STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: 9/29/23 CENSUS: 84 SAMPLE SIZE: 20 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 689 SS=D	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, interviews, and record review it was determined that the facility failed to ensure a Ex.Order 26.4(b)(1), specifically a Ex.Order 26.4(b)(1) [redacted], was in place and functioning for a resident with a history of Ex.Order [redacted]. This deficient practice was identified for 1 of 2	F 689	CRITERIA 1: Resident #49 - Bathroom door alarm was replaced and activated on 9/27/23. Door was closed. CRITERIA 2:	10/31/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/12/2023

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

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F 689	Continued From page 1 residents reviewed for [redacted], Resident #49, and was evidenced by the following: According to the Admission Record, Resident #49 had diagnoses that included but were not limited to [redacted] A review of the Quarterly Minimum Data Set (MDS), an assessment tool, dated 9/10/2023, revealed that the resident had a Brief Interview for Mental Status (BIMS) of [redacted]" which indicated that the resident's [redacted]. An additional review of the MDS revealed the resident had [redacted]. A review of the Resident's care plan revised on 9/7/23 included that the resident was at risk for [redacted] related to [redacted] with a goal that the resident would be free of major [redacted]. Interventions included but were not limited to; Ex.Order 26.4(b)(1) added for safety which was initiated on 8/29/23. A review of progress notes, dated 8/27/23 at 3:10 am, reflected that the staff responded to an alarm and found the resident lying on the bathroom floor holding onto their [redacted]. A review of the resident's Incident Report (IR), dated 8/27/23, revealed that the resident was found on the floor in the bathroom and sustained a [redacted] to their [redacted]. The [redacted] investigation review indicated that a Ex.Order 26.4(b)(1) was added for safety on 8/28/23. On 09/27/23 at 10:45 AM the surveyor observed Resident #49 seated in a [redacted] in their	F 689	All residents have the potential to be affected by the deficient practice of failing to ensure that a [redacted] intervention, specifically a Ex.Order 26.4(b)(1), is in place and functioning for a resident with a history of falls. CRITERIA 3: The certified nursing assistant that was assigned to resident #49 on 9/27/23, 7a-3p shift, was counselled by the Director of Nursing and Assistant Director of Nursing on the same day. On 10/06/23, The Assistant Director of Nursing/Staff Educator started a mandatory inservice for all certified nursing assistants, nursing assistants and resident service assistants on the completion of safety checks as per facility protocol and on immediate reporting and replacement of any [redacted] prevention equipment that is observed to be faulty and non functional. All Charge Nurses are to ensure that safety checks are completed by the assigned staff and signed for before the end of each shift daily. Findings will be reported to the Unit Manager. CRITERIA 4: Unit Managers or designee will perform weekly spot checks on placement and	

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F 689	Continued From page 2 room. The surveyor observed the bathroom door was open with no audible alarm sounding. On 09/27/23 at 10:58 AM, the assigned certified nurses aide (CNA) entered the resident's room. The surveyor asked the CNA how they knew how to take care of residents who hac Ex.Order 2. The CNA stated they used a paper "cheat sheet", that let the staff know about resident care and alarms the resident should have. At that time, the surveyor asked the CNA to check the bathroom door. The CNA stated she didn't know about that alarm, looked at the Ex.Order 26.4(b)(1) and stated that the alarm wasn't working. On 09/27/23 at 10:59 AM the assigned Licensed Practical Nurse (LPN) was outside of the resident's room and stated she hadn't seen the resident yet, but the alarm was working the day prior. She added that the bathroom door should be closed. On 09/27/23 at 11:10 AM, the surveyor reviewed the CNA "cheat sheet" (titled daily report) with the CNA which indicated that the resident had a Ex.Order 26.4(b)(1). During an interview with the surveyor on 09/27/23 at 11:22 AM, the LPN stated that she and the Unit Manager (UM) informed the staff of interventions for the residents verbally and that their assignment (daily report) sheet would be updated. She stated that Resident #49's bathroom door should have been closed so if it was opened, the alarm would go off. During an interview with the surveyor on 09/27/23 at 12:12 PM, the Director of Nursing (DON) stated after a fall, the resident's care plan was	F 689	function of Ex.Order 26.4(b)(1), and to ensure that bathroom door is always closed. Unit managers or designee will submit a report of findings from the weekly spot checks that includes but not limited to, any root causes identified, and any corrective actions implemented. Reports will be submitted monthly for 3 months to the Director of Nursing and Administrator. All reports will be discussed at the Quality Assurance and Performance Improvement meeting held quarterly.	

