/25. All residents have the potential to be affected by this deficient practice. Systemic Changes: The facility has established a new 2025/2026 Capital Budget plan to replace all solid core wood doors in corridors with steel craft fire rated doors. All doors found deficient for positive latch, gaps or warping during Quality Assurance inspections by the Maintenance Director or designee conducted at least monthly will be replaced immediately. Monitoring: All corridor doors will be inspected weekly by the Maintenance Director or designee for 4 weeks and then monthly each year. The benchmark is set for 100% compliance. Any variance in positive latching, gap or warping will be reported to the Quality Assurance and Performance Improvement Committee at least Quarterly		
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	K 911		3/20/25	

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K 911	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/14/25 in the presence of the US FOIA (b)(6), it was determined the facility failed to guard live electrical parts in accordance with NFPA 99: 2012 Edition Chapter 6 and NFPA 70, National Electric Code, 2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 11:10 AM of the C-wing serving pantry revealed a hand washing sink water source with a single electrical outlet under the sink that was not Ground Fault Circuit Interrupted (GFCI) protected.</p> <p>An observation at 11:27 AM of the activities room revealed an open electrical receptacle box approximately 7 feet up, recessed in the wall without a cover plate leaving exposed wires.</p> <p>In interviews at the times, the US FOIA (b)(6) confirmed the observations.</p> <p>The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference at 3:58 PM.</p> <p>N.J.A.C. 8:39-31.2(e) NFPA 70</p>	K 911	<p>Plan of Correction</p> <p>Correction The electrical outlet in the C-wing serving pantry was replaced with a medical grade GFCI outlet by a licensed electrician on 3/14/25.</p> <p>The electrical receptacle box cover was installed by the electrician on 3/14/25.</p> <p>Identify: An inspection of all outlets within 6 feet of a water source was conducted by the licensed electrician to identify any outlets that required GFCI. No other outlets were identified as deficient.</p> <p>The electrician conducted an inspection of all outlets in common areas and offices to identify missing receptacle covers. No additional covers were missing.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Systemic Changes: A new policy and procedure was developed by the Administrator and Maintenance Director to address new installation of electric and plumbing which requires the consideration of code enforcement to be addressed in contractor bids as applicable. The Maintenance Director reviews all bids to enforce this requirement. The specification to identify areas where GFCI</p>		

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K 911	Continued From page 16	K 911	is required when within 6 feet of a water source is included. The inspection of all outlets in common areas and offices was added to the facility Monthly Life Safety Program Audit to be conducted by the Maintenance Director or designee. and was added to the annual electrical inspection requirements to be conducted by the licensed electrician annually. Monitoring: The inspection of all outlets will occur weekly for 4 weeks, monthly for 2 months and then quarterly for 2 quarters. by the Maintenance Director or designee. The benchmark for compliance is set at 100%. Any variance will be reported to the Quality Assurance and Performance Improvement Committee at least Quarterly.		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		3/25/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315022	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2025
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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) COMPLETION DATE	
K 918	<p>Continued From page 17</p> <p>day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and interviews on 3/13/25 and 3/14/25 in the presence of the US FOIA (b)(6), it was determined the facility failed to perform annual and 36 month load bank tests and maintain records for 2 of 2 diesel powered generators in accordance with NFPA 110: 2010 Edition, Chapter 8. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>1. A record review on 3/13/25 of the 2250 kilowatt (kW) diesel powered generator log revealed:</p> <p>a. The generator was exercised monthly at a load</p>	K 918	<p>Plan of Correction</p> <p>Completion</p> <p>The vendor completed a Load Bank Test for 4 hours on the 2250 kilowatt diesel powered generator on 3/25/25.</p> <p>The vendor completed a Load Bank Test for 4 hours on the 60 kilowatt diesel powered generator on 3/25/25.</p> <p>Identify:</p> <p>There are no additional generators that require a Load Bank Test. All resident have the potential to be effected by this deficient practice.</p>		

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K 918	<p>Continued From page 18</p> <p>that was less than 30% of the name plate kW rating and there was no document of an annual Load Bank Test at the required supplemental loads for a duration of not less than 1.5 hours in the past 12 months.</p> <p>b. There was no document of the generator being exercised in the last 36 months for 4 continuous hours at a load of 30% of its nameplate kW rating or a 4 hour Load Bank Test performed at the required supplemental loads for the required durations of time.</p> <p>2. A record review on 3/13/25 of the 60 kW diesel powered generator revealed:</p> <p>a. The generator was exercised monthly at an unrecorded and undetermined load. It was unknown if the load was less than 30% of the name plate kW rating and there was no document of an annual Load Bank Test at the required supplemental loads for a duration of not less than 1.5 hours in the past 12 months.</p> <p>b. There was no document of the generator being exercised in the last 36 months for 4 continuous hours at a load of 30% of its nameplate kW rating or a 4 hour Load Bank Test performed at the required supplemental loads for the required durations of time.</p> <p>In an interview on 3/14/25 the [US FOIA] confirmed the record review.</p> <p>The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life Safety Code exit conference on 3/14/25 at 3:58 PM.</p>	K 918	<p>Systemic Changes:</p> <p>The completion of the 36 month Load Bank Test for 4 hours on the 2250KW generator was added to the budget and added to the vendor service list. The completion of the 36 month Load Bank Test for 4 hours on the 2250KW generator was added to the Quality Assurance and Performance Improvement Process. The 60 KW Generator was added to the Quality Assurance and Performance Improvement Process for annual load bank testing for 4 hours.</p> <p>Monitoring:</p> <p>The Maintenance Director or designee is responsible for the completion of both the annual and 36 month load tests. Completion will be recorded by the Maintenance Director or designee and will be reviewed by the Quality Assurance and Performance Improvement Committee at least quarterly. The benchmark has been set at 100%.</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

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K 918	Continued From page 19 N.J.A.C. 8:39-31.2(e)	K 918			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315022	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 5/20/2025	Y3
NAME OF FACILITY MEADOW LAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MEADOW LAKES EAST WINDSOR, NJ 08520		

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 _____ Reg. # NFPA 101 LSC K0222	Correction Completed 03/27/2025	ID Prefix _____ Reg. # NFPA 101 LSC K0293	Correction Completed 03/20/2025	ID Prefix _____ Reg. # NFPA 101 LSC K0324	Correction Completed 03/18/2025
ID Prefix _____ Reg. # NFPA 101 LSC K0343	Correction Completed 05/20/2025	ID Prefix _____ Reg. # NFPA 101 LSC K0353	Correction Completed 04/04/2025	ID Prefix _____ Reg. # NFPA 101 LSC K0355	Correction Completed 03/21/2025
ID Prefix _____ Reg. # NFPA 101 LSC K0363	Correction Completed 04/18/2025	ID Prefix _____ Reg. # NFPA 101 LSC K0911	Correction Completed 03/20/2025	ID Prefix _____ Reg. # NFPA 101 LSC K0918	Correction Completed 03/25/2025
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/18/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		