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F 689	Continued From page 3 updated by the nurse or the Unit Manager, and the "transfer sheet" (daily sheet) with interventions would be updated for the CNAs. The DON added that the CNAs also access the resident's care plan. She stated the CNAs completed safety checks at the start and the end of the shift to ensure alarms were in place and functioning. She explained that the door to Resident #49's bathroom should have been closed and the alarm should have been checked for placement and functioning. During an additional interview with the surveyor on 09/28/23 at 10:01 AM, the DON stated that the Ex.Order 26.4(b)(1) was part of the resident's care plan and the CNA should have ensured Resident #49's alarm was in place for safety. A review of a facility policy titled, "Comprehensive Resident Centered Care Plans" dated 6/1/2023, included but was not limited to; "It is the policy of the facility to promote seamless Interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention." NJAC 8:39- 27.1(a)	F 689		
F 690 SS=F	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		10/31/23

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F 690	Continued From page 4 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with Ex.Order 26 [redacted] based on the resident's comprehensive assessment, the facility must ensure that a resident who is Ex.Order 26.4(b)(1) receives appropriate treatment and services to restore as much normal Ex.Order 26.4(b)(1) as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain proper care of EX Order 26 § 4b1 [redacted] to prevent EX Order 26 § 4b1 (UTIs) for 4 of 4 residents (Resident #41, #23, #20 and #14) reviewed for EX Order 26 § 4b1 use. This deficient practice was evidenced by the following:	F 690	CRITERIA 1: Resident #41; #23 and #20-On 9/28/23, Primary Physicians were notified and EX Order 26 § 4b1 will be switched to EX Order 26 § 4b1 [redacted] to ensure that placement is below the EX Order 26 § 4b [redacted]. All EX Order 26 § 4b1 [redacted] are changed weekly. Resident #14- EX Order 26 § 4b1 will be	

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F 690	Continued From page 5 1. On 9/27/23 at 10:33 AM, Resident #41 was observed lying in bed with both eyes closed. The surveyor reviewed the medical record for Resident #41. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in EX Order 26 § 4b1 with diagnoses that included EX Order 26 § 4b1 [redacted]. A review of the 9/13/23 Quarterly Minimum Data Set (MDS), an assessment tool, revealed the resident had a Brief Interview for Mental Status (BIMS), which indicated that the resident had a score of [redacted] out of 15 indicating the resident had EX Order 26 § 4b1 [redacted]. A review of the order summary revealed a physician order dated 3/14/23, to change the EX Order 26 § 4b1 [redacted] on the 8th of each month on 7-3 shift. Further review revealed that the Ex.Order 26.4(b)(1) [redacted] k was to be changed weekly every Thursday on the 11 to 7 shift. A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area created on 5/26/21, which revealed the resident had an EX Order 26 § 4b1 [redacted]. Interventions included securing the EX Order 26 § 4b1 [redacted].	F 690	switched to a a EX Order 26 § 4b1 [redacted] when in bed and to EX Order 26 § 4b1 [redacted]. All EX Order 26 § 4b1 [redacted] are changed weekly. CRITERIA 2: All residents have the potential to be affected by the deficient practice of placing the EX Order 26 § 4b1 [redacted] on the bed at the same level as the EX Order 26 § 4b [redacted]. CRITERIA 3: The Infection Preventionist and Assistant Director of Nursing/Staff Educator started a mandatory inservice on 9/28/23 for all nursing staff which includes but not limited to, a review of current facility policy on EX Order 26 § 4b [redacted] EX Order 26 § 4b1 [redacted], proper infection control procedures and placement of EX Order 2 [redacted] and the proper use and placement of EX Order 26 § 4b1 [redacted] to ensure that it is below the EX Order 26 § 4b [redacted]. Charge Nurses on each shift will check all residents with EX Order 26 § 4b1 [redacted] to ensure that it is patent and situated below the level of the EX Order 26 § 4b [redacted]. This will be signed for in the Treatment Administration Record. Resident #41- on 9/29/23, Both Hospice Aides were reeducated by the Infection Preventionist on proper infection control procedures	

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F 690	Continued From page 6 On 9/27/23 at 11:55 AM, the surveyor interviewed the Certified Nursing Assistant (CNA), who stated the resident used a Ex.Order 26.4(b)(and the Ex.Order 26.4(b)(stayed in the bed with the resident. On 9/27/23 at 12:00 PM, the surveyor interviewed the Registered Nurse (RN), who stated that the EX Order 26 § 4b1 were changed weekly and she monitored the resident's output. The nurse exposed the EX Order 26 § 4b1 that was lying in the bed next to the resident. The EX Order 26 § 4b1 had EX Order 26 § 4b1 in the bag. The RN further stated that that was the type of EX Order that the facility used and the staff did not change to a EX Or . On 9/28/23 at 9:41 AM, the surveyor observed the Infection Preventionist/Registered Nurse (IP/RN) and the Director of Nursing (DON) at the resident's bedside with the EX Order 26 § 4b1 bag lying next to the resident. The IP/RN stated that EX Order 26 § 4b1 lay in the bed with residents and the EX Order 26 § 4b1 do not hang on the side of the bed. On 9/28/23 at 9:51 AM, the surveyor interviewed the IP/RN who stated the facility used a EX Order 26 § 4b1 at the facility for 6 years. She further stated that it was the system that the facility used, and the EX Order 26 § 4b1 did not hang off the side of the bed. The policy for EX Order 26 § 4b1 care dated 9/28/23 stated that the EX Order 26 § 4b1 must remain patent, with the EX Order 26 § 4b1 , to maintain EX Order 26 § 4b1	F 690	which include but not limited to proper placement of EX Order 26 § 4b1 Hospice will reinservice Aides on Facility's policy on EX Order 26 § 4b1 and provide proof of competency evaluations on infection control and proper disposal of contents of EX Order 26 § 4b1 prior to being assigned to Heath Village. CRITERIA 4: Unit managers or designees will conduct spot checks to ascertain compliance on proper placement of Ex.Order 26.4(b)(1) for 3 months. Reports will be submitted monthly to the Director of Nursing and Administrator. All reports will be discussed at the Quality Assurance and Performance Improvement meetings held quarterly.	

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F 690	Continued From page 7	F 690		

2. On 09/26/23 at 10:52 AM, a surveyor observed Resident #23 in bed with a EX Order 26 § 4b1 [redacted].

The surveyor reviewed the medical record for Resident #23.

A review of the Admission Record face sheet reflected the resident was re-admitted to the facility in EX Order 26 § 4b1 with diagnosis which included EX Order 26 § 4b1 [redacted].

A review of the Admission MDS dated 07/3/2023, the resident had a BIMS score of [redacted] out of 15, which indicated a EX Order 26 § 4b1. Further review of the MDS indicated the resident as dependent on staff for all activities of EX Order 26 § 4b1 [redacted] and required the use of an indwelling EX Order 26 § 4b1.

A review of the ICCP included a focus area created on 06/28/2023, that the [Resident] has EX Order 26 § 4b1 [related to] retention [...] at risk for complications associated with EX Order 26 § 4b1 [redacted]. Interventions included: EX Order 26 § 4b1 [redacted]

On 09/28/2023 at 10:00 AM, the surveyor entered the resident room and did not observe a EX Order 26 § 4b1 hanging from Resident #23's bed.

On 09/28/2023 at 10:01 AM, the surveyor

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F 690	Continued From page 8	F 690		

interviewed CNA #1 who confirmed that the resident had a EX Order 26 § 4b1 and prefered to stay in bed. CNA confirmed that the EX Order 26 § 4b1 could also be used as a EX Order 26.4(b), but the resident did not like to wear it.

On 09/28/2023 at 11:01 AM, the surveyor, in the presence of RN #1, entered the room of Resident #23 and requested permission to look at their EX Order 26 § 4b1. RN #1 removed the blanket and revealed the EX Order 26 § 4b1 on the bed by the resident's EX Order 26 § 4b1.

On 09/28/2023 at 11:45 AM, the surveyor interviewed RN #1 who confirmed that Resident #23 had history of EX Order 26 § 4b1 [redacted]. Upon viewing the EX Order 26 § 4b1 on the bed, RN #1 acknowledged that the EX Order 26 § 4b1 "ideally" should be positioned below the level of the EX Order 26 § 4[redacted]r. When asked why is it was important for the EX Order 2[redacted] bag to be below the level of the EX Order 26 § 4b1 RN #1 reported, "EX Order 26 § 4b1 [redacted], EX Order 26 § 4b1 [redacted]". When asked if there was a way to hang the EX Order 26 § 4b1 on the bed, RN #1 stated "no".

The policy for EX Order 26 § 4b1 dated 9/28/23 stated that the EX Order 26 § 4b1 [redacted].

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F 690	Continued From page 9	F 690		

3. On 9/26/23 at 11:14 AM, the surveyors observed Resident #20 lying in bed with [redacted].

The surveyor reviewed the medical record for Resident #20, which reflected the following:

A review of the Admission Record face sheet reflected the resident was admitted to the facility on [redacted] with diagnosis which included but not limited to [redacted].

The Admission MDS, an assessment tool, dated [redacted] reflected that the resident was admitted to the facility on [redacted] and had a BIMS score of [redacted] out of 15, reflecting an [redacted]. The assessment reflected that the resident's [redacted] is not rated, and always [redacted] of [redacted].

The Admission MDS also revealed that the resident functional status reflected that the resident walk in room and walk in corridor, revealed that the activity did not occur.

The Care Plan created on 7/01/23 reflected that Resident #20 has an [redacted] related to a history of [redacted] and [redacted]. The care plan intervention includes [redacted].

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F 690	Continued From page 10 EX Order 26 § 4b1 "	F 690		

On 9/28/23 at 9:58 AM, the surveyor interviewed the nurse's aide and stated that the EX Order 26 § 4b1 EX Order 26 § 4b1

On 9/28/23 at 01:24 PM, the surveyor verified the resident's ambulatory status with the MDS Coordinator. The MDS Coordinator verified with the surveyor that the resident has Ex.Order 26.4(b)(1) since admission.

The policy titled Heath EX Order 26 § 4b1 dated 9/28/23 revealed under procedures, "9. Ex.Order 26.4(b)(1) are not routinely used, unless resident is EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1

4. On 09/26/23 at 11:30 AM, the surveyor observed resident #41 in the room laying on a low air mattress bed. The resident was not interviewable, and their eyes were closed. Two Hospice aides were in the room and one Hospice aide stated the resident does not respond now. The resident used to get out of bed using a mechanical lift to transfer to a EX Order 26 § 4b1 but is now Ex.Order 26.4(b)(1) . The resident has been in EX Order 26 § 4b1 for about four months.

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F 690	Continued From page 11	F 690		

On 09/26/23 at 11:37 AM, the surveyor observed the EX Order 26 § 4b1 [redacted] The surveyor observed the EX Order 26 § 4b1 wearing gloves and [redacted] The aide then disconnected the EX Order 26 § 4b1 [redacted] The surveyor observed the aide [redacted] and then came out of the bathroom with the same gloves on. No changing of gloves or handwashing was observed. The aide proceeded to touch the overhead bed table, bed sheets, bed rails and the resident with the same gloves on.

On 09/26/23 at 12:05 PM, the surveyors interviewed the [redacted] Registered Nurse, who stated the resident has a Diagnoses of [redacted]

On 09/28/23 at 10:25 AM, the DON submitted the facility Policy and Procedure for EX Order 26 § 4b1 Care dated 12/8/2021 and updated 9/28/23. The Policy and Procedure for EX Order 26 § 4b1 stated, "EX Order 26 § 4b1 [redacted].

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	315072	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 12	F 690		

On 09/28/23 at 12:15 PM, the surveyor discussed the above concerns with Administration, DON, Infection Preventionist and Assistant Director of Nursing.

5. On 9/26/23 at 10:55 AM, the surveyor observed Resident #14's room door with a STOP sign indicating Contact Precautions. The surveyor donned the proper personal protective equipment (PPE) and entered the resident's room. The surveyor observed Resident #14 sitting in a [redacted]. The resident stated that he/she was very happy with the care living here in the facility and had no issues.

On 9/27/23 at 11:17 AM, the surveyor interviewed the IP who stated that Resident #14 recently was placed on Contact Precautions because he/she had a [redacted]) in the [redacted].

The surveyor reviewed the medical record for Resident #14.

A review of the quarterly MDS, an assessment tool used to facilitate the management of care, dated 8/20/23, reflected that the resident had a BIMS score of [redacted] out of 15, indicating that the resident had an [redacted].

A review of the Order Summary Report reflected a physician's order dated 4/23/22 for "[redacted]"

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 13	F 690		

A review of the individualized plan of care (IDCP) created on 4/2/22 with a revision date of 9/26/23 reflected a focus area that the resident EX Order 26 § 4 [redacted] The IDCP also reflected an intervention initiated on EX Order 26 § 4b [redacted] to 'EX Order 26 § 4b1 [redacted]

On 9/28/23 at 10:30 AM, the surveyor donned the proper PPE and entered the room of Resident #14. The surveyor observed the resident sitting in a EX Order 26 § 4b1 [redacted]. The resident stated that he/she had a EX Order 26 § 4b1 [redacted] and showed the surveyor his/her left leg which had a EX Order 26 § 4b1 [redacted] that was covered by the resident's sweatpants. The resident stated that the EX Order 26 § 4b1 [redacted] to EX Order 26 § 4b1 [redacted]. The resident stated that the nurses took care of the EX Order 26 § 4b1 [redacted]. The resident then stated that at night when he/she went to bed the EX Order 26 § 4b1 [redacted] while he/she was lying in bed.

On 9/28/23 at 10:44 AM, the surveyor interviewed the CNA #2 who stated that Resident #14 had a EX Order 26 § 4b1 [redacted]. The CNA #2 added that the EX Order 26 § 4b1 [redacted] to the resident's EX Order 26 § [redacted] The CNA #2 also stated that EX Order 26 § 4b1 [redacted] The CNA #2 added that she had worked at the facility for 30 years and a while back they had used a different kind of EX Order 26 § 4b1 [redacted] The CNA #2 added

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	315072	A. BUILDING _____ B. WING _____	C 09/29/2023

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HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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F 690	Continued From page 14 that only EX Order 26 § 4b1 were used even when residents were lying in bed. On 9/28/23 at 12:24 PM, the survey team met with the LNHA, DON, IP, and Assistant Director of Nursing (ADON). The DON stated that after surveyor inquiry they were reviewing the continued use of only the EX Order 26 § 4b1 and updating the facility EX Order 26 § 4b1 policy. A review of the facility policy dated 9/28/23 for EX Order 26 § 4b1 provided by the DON revealed that the procedures included EX Order 26 § 4b1 [redacted] ." In addition, "EX Order 26 § 4b1 [redacted] ."	F 690		
F 755 SS=D	NJAC-8:39-19.4 (a)5, 27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		10/31/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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F 755	Continued From page 15 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to accurately document the administration of controlled medication for 1 sampled resident (Resident #7) identified upon inspection of 1 of 4 medication carts (Willow unit). The evidence was as follows: On 9/28/23 at 10:44 AM, the surveyor in the presence of the Registered Nurse (RN) inspected the Willow unit medication cart. The surveyor and the RN reviewed the controlled medications located in a secured and locked controlled medications box. When the controlled medication inventory was compared to the corresponding declining inventory sheet, the surveyor identified the following concerns.	F 755	CRITERIA 1: Resident #7 - The Charge Nurse who had signed the MAR on 9/22/23 at 8:00 am was counselled verbally via telephone on 9/28/23 and was issued a written warning for failure to follow policy and procedure on Controlled Substances. CRITERIA 2: All residents have the potential to be affected by the deficient practice of failure to accurately document the administration of a controlled medication on the corresponding declining inventory sheet.	

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	315072	A. BUILDING _____ B. WING _____	C 09/29/2023

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F 755	Continued From page 16 Resident #7's EX Order 26 § 4b1 did not match the declining inventory sheet quantity. The bottle of EX Order 26 § 4b1 had the tamper evident seal removed indicting the bottle had been opened and the corresponding declining inventory sheet indicated there had been no doses removed from that EX Order 26 § 4b1 bottle. At that time, the RN stated she had not administered EX Order 26 § 4b1 to the resident that day and acknowledged the tamper evident seal had been removed from the bottle of EX Order 26 § 4b1 and the declining inventory sheet reflected there had been no doses removed from the bottle. The RN further stated when administering a EX Order 26 § 4b1, the nurse was to remove the dose from inventory and complete the declining inventory sheet indicating the medication had been removed from stock, administer the medication, and then sign the medication administration record (MAR) which indicated the medication had been administered. On 9/28/23 at 11:22 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). Together the surveyor and the ADON reviewed the declining inventory sheet for EX Order 26 § 4b1 for the resident, and the corresponding MAR. The ADON acknowledged according to the September 2023 MAR a dose of EX Order 26 § 4b1 had been given on 9/22/23 at 8 AM, however the corresponding declining inventory sheet did not indicate a dose of EX Order 26 § 4b1 had been given on that date. The ADON further acknowledged the tamper evident seal had been removed from the resident's EX Order 26 § 4b1 bottle. The ADON stated the process was the nurse removed the medication, signed	F 755	CRITERIA 3: On 9/28/23, the Assistant Director of Nursing/Staff Educator started a mandatory inservice for all nurses to review the facility policy and procedure of Controlled Substance administration and checking the tamper-resistant seal of all narcotic liquid solutions as part of the counting process done at the beginning and end of each shift. Unit Managers or designee will do a weekly audit on all bottled liquid narcotic medications to check the tamper-resistant seals are intact and to ensure that the amount aligns with the documentation on the corresponding declining inventory sheet. Reports of weekly findings will be reported to the Director of Nursing and Administrator monthly. CRITERIA 4: Pharmacy Consultants will conduct audits on Controlled Medications declining inventory sheets monthly and reports will be submitted to the Director of Nursing and Administrator. All reports will be discussed at the Quality Assurance and performance improvement meetings held quarterly.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING _____ B. WING _____	C 09/29/2023

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F 755	Continued From page 17	F 755		

the declining inventory sheet, administered the medication, and then signed the MAR that the medication was given. The ADON acknowledged the nurse did not follow that process on 9/22/23.

On 9/29/23 at 10:09 AM, the surveyor attempted to interview via telephone the nurse who had signed the MAR on 9/22/23 at 8:00 AM, the nurse did not pick up the call.

On 9/29/23 at 10:20 AM, the surveyor interviewed the facility consultant pharmacist (CP) who stated the declining inventory sheet was for inventory control, to ensure the medication counts were accurate. The CP acknowledged the nurse should have documented on the declining inventory sheet that the medication had been removed from stock, administered the medication, and then documented the dose on the MAR.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX Order 26 § 4b1 with diagnoses which included EX Order 26 § 4b1 [redacted]

A review of the Order Summary Report (OSR) included physician's orders (PO) dated 9/20/23, for EX Order 26 § 4b1 [redacted]

A review of the corresponding September 2023 Medication Administration Record (MAR) revealed the resident received a dose of

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	315072	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	**451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840**

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F 755	Continued From page 18 Ex.Order 26.4(b)(1) on 9/22/23 at 8:00 AM. A review of the facility's undated "Controlled Substances" policy dated 6/1/23...when a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the declining inventory sheet and the medication administration record (MAR): 1. date and time of administrations (MAR and declining sheet) 2. amount administered (declining sheet) 3. remaining quality (declining sheet) 4. initials of the nurse administering the dose, completed after the medication is actually administered (MAR and declining sheet). NJAC 8:39- 29.2(d), 29.7(c)	F 755		

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	315072	A. BUILDING _____ B. WING _____	R-C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	**451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840**

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{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 11/08/2023 to verify the facility's POC from the 9/29/2023 Recertification survey. The facility was found to be in compliance with their POC.	{F 000}		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315072 Y1	A. Building B. Wing Y2	11/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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 F0689	Correction	ID Prefix F0690	Correction	ID Prefix F0755	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	10/31/2023	LSC	10/31/2023	LSC	10/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031402	A. BUILDING: _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	CRITERIA 1: Staffing Coordinator, Director of Nursing and Assistant Director of Nursing will continue to make every attempt to ascertain that there will be adequate staff to meet State C.N.A. staffing requirements. Heath Village will continue to utilize Contracted agency C.N.A.s to fill in for open shifts to meet C.N.A. staffing requirements	10/31/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031402	A. BUILDING: _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	The Human Resources team has been and continues to actively hire Certified Nursing Assistants and eligible Nursing Assistants. CRITERIA 2: All residents have the potential to be affected by the deficient practice of not meeting the minimum New Jersey staffing requirements for Certified Nursing Assistants. CRITERIA 3: The Staffing Coordinator will continue to provide a daily and weekly report to the Director of Nursing and or designee regarding all efforts made to comply with State staffing requirements. Results will be reported to Administrator. An HR recruitment/ Onboarding Coordinator position was created as an addition to the Human Resources team to focus on Hiring Strategies by organizing off site job fairs; C.N.A. school visits and coordinating with community outreach programs to promote employment opportunities at heath Village. Heath Village administration enhanced our retention strategies for both new and existing employees by raising base and starting rates for full time, part time and Per Diem nurses and C.N.A.s. Referral bonuses were offered to existing employees.	

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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks 9/10/23 to 9/16/23 and 9/17/23 to 9/23/23, revealed the following: The facility was deficient in CNA staffing for residents on 2 of the 14-day shifts as follows: -9/10/23 had 10 CNAs for 93 residents on the day shift, which required at least 12 CNAs. -9/15/23 had 10 CNAs for 89 residents on the day shift, which required at least 11 CNAs. On 9/28/23 at 1:25 PM, the LNHA in the presence of the DON and survey team, acknowledged the facility did not always meet the one CNA to eight resident ratios for the day shift. NJAC 8:39-5.1(a)	S 560	We continue to offer childcare services in our Friendship center located in our Independent Campus at a discounted rate of 50% Human Resources will continue to run ads to attract applicants. Administrator and Chief Executive Officer established a contract with a recruitment agency to sponsor qualified and eligible applicants internationally for permanent placement and/or contract employment at our facility. Currently awaiting Labor certificate. CRITERIA 4: Hiring update meetings are held weekly by the Chief Executive Officer, Administrator, Director of Nursing, Human Resources recruitment onboarding Coordinator and Staffing Coordinator to review status of potential applicants. The Human Resources Director or designee will submit reports on the status of recruitment and retention efforts to the QAPI committee monthly for the next 6 months. The Quality Assurance and Performance Improvement Committee will determine further action plans.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
031402 Y1	A. Building B. Wing Y2	11/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/31/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING **01** B. WING _____	C **09/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	**451 SCHOOLEY'S MOUNTAIN RD** **HACKETTSTOWN, NJ 07840**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/27/2023 and 09/28/2023, and Heath Village was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Heath Village is a single story, Type II Protected building that was built in January 2021. The facility is divided into 9 smoke zones. The facility has a 375 KW emergency generator that runs off of Diesel or Natural Gas.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 09/27/2023 and 09/28/2023 in the presence of facility management, it was determined that the facility failed to: 1) To provide one (1) illuminated exit sign to clearly identify the exit access path to reach an exit discharge door.	K 293	CRITERIA 1: An additional exit sign was installed by Wires Electric Inc. in the enclosed courtyard between Willow and Hickory households on 09/27/23.	10/31/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/12/2023

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

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K 293	Continued From page 1 This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is	K 293	CRITERIA 2: All residents have the potential to be affected by the deficient practice of failure to provide (1) illuminated exit sign to clearly identify the exit access path to reach an exit discharge door. CRITERIA 3: Maintenance staff will conduct monthly inspections and testing of all exit signs including those located in enclosed courtyards. All findings will be logged in the life safety book. Maintenance Foreman will continue to monitor and review all inspections and corrective actions that are logged in the life safety book weekly. CRITERIA 4: Both the Director of Maintenance and the Assistant Director of Maintenance/Grounds will review all findings and will submit a monthly report to the Administrator. All reports will be discussed at the Quality Assurance and Performance Improvement meeting held quarterly.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING **01** B. WING _____	C **09/29/2023**

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K 293	Continued From page 2 less, from the nearest visible exit sign." On 09/27/2023 (day one of survey) during the survey entrance at approximately 9:47 AM, a request was made to the Administrator (Admin.) and Director of Maintenance (DOM) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building. There are three (3) outside enclosed (surrounded by the building) courtyards. Starting at approximately 10:06 AM on 09/27/2023 and continued on 09/28/2023 in the presence of the facility DOM and MS a tour of the facility was performed. During the two (2) day building tour the of the facility the surveyor observed one (1) location that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, On 09/27/2023: 1) At approximately 11:22 AM, the surveyor observed inside the outside enclosed courtyard located between the Willow Terrace unit and Hickory Lodge unit failed to have one illuminated exit sign to clearly identify the second exit access route out of the enclosed center courtyard. The MS confirmed the findings at the times of observations. On 09/28/2023 at approximately 12:50 PM, the Administrator was informed of the Life Safety Code deficiency during the survey exit. Fire Safety Hazard.	K 293		

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	315072	A. BUILDING **01** B. WING _____	C **09/29/2023**

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K 293	Continued From page 3 NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 911 SS=D	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) This REQUIREMENT is not met as evidenced by: Based on observation on 09/27/2023 and 09/28/2023, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 11 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70,	K 911	CRITERIA 1: On 9/27/23, Wires Electric Inc. replaced the 2 Duplex electrical outlets located in the Dentist room (located 4'7" to the right of the handwashing sink) and the Podiatrist room (located 4' on left hand side of sink) that failed to de-energize while testing. CRITERIA 2: All residents have the potential to be affected by failure to install a ground-fault circuit interrupter outlet within 1.8 M(6 feet) of the outside of a sink. CRITERIA 3: The Maintenance team leader or	10/31/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING **01** B. WING _____	C **09/29/2023**

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K 911	Continued From page 4 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 09/27/2023 (day one of survey) during the survey entrance at approximately 9:47 AM, a request was made to the Administrator (Admin.) and Director of Maintenance (DOM) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building. There are six (6) Resident wings and an Administrative wing in the facility. Starting at approximately 10:06 AM on 09/27/2023 and continued on 09/28/2023 in the presence of the facility DOM and MS a tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested eleven (11) electrical outlets in wet (with-in 6 feet of a sink) locations with two (2) electrical outlets that failed to de-energize when tested in the following locations, On 09/27/2023:	K 911	designee will conduct monthly inspections that will include checking that all sinks with outlets located within 6 feet of outside of sink will have ground-fault circuit interrupter protection. Findings will be logged in the Life safety book. Maintenance Foreman will continue to monitor all inspections and corrective actions conducted by the maintenance staff weekly. CRITERIA 4: Director of Maintenance and Assistant Director of Maintenance/Grounds will review all findings in the Life safety book and will submit a report to the Administrator monthly. All reports will be discussed at the Quality Assurance and Performance Improvement meetings held quarterly.	

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K 911	Continued From page 5 1. At approximately 10:29 AM, inside the Administrative wing's Dentist room, one Duplex electrical outlet located four feet seven inches (4'-7") to the right of the hand washing sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 2. At approximately 10:32 AM, inside the Administrative wing's Podiatrist's room, one Duplex electrical outlet located four feet (4') to the left of the hand washing sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The MS confirmed the findings at the time of observations. On 09/28/2023 at approximately 12:50 PM, the Administrator was informed of the Life Safety Code deficiency during the survey exit. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 929 SS=E	Gas Equipment - Precautions for Handling Oxyg CFR(s): NFPA 101 Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99)	K 929		10/31/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 929	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation on 09/27/2023 and 09/28/2023 it was determined that the facility failed to ensure freestanding compressed Oxygen cylinders were properly chained or supported in a proper cylinder stand or cart in accordance with NFPA 99 Health Care Facilities Code (2012 Edition) Section 11.6.2.3(11). This deficient practice had the potential to affect 16 residents. Findings include: During the building tour on 09/27/2023 in the presence of the facility's Director of Maintenance (DOM) and Maintenance Staff (MS) the surveyor observed oxygen cylinders that were not properly chained or supported in a stand or a cart in the following locations, 1) At approximately 11:05 AM, the surveyor observed inside the Willow Terrace Unit Nurses Station oxygen storage room two (2) "E-Type" cylinders that were not properly supported in a stand or cart. These two cylinders were free standing. 2) At approximately 12:01 PM, the surveyor observed inside the Willow Terrace Unit Nurses Station oxygen storage room one (1) "E-Type" cylinder that were not properly supported in a stand or cart. These two cylinders were free standing. The MS confirmed the findings at the time of observations. On 09/28/2023 at approximately 12:50 PM, the	K 929	CRITERIA 1: Maintenance personnel immediately secured the two "E" type cylinders located in the Willow Terrace nurses suite oxygen storage room. CRITERIA 2: All residents have the potential to be affected the deficient practice of failure to ensure that freestanding compressed oxygen cylinders were properly chained or supported in a proper cylinder stand or cart in accordance with NFPA 99 Healthcare Facilities code (2012 Edition) Section 11.6.2.3 (11). CRITERIA 3: A mandatory inservice was initiated by the Assistant Director of Nursing on the proper securement of all freestanding compressed oxygen tanks for all Heath Village employees on 09/29/23. Additional oxygen carts were installed in the oxygen rooms on 10/10/23. Maintenance staff will inspect the 4 oxygen rooms weekly for one month, then monthly for 2 months to ensure compliance. Findings will be logged in the Life safety book.	

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K 929	Continued From page 7 Administrator was informed of the Life Safety Code deficiency during the survey exit. NJAC 8:39-31.2(e) NFPA 99	K 929	Maintenance Foreman will continue to monitor all inspections and corrective actions logged in the life safety book weekly. Proper securement of freestanding compressed oxygen tanks will be included in the orientation process of all new employees. CRITERIA 4: Director of Maintenance and Assistant Director of Maintenance/Grounds will review all findings logged in the Life Safety book and will submit a Monthly report to the Administrator. All reports are discussed at the Quality Assurance and Performance Improvement meetings held quarterly.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315072 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	10/31/2023	LSC K0911	10/31/2023	LSC K0929	10/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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FOLLOWUP TO SURVEY COMPLETED ON	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO