STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING _____ B. WING _____	06/14/2022

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 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: 06/14/22 Census: 80 Sample: 18 +3 =21 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 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		7/30/22

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

Electronically Signed | 07/07/2022

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 625	Continued From page 1 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for 2 of 2 resident's (Resident #15 and #46) reviewed for hospitalizations. This deficient practice was evidenced by the following: 1. On 06/06/22 at 10:54 AM, the surveyor observed Resident #15 in their room sitting in a wheelchair self propelling around. On 06/07/22 at 9:45 AM, the surveyor observed Resident #15 in their room sitting in a wheelchair. The surveyor interviewed Resident #15 who stated he/she was recently in the hospital for "NJ Ex Order 26.4(b)(1) ." A review of the facility provided Admission Record revealed that Resident #15 was admitted with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) a NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) .	F 625	CRITERIA I: 1. Resident #46: The facility provided the resident or resident representative written notification of the revised facility's bed hold policy on 6/21/22. 2. Resident #15:The facility provided the resident or resident representative written notification of the revised facility's bed hold policy on 6/27/22. CRITERIA II: All residents that are transferred to the hospital will have the potential to be affected by the deficient practice of failure to provide a written notification of facility's bed hold policy. CRITERIA III: 1. Policy and procedure was revised to include upon discharge to the hospital, all residents and/or resident representative will receive written notification of discharge from a nursing designee and will receive notification of the bedhold policy. 2. A copy of the letter will be given/sent to resident/resident representative. A call	

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F 625	Continued From page 2 A review of the facility provided Universal Transfer Form, dated [redacted], revealed that Resident #15 was transported to the hospital "ED [emergency department] to Hosp [hospital] Admission." A review of a nurse's Progress Note, dated [redacted] at 22:45 [10:45 PM], revealed Resident #15 informed staff that he/she was having "[redacted]" and became [redacted] The physician was contacted and ordered the resident to be sent to the hospital emergency room for evaluation. A review of a nurse's Progress Note, dated [redacted] at 2:20 AM, indicated that Resident #15 was being admitted to the hospital. The surveyor reviewed Resident #15's Electronic Medical Record and medical chart at the facility and was unable to locate any written notice of bed hold that would have been provided to the resident or resident representative. On 06/13/22 at 11:19 AM, the surveyor interviewed the [redacted]) who would have been responsible for the bed hold notifications, she stated that she did not have any letters that were sent out for Resident #15 when he/she went to hospital regarding bed hold. On 06/13/22 at 11:35 AM, the surveyors informed the [redacted] and [redacted]) of no documented evidence that written notification about bed hold were sent to families of residents admitted to the hospital.	F 625	will also be made to the resident representative notifying them of the bedhold policy and to inquire if they would like to hold the bed. Their response will be documented in the resident medical record. 3. A copy of the bedhold letter will be filed in the Social Service office. CRITERIA IV: 1. Policy and procedure reviewed annually by Social Services and Administrator. 2. Social Services department will randomly monitor weekly for six months then monthly and report results of findings to administrator. 3. Results of the monitoring will be reported at the quarterly Quality Assurance Performance Improvement meetings.	

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F 625	Continued From page 3	F 625		

2. On 6/7/22 at 9:40 AM, the surveyor reviewed Resident #46's medical record, which revealed that the resident was transferred to the hospital on NJ Ex Order 2[illegible]. The surveyor did not observe evidence of written notification of the facility's bed hold policy prior to the transfer to the hospital to the resident or the resident's representative.

On 6/7/22 at 11:27 AM, the surveyor interviewed the U.S. FOIA who stated that the facility automatically holds a long-term care (LTC) resident's bed, and that the bed hold policy is provided on admission. The U.S. FOIA then stated that when a resident on the subacute unit was transferred to the hospital, the facility called the resident's family and notified them of the fee amount to hold the bed. The U.S. FOIA added that the facility used to send a written letter in the past but that the facility no longer sent them. The surveyor requested the U.S. FOIA provide any documented evidence that Resident #46 or the resident's representative received written notification of the bed hold policy when the resident was transferred to the hospital.

On 6/13/22 at 9:08 AM, the U.S. FOIA provided the surveyor with a letter that notified Resident #46's representative that the resident was transferred to the hospital and the reason. The letter did not include written notification of the bed hold policy, or the fee charged. The U.S. FOIA provided a copy of the admission agreement with the following highlighted: "Bed hold-private pay billing-beds will be held for LTC resident when discharge to a hospital unless otherwise notified by the resident or responsible party."

On 6/13/22 at 10:37 AM, the surveyor interviewed

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the [U.S. FOIA] who stated that for Resident #46, who resided on the LTC unit, there was an automatic bed hold and the facility charged the resident the rate minus a 10% discount. The surveyor asked the [U.S. FOIA] if the resident or resident's representative was notified of the bed hold charge and policy at the time of transfer to the hospital. The [U.S. FOIA] stated that the resident and resident's representative were notified on admission that there would be a bed hold charge. She further stated that the facility does not notify the resident or the resident's representative of the bed hold charge or policy when they are transferred.

On 6/14/22 at 10:41 AM, during surveyor interview in the presence of the survey team, the [U.S. FOIA (b)] stated that the information the [U.S. FOIA] provided was what the facility had been doing in regard to the bed hold charge and policy.

A review of the facility provided undated policy titled, "Bed Hold Policy", included the following:
Policy: It is the policy of Heath Village to hold offer to hold the bed if the resident, patient or responsible party is accepting of this at a private pay rate.
Procedure:
1. Long-term care (Private Pay): Beds will be held for long-term care residents of The [name redacted] when discharged/transferred to a hospital or other facility unless otherwise notified by the resident or responsible party. If upon discharge, the resident or responsible party request the bed not to be held, they must notify staff at The Meadows, than all personal belongings must be removed at the time of discharge and the bed reassigned. The daily rate will continue to be charged to the resident until

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F 625	Continued From page 5 the day all of the resident's belongings have been removed from the room. 2. Long-term care (Medicaid): The [name redacted], in compliance with the Medicaid Program, will hold a bed for 10 days when a person is discharged to a hospital unless otherwise notified by the The [name redacted] patient or responsible party. A resident whose hospitalization or therapeutic leave exceeds the 10 day bed hold period under the Medicaid bed hold policy will be readmitted to the facility immediately upon the first availability of a bed in a semi-private. The resident has the option of using personal funds to ensure return to the same occupancy at the regular daily rate upon the expiration of the mandated 10 day bed hold. If upon discharge to a hospital, and upon resident's or responsible party's request that the bed is not to be held for 10 days, then all personal belongings must be removed by the responsible party at the time of discharge to the hospital, and the bed may be reassigned. 3. Subacute rehab/respite: The [name redacted] will not hold a bed for a rehab/respite patient when discharged/transferred to a hospital or other facility unless specifically requested by the patient or responsible party. All bed hold days will be discounted 10% off the stated per diem rate while absent from the facility. If not holding the bed, all personal belongings must be removed by the responsible party at the time of discharge or the private pay daily rate charge will apply. The policy did not contain information regarding written notification of the facility's bed hold policy upon transfer to the hospital.	F 625		

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F 625	Continued From page 6 N.J.A.C. 8:39-5.1 (a)	F 625		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to follow professional standards of clinical practice concerning 1.) administration of medications for 1 of 4 residents(Resident #15) and 2.) following a physician's order for a resident who is on NJ Ex Orde for 2 of 2 residents (Resident #38 and Resident #45). This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	CRITERIA I: 1. Resident #15:RN unit manager met with resident and reviewed process of self-administration of medications on 6/8/22. Resident opted NJ Ex Order 26.4b1 at this time 2. Resident #15: MD was notified of resident's medications that were given outside of the time frame parameters on NJ Ex O. 3. Resident #38: MD was notified on 6/8 about NJ Ex Order 26.4(b)(1) recorded on NJ Ex O, NJ Ex O and NJ Ex Ord. 4. Resident #45: MD was notified on 6/9 of all the NJ Ex Order 26.4(b)(1) that showed NJ /day from NJ Ex Order 26.4 - NJ Ex Order 2. 5. Resident #45: MD was notified on 6/9 of that there were NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4; NJ Ex Order 26.4; NJ Ex Order 2 and NJ Ex Order 2. CRITERIA II:	7/30/22

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F 658	Continued From page 7 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." This deficient practice was evidenced by the following: 1. On 06/07/22 at 10:02 AM, the surveyor observed Resident #15 in his/her room sitting in a wheelchair. The surveyor observed two small plastic cups, one containing pills and the second containing applesauce sitting on the overbed table. Resident #15 stated that he/she takes medications NJ Ex Order 26.4(b)(1) but never signed papers to be able to do so and nobody ever educated him/her on what to do. Resident #15 stated that he/she NJ Ex Order 26.4(b)(1) but knew some of them and would take the medications when NJ Ex Order 26.4(b)(1). Resident #15 tilted the small plastic cup and the surveyor observed NJ Ex Order 2 pills. Resident #15 was unable to identify the pills. The surveyor reviewed Resident #15's medical records. The Admission Record (an admission summary) revealed that Resident #15 had been admitted with diagnoses which included but were not	F 658	All residents have the potential to be affected by the deficient practice. CRITERIA III: 1. Resident #15: U.S. FOIA was counselled and re-educated by ADON on medication administration process on 6/7/22. 2. Resident #15: ADON conducted a medication pass competency on this LPN on 6/9/22. 3. Mandatory In-service will be completed for all nurses, on medication administration, and management by 7/20/22, and will be conducted annually thereafter by ADON/designee. 4. U.S. FO and U.S. FOIA were educated by ADON on following physicians orders and reporting weight fluctuations. 5. Mandatory inservices will be conducted for all nursing staff on weight policy and procedure, recognizing change in condition by ADON/Designee. CRITERIA IV: 1. Pharmacy Consultant will continue to schedule medication pass observations monthly. 2. Random medication pass audits will be completed by ADON or designee with a minimum of 2 nurses per month for the	

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F 658	Continued From page 8 limited to: NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1). According to the Annual Minimum Data Set (MDS) dated [redacted], a tool used to facilitate the management of care, revealed that Resident #15 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). The "Nursing Admission Assessment", dated [redacted], revealed that Resident #15 had both [redacted] and NJ Ex Order 26.4(b)(1), [redacted], and [redacted] of NJ Ex Order 26.4(b)(1), and could be [redacted] The facility provided; "Order Summary Report" for [redacted] did not reflect documented evidence to indicate Resident #15 was [redacted] his/her medications. According to the Care Plan with an initiated date of [redacted], revealed a focus area that Resident #15 displayed signs/symptoms of [redacted] as evidenced by [redacted] and/or NJ Ex Order 26.4(b)(1) [redacted] On 6/07/22 at 10:11 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she was an agency nurse who had been working at the facility for four weeks. The LPN stated that Resident #15's medications were scheduled for 9 AM and she was aware it was after the hour time range to administer the medications. The LPN stated, "I ran out for a bell.	F 658	next 6 months results will be reported to DON/ Administrator. 3. ADON or designee will continue to conduct medication pass observation competency yearly on every nurse results will be reported to DON/ Administrator. 4. Findings of the monitoring will be reported at the quarterly QAPI meeting. 5. Random charge audits will be conducted by the unit managers/ designee on all residents with orders for daily weights weekly for 6 months then monthly there after. 6. Findings of the monitoring will be reported at the quarterly QAPI meeting.	

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I usually let Resident #15 take them [medications] but I have to watch him/her. That was on me. I should not leave them.[medications] Anyone could walk in and take them [medications] and the resident NJ Ex Order 26.4(b)(1) [medications]." The LPN further stated that she knew at least one of the medications was NJ Ex Order 26.4b1 but would have to look up the other medications to see what they were and that she would go get the pills from the resident room.

On 6/07/22 at 10:17 AM, the surveyor interviewed the U.S. FOIA (b) (6)) for Resident #15. She stated that the process for medication pass would be to follow the five rights, knock on the resident's door, and administer medications with precautionary measures. The U.S. FOIA (b) (6) stated that no residents on the unit were able to self-administer medications. The U.S. FOIA (b) (6) further stated that pills should never be left in a resident's room because the pills might not be taken by the resident or someone else could take them.

On 6/07/22 at 10:46 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that medication administration consisted of the five rights, nurses should introduce themselves to the resident, know the medications they are administering, check the medications against the Medication Administration Record (MAR), watch the resident take the medications, and never leave medications in the resident's room. The U.S. FOIA stated that others could take the medications and/or the resident may not remember to take the medications. If a resident refused to take the medications at that time, the nurse must take the medications away and destroy them. The U.S. FOIA stated that nurses all have medication competencies including the

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agency nurses.

On 6/09/22 at 10:10 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that she was told by the LPN that she went to administer Resident #15's pills, heard an alarm, went to answer the alarm, and forgot to go back to Resident #15. The U.S. FOIA (b) stated that the LPN should have taken the medications with her and not have left them in the resident's room. The U.S. FOIA (b) further stated that since it was after 10 am and the medications were not in her sight, the LPN should have removed the medications and gave new pills because the LPN would not have known what medications were in that cup or missing from the cup. The U.S. FOIA (b) stated that the LPN should have called the physician about the late administration of medications and should have documented the conversation, but "it did not get done."

2. On 6/8/2022 at 9:35 AM, the surveyor observed Resident #38 at the bedside sitting in their chair and NJ Ex Order 26.4b1 to the surveyor's question appropriately. The resident had NJ Ex and NJ Ex Order 26.4(b)(1) at that time. The resident stated he/she had NJ Ex Order 26 since admission but had no concerns.

The surveyor reviewed Resident #38's medical records.

The Admission Record reflected that the resident had diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) , which occurs when NJ Ex Order 26.4(b)(1) .

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The Admission MDS dated NJ Ex Order 26.4(b) reflected that the resident had a BIMS score of NJ Ex out of 15, which reflected the resident had an NJ Ex Order . It also reflected that the resident had no NJ Ex Order 26.4(b)(1)).

According to the "Order Summary Report" for NJ Ex Order 26.4(b)(1), revealed an order dated NJ Ex Order 26.4(for daily NJ Ex Order 26.4 everyday shift and to call the medical doctor (MD) if there is a NJ Ex Order 26.4(b)(1) or more/day.

The electronic Medication Administration Record (eMAR) reflected the following dates with NJ or more/day NJ Ex Order 26.4(b)(1)

NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))

A review of the resident's hybrid (paper and electronic/computer-generated) medical records did not reflect documented evidence that the physician was notified of the resident's NJ Ex Order 26.4(b) on NJ Ex Order 26.4, NJ Ex Order 26.4, and NJ Ex Order 2.

On 6/8/22 at 10:08 AM, the surveyor interviewed the U.S. FOIA (b) (6) She acknowledged that the resident had an MD order for NJ Ex Ord and that the nurse should have called the MD for NJ Ex Order 26.4(b)(1). She further stated that the resident was NJ Ex Order 26.4(b)(1) during the morning shift by the Certified Nursing Aide (CNA). The CNA was then expected to record the NJ Ex Order 2 in the resident's electronic medical record (EMR) and report it to the RN. The RN reviewed the resident's NJ Ex Order 26 EMAR in

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the presence of the surveyor and she acknowledged to surveyor that the resident had NJ Ex Order 26.4(b)(1) on NJ Ex Order 2. She further explained that the nurse "should've called [name redacted]" to notify him of the NJ Ex Order 26.4(b)(1) and "should've documented in the nurse's notes" that the MD was notified of the NJ Ex Order 26.4(b)(1). The RN could not provide any information to reflect that the MD was notified of the NJ Ex Order 26.4(b)(1) on NJ Ex Order 2.

On 6/8/22 at 10:34 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the resident had a diagnosis of NJ Ex Order 26.4(b)(1)). She could not speak to why the MD was not contacted about the resident's NJ Ex Order 26.4(b)(1) of at least NJ E on NJ Ex Order 26.4, NJ Ex Order 26.4, and NJ Ex Order 2 and why there was documented evidence in the EMR to reflect that the MD was alerted of the NJ Ex Order 26.4(b)(1). Furthermore, she stated that the nurses should have called and notified the MD of the resident's NJ Ex Order 26.4(b)(1) and "should've documented in the nurse's notes" that the MD was notified. The U.S. FOIA (b) (6) also stated that it was important for the nurses to follow the MD's order for NJ Ex Order 26.4(b)(1) and to notify the MD if the resident had a NJ Ex Order 2 . as "this could be an indication of resident's change in condition."

At 11:08 AM, the U.S. FOIA (b) (6) informed the surveyor that the resident's MD visited the resident on NJ Ex Order 26.4, NJ Ex Order 2, and NJ Ex Order 26.4. She acknowledged to the surveyor that there was no documented evidence in the Office/Outpatient Visit physician's notes dated NJ Ex Order 26.4, that the MD was notified and aware of a NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4.

3. On 6/3/22 at 11:45 AM, the surveyor observed Resident #45 sitting in their NJ Ex Order 26.4b1,

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NJ Ex Order 26. NJ Ex Orde and he/she was NJ Ex Order 26.4b1 to the surveyor's question appropriately. The resident had NJ Ex Order 26.4(b)(1) and denied NJ Ex Order 26.4(b)(1) at that time. The resident stated he/she had NJ Ex Order 26.4(b)(1) since admission but was "not worried about it."

The surveyor reviewed Resident #45's medical records.

According to the resident's Admission Record reflected that the resident had diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) .

The Quarterly MDS dated NJ Ex Order 26.4(b , reflected that the resident had a BIMS score of NJ Ex out of 15, which indicated that the resident had an NJ Ex Order . It also reflected that the resident had no NJ Ex Order

The "Order Summary Report" dated NJ Ex Order 26.4(b)(1) , revealed an order dated NJ Ex Order 26.4(b)(1) for NJ Ex Ord one time a day and to call the MD if there was a NJ Ex Order 26.4(b)(1) .

The eMAR reflected the following dates with NJ :

NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))

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NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 2 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))
NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1))

According to the resident's hybrid medical records did not reflect documented evidence that the physician was notified of the resident's NJ Ex Order 2 on the dates indicated above. Furthermore, there was no evidence for a NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 2 and NJ Ex Order 26

On 6/9/22 at 10:09 AM, the U.S. FOIA (b) (6) stated that she could not speak to nor provide documented evidence that the MD was notified of the resident's at least NJ Ex Order 26.4(b)(1) but did acknowledge there should have been documentation. She stated that the MD should have been notified "at that moment" when the nurses discovered a NJ Ex Order 26.4(b)(1) for that resident. Furthermore, she acknowledged to the surveyor that there was no NJ Ex Order 2 documented on NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 26 and NJ Ex Order 2 and could not speak to why the NJ Ex Order 26.4 were not documented.

At 10:15 AM, the U.S. FOIA (b) (6) acknowledged to the surveyor that the resident's MD visited the resident on NJ Ex Order 26.4(, NJ Ex Order 26.4 , and NJ Ex Order 26.4 and that there was no documented evidence in the

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MD Office/Outpatient Visit notes that the MD was notified and made aware of NJ Ex Order 26.4(b)(1) on the dates indicated above from the eMAR.

At 10:23 AM, the surveyor conducted a phone interview with the U.S. FO in the presence of the U.S. FOIA (b) (6). The U.S. FO acknowledged to the surveyor that she was the US FOIA (b)(6) assigned to the resident on NJ Ex Order 2. She also acknowledged that the resident had a NJ Ex Order 26.4(b)(1) on that day. She stated that she did not call the MD to notify the resident's NJ Ex Order 26.4(b)(1) because she was not comfortable with the resident's NJ Ex Order 2 given by the U.S. FOIA and stated that the resident " NJ Ex Order 26.4 . She stated that she asked the U.S. FOIA to NJ Ex Order 26.4 the resident for NJ Ex Order 2 verification, but she did not follow up with the U.S. FOIA and stated, "I should have followed up" and documented it in the nurse's progress notes and acknowledged that she did not do so. The U.S. FO stated that she did record and sign for the resident's NJ Ex Order 2 in the eMAR on NJ Ex Order 2. She also stated that she should have called and notified the MD of the resident's NJ Ex Order 26.4(b)(1) and potential NJ Ex Order 26.4(b)(1) and documented it in the nurses notes but she did not do so. The U.S. FOIA (b) (6) was present all throughout the surveyor's interview with the US FOIA.

At that time, the U.S. FOIA (b) (6) acknowledged that the US FOIA should have followed up with the US FOIA (b for the resident to reweigh for verification, notified the MD of the resident's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b , and documented this in the nurse's notes, and stated "absolutely."

On 6/10/22 at 11:16 AM, the team met with the U.S. FOIA (b) (6)), U.S. FOIA (b and U.S. FOIA (b) (6)

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U.S. FOIA (b) (6) to discuss the above concerns. The U.S. FOIA stated that the nurses should have notified the MD and assessed the residents for signs and symptoms of NJ Ex Orde and it should have been documented in the nurses' notes in the EMR. Furthermore, she stated that a NJ Ex Order 26.4(b)(1) beyond the prescribed parameters would be considered a change in condition which is why the nurses should perform NJ Ex Order 26.4(b)(1) to ensure the NJ Ex Order 26.4(b)(1) was not related to NJ Ex Orde

On 6/14/22 at 11:55 AM, the team met with the U.S. FOIA (b) U.S. FOIA (b) (6) U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6). No further information was provided prior to the survey team's exit.

A review of the facility's policy on Weight Policy and Procedure updated on 10/15/22 reflected that a charge nurse was to report a NJ Ex Order 26.4(b)(1) as ordered by the physician. It was also indicated that for NJ Ex Order 26.4(b)(1), the nurse must document the NJ Ex Order 26.4(b)(1) . and what was addressed to the MD.

A review of the facility's Procedure for Notification of Changes for Resident reflected that the nurse would notify the resident, resident's physician and the resident representative(s) for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. It also indicated to document the notification and record any new orders in the resident's medical record.

A review of the facility provided, "Medication Pass Observation", dated 05/02/22, included but was not limited to 9.c. resident observed to ensure swallowed meds [medications], and revealed LPN was deemed competent to follow all steps to

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F 658	Continued From page 17 administer medications safely. A review of the facility provided, "Position Description, Performance and Competency Review" for position title LPN, undated, included but was not limited to duties and responsibilities to perform medication and treatment duties. A review of the facility provided, "Self-Administration of Medications" policy and procedure, dated 10/30/17, included but was not limited to a resident may only self-administer medications after the [Interdisciplinary Team] IDT has determined which medications may be safely self-administered. The facility was unable to provide any documentation or determination that Resident #15 was deemed competent to self-administer his/her own medication. A review of the facility provided, "Administration of Medications", undated, included but was not limited to 4. Administer oral medication and remain with the resident while he/she takes the medication. Never leave a drug in resident's room. 10. If a resident refused to take a medication, indicate by a circle on administration record and on back of record. NJAC 8:39-11.2(b), 27.1(a)	F 658		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		7/30/22

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F 732	Continued From page 18 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that, the facility failed to post the nurse staffing information on 0 of 3 areas of the facility in a prominent place within the facility readily accessible to the residents and the visitors.	F 732	CRITERIA 1: 1. On 6/10 staffing coordinator/designee began posting the NHRCSR at the main entrance and at the Laurel/Juniper entrance.	

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F 732	Continued From page 19 This deficient practice was evidenced by the following: On 6/3/22 at 9:00 AM, upon entry into the facility the surveyors did not observe that there was a Nursing Home Resident Care Staffing Report (NHRCSR), or a similar form with the required data, displayed in the facility lobby for residents or visitors to view. On 6/8/22 at 9:48 AM, the surveyor did not observe a NHRCSR displayed in the facility lobby. The surveyor interviewed the U.S. FOIA (b) (6) who stated that she had a copy of the "Daily Schedule" (DS) at her desk. The surveyor observed the DS which included the names of the staff that were scheduled to work on each unit for that day. The DS did not include the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care by shift: Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides. The DS also did not include the census of the facility. The U.S. FOIA (b) (6) stated that she would highlight the names of the staff listed as they came into the facility. On 6/8/22 at 10:10 AM, the surveyor interviewed the U.S. FOIA (b) (6)) on the Juniper Unit. The U.S. FOIA stated that there was a DS and assignment sheet and that it was kept in the office behind the closed doors. The surveyor asked the U.S. FOIA if there was any NHRCSR displayed for residents or visitors to view. The U.S. FOIA stated that she had not seen anything posted for resident or visitors to view. On 6/8/22 at 10:17 AM, the surveyor interviewed the U.S. FOIA (b) (6) on the Juniper Unit. The	F 732	CRITERIA II: ALL residents have the potential to be affected by the deficient practice. CRITERIA III: 1. Staffing Coordinator/Designee were educated on the policy and procedure on the Nursing Home resident care staffing report requirements for nurse staffing on 6/10/22. 2. On 6/10 staffing coordinator/designee began posting the NHRCSR daily at the two main entrance points of the facility (Main entrance, and Laurel/Juniper) CRITERIA IV: 1. Director of Nursing/designee will check posting of the NHRCSR on both entrances daily and report results to the Administrator. 2. Findings will be reported at the quarterly QAPI meeting.	

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U.S. FO stated that the DS was kept in the Nursing Station. She added that the DS was at the main desk but that she was not sure if it was visible for resident or visitors to see.

On 6/8/22 at 10:29 AM, the surveyor asked the U.S. FOIA (b) (6) if a resident or a visitor would be able to view the DS. The U.S. FOIA (b) (6) stated that no one had asked her to view it and that if someone did, that she would have to ask someone if they were allowed to view it. The U.S. FOIA (b) (6) confirmed that the DS did not have the hours, the staff worked, or the facility census listed on it.

On 6/9/22 at 11:56 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that she usually posts a DS at the entrance on the Laurel unit. The surveyor asked the U.S. FO if that was the main entrance. The U.S. FO stated that the entrance on the Laurel unit was used during the evening hours and weekends when the main entrance was closed. The U.S. FO confirmed that she did not post a NHRCSR which included the hours worked at either entrance. The surveyor asked the U.S. FO the reason she had not posted the NHRCSR. The U.S. FO stated that she submitted the NHRCSR to the appropriate agency and kept a copy of it but that she was not aware that she was supposed to post it.

On 6/10/22 at 9:08 AM, the surveyor interviewed the U.S. FOIA (b) (6)) of the Laurel and Juniper units who stated that she received a DS from the U.S. FO and that it was posted at the Nurses Station and that it was not out in the public area visible to residents or visitors. The surveyor asked the US if a DS or NHRCSR was posted in a public area, and she stated that she was not aware that it was

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F 732	Continued From page 21 posted anywhere for residents or visitors to view. The U.S. FOIA (b) (6) added that in the past it was posted but was not sure why it had been stopped being posted. On 6/10/22 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed that the NHRCSR was not posted for residents or visitors to view. A review of the facility provided policy titled, "Staffing Protocol", with a revised date of 10/26/2020, included the following: Policy: [name redacted] will provide nursing services and licensed nursing and ancillary personnel at all times. Objective: To fully staff each unit as required by standards, acuity levels, and by skill level of staff to properly meet the needs of all residents. 1. To determine minimum staffing, multiply the total number of residents by 2.5 hours a day. 2. In addition, the acuity levels will be calculated and added to that total ... 4. Staffing coordinator/designee will log in to nj.gov to report staffing totals as per regulation. Staffing is reported for each shift for each day. 5. Nursing staffing is posted daily.	F 732		
F 761 SS=D	NJAC 8:39-41.2 (a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		7/30/22

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F 761	Continued From page 22 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 2 of 6 medication carts inspected. This deficient practice was evidenced by the following: On 6/10/22 at 10:30 AM, the surveyor inspected the Balsam unit medication cart #1 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened bottle of Timolol Ophthalmic drops (medication used for Glaucoma. Glaucoma is a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye) and an opened bottle of Cosopt Ophthalmic drops (medication used for Glaucoma) that were both	F 761	CRITERIA I: 1. Timolol and Cosopt eye drops were discarded immediately, and new drops were ordered 2. Glargine Insulin Pen was discarded immediately, and a new pen was ordered. CRITERIA II: All residents who have orders for eyedrops and insulin pens the potential to be affected by the deficient practice. CRITERIA III: 1. Both LPNs were educated regarding	

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	315072	A. BUILDING _____ B. WING _____	06/14/2022

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F 761	Continued From page 23 opened on 4/23/22 and were expired. The surveyor interviewed LPN #1 who stated that both the Timolol and Cosopt Ophthalmic drops were expired and should have been removed from the medication cart. On 6/10/22 at 10:55 AM, the surveyor inspected the Juniper unit medication cart in the presence of LPN#2. The surveyor observed an opened Glargine Insulin Pen (medication used for Diabetes) with an opened date of 5/26/22 that contained no resident's name on the pen. The surveyor interviewed LPN #2 who stated that all insulins including pens and vials should contained the name of the resident. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. Timolol Ophthalmic drops once opened have an expiration date of 28-days 2. Cosopt Ophthalmic drops once opened have an expiration date of 28-days. On 6/10/22 at 11:20 AM, the surveyor met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), and no further information was provided by the facility. A review of the facility's policy for Disposal of Medications and Medication-Related Supplies that was dated 4/22 and was provided by the U.S. FOIA indicated the following: "When medications are discontinued by the prescriber or the resident is discharged and medications are not sent with the resident, the medications are marked as discontinued and stored in a secure and separate area from the active supply, marked "discontinued" and	F 761	the checking and removal of all expired medications, and proper labeling of all medications. 2. Mandatory education for nurses on Labeling/Storing of drugs and Biologicals was started on 6/10/22 by the ADON and will be completed by 7/30/2022. CRITERIA IV: 1. Weekly audits to be conducted by Unit Managers/designee to check medication carts for proper labeling/storing requirements results will be reported to the DON/ADON/Administrator. 2. Pharmacy consultants will continue to do monthly audits of medication carts to check for proper labeling/storing requirements results will be reported to the DON/ADON/ Administrator. 3. Pharmacy representative will conduct audits of the medication carts on a quarterly basis. 4. Results of the monitoring will be reported at the quarterly Quality Assurance Performance improvement meetings.	

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F 761	Continued From page 24 securely stored until destroyed." "C. Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration). Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy." A review of the facility's policy for Specific Medications Administration Procedures that was dated 4/22 and was provided by the [redacted] indicated the following: "D. Check expiration date on package/container before administering any medications. When opening a multidose container, place the date on the container." NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/20/22

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F 880	Continued From page 25 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 26 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent documentation, it was determined that the facility failed to a.) ensure that the facility's policy for the appropriate personal protective equipment (PPE) for staff to wear for a resident who was newly admitted to the facility, to address the risk for infection transmission, and was in accordance with acceptable standards of infection control practice, and b.) wear all required PPE in the room of a newly admitted resident who was on NJ Ex Order 26 [redacted] and was NJ Ex Order 26.4(b)(1) for 2 of 3 staff, according to the facility policy and New Jersey Department of Health guidance. This deficient practice was identified for one of two NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4b1 residents reviewed, Resident #172, and was evidenced by the following: a) During an interview with the survey team on 06/06/22 at 09:39 AM, the U.S. FOIA (b) (6) [redacted]) stated that NJ Ex Order 26.4b1 residents that were NJ Ex Order 26.4b1 were placed on NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) requiring PPE: face shield, gown, gloves, and a surgical mask,	F 880	I. CRITERIA I: Resident # 172 completed required NJ Ex Order 26.4(b)(1) [redacted] on 6/13/22. II. CRITERIA III. All Residents that have orders for Contact/Droplet isolation have the potential to be affected by the deficient practice. III. CRITERIA III: 1. On 6/8/22, Assistant Director of Nursing notified the US FOIA (b)(6) Company of her failure to adhere to proper PPE use when entering resident's rooms who are on Droplet/Contact precautions. On 6/9/22 Company provided proof or re-educating said U.S. FOIA (b) (6). 2. A root cause analysis was done by the Performance Improvement Plan team and determined that misinterpretation of the	

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F 880	Continued From page 27 when entering the room. The [U.S. FOIA (b)] stated that [NJ Ex Order 26.4(b)] residents were placed on [NJ Ex Order 26.] with an NJ Ex Order 26.4(b)(1) , requiring [NJ Ex O] precautions: [NJ Ex Order 2] gloves, [NJ Ex Order 26.4(b)(1)] and [NJ Ex Ord] During a tour of the [NJ Ex Order 26] Unit on 06/06/22 at 11:19 AM, Surveyor #1 observed a sign outside the room of Resident #172 that read "NJ Ex Order 26.4(b)(1) ." The door did not have a NJ Ex Order 26.4(b)(1) . There was a [NJ Ex Order 26.4(b)(1)] cart outside the door. On 06/06/22 at 11:29 AM, Surveyor #1 observed Physical Therapist (PT) #1 knock on the door of Resident #172's room. She was wearing a surgical mask and a [NJ Ex Order 26.4(b)(1)]. She donned (put on) [NJ Ex Order 26.] and gloves. She entered the room and closed the door. The surveyor reviewed Resident #172's medical records. According to the Admission Record (AR), Resident #172 was admitted from an [NJ Ex Order 26.4(b)(1)] hospital with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) and [NJ Ex Order] The physician orders revealed an order for [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.] for preventative measures every shift for 10 Days with a started date of [NJ Ex Order 2] and end date of [NJ Ex Order 26.4(] The on-going personalized Care Plan revealed a focus area that Resident #172 was not NJ Ex Order 26.4(b)(1), dated [NJ Ex Order 26.4(b] . The	F 880	guidelines and PPE fatigue were among the contributing factors that led to the deficient practice. 3. Reviewed and revised policy and procedure on PPE requirement for residents who are unvaccinated/not up-to-date with the COVID 19 vaccines to align with the State Executive Orders and DOH and CDC recommendations. 4. Educated all staff on policy and procedure. The following mandatory infection Control in services will be conducted by Infection Preventionist/Director of US FOIA (b)(6) nd will be completed by July 20, 2022. a. MODULE 1 INFECTION PREVENTION & CONTROL PROGRAM - TOPLINE STAFF(NURSING AND NON NURSING)and INFECTION PREVENTIONIST https://courses.cdc.train.org/Module1_IPC_Program_LTC/index.html b. MODULE 5 OUTBREAKS - TOPLINE STAFF (NURSING AND NON NURSING) and INFECTION PREVENTIONIST https://courses.cdc.train.org/Module5_Outbreaks_LTC/#:~:text=Module%20Five%20will%20provide%20an%20overview%20of%20outbreak,the%20buttons%20at%20the%20bottom%20of%20your%20screen. c. MODULE 4 INFECTION SURVEILLANCE - TOPLINE STAFF - (NURSING AND NON NURSING) and	

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F 880	Continued From page 28 Interventions included but were not limited to encourage to NJ Ex Order 26.4(b)(1) during visitations and during NJ Ex Order 26.4(b)(1) activities due to increased risk. According to the social services note dated NJ Ex Order 2 at 11:30 AM, indicated that Resident #172 "declined the NJ Ex Order 26.4(b)(1) Resident #172 is not NJ Ex Order 26.4(b)(1)" ... Resident #172 "and family were educated on the need for PPE during visitation until he/she is off NJ Ex Order 26.4(due to NJ Ex . They are aware the PPE is located outside the room and that surgical masks can be provided should they only have cloth masks". During an interview with Surveyor #1 on 06/07/22 at 11:48 AM, the U.S. FOIA (b) (6)) stated that NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4b1 had signs for NJ Ex Order 26.4(b)(1) requiring NJ Ex Order 2 gloves, a NJ Ex Order 26.4(b)(1) , and a NJ Ex Order 26.4(b)(1) to be worn in the room. She stated that exposed residents had signs for NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) During an interview with Surveyor #1 on 06/08/22 at 10:31 AM, th U.S. FOIA (b) (6) stated that new admissions that were NJ Ex Order 26.4(b)(1) were placed on NJ Ex Order 26.4(b)(1) , requiring a NJ Ex Order 26.4(b)(1) , gloves, NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) to enter the room. She stated that Resident #172 was NJ Ex Order 26.4(b)(1) and was on NJ Ex Order 26.4(b)(1) requiring PPE: NJ Ex Order 2 NJ Ex Order 26.4(b)(1) , gloves, and NJ Ex Order 26.4(b)(1) to be worn in the room. She stated that the facility followed guidelines	F 880	INFECTION PREVENTIONIST https://courses.cdc.train.org/Module4_InfectionSurveillance_LTC/ d. MODULE 6A PRINCIPLES OF STANDARD PRECAUTIONS - ALL STAFF https://courses.cdc.train.org/Module6A_Principles_StandardPrecautions_LTC/ e. MODULE 6B PRINCIPLES OF TRANSMISSION BASED PRECAUTIONS - ALL STAFF https://courses.cdc.train.org/DHQP_LongTermCare/Module6B-2021_PrinciplesofTransmission-BasedPrecautions_final/page168.html f. CDC COVID 19 KEEP COVID 19 OUT! - ALL STAFF https://www.youtube.com/watch?v=7srwrF9MGdw g. CLOSELY MONITOR RESIDENTS - ALL STAFF https://www.youtube.com/watch?v=1ZbT1Njv6xA h. USE PPE CORRECTLY FOR COVID 19 - ALL STAFF https://www.youtube.com/watch?v=YYTATw9yav4 (ALL STAFF) 4. ALL Contractors will be required by the facility to complete all Mandatory Infection Control In-services and provide proof of completion no later than July 20,2022.	

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F 880	Continued From page 29 from the Center of Disease Control (CDC) and New Jersey Department of Health (NJ DOH) and discussed the guidelines with team, which included the U.S. FOIA (b) (6) doctor. In the presence of the survey team and the U.S. FOIA (b) (6)) on 06/08/22 at 11:38 AM, the U.S. FOIA (b) stated that they were following the guidance from NJ DOH dated NJ Ex Order 26.4. The U.S. FOIA (b) read #5 of the guidance: New or readmitted NJ Ex Order 26.4(b)(1) patients/residents who are not up to date ... "the patients/residents should be placed NJ Ex Order 26.4(b)(1) and cared for using NJ Ex PPE (NJ Ex Order 2 gloves, NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26.4(b)(1) or equivalent or NJ Ex Order 26.4(b)(1)). The U.S. FOIA (b) stated that the purpose of NJ Ex Order 26.4(b)(1) was to minimize the risk of NJ Ex Order 26.4(b)(1 She stated that the guidance was for the facility to follow. She further stated that "guidance is open for interpretation per their ID doctor and that the guidance refers to "consideration for NJ Ex Order 26.4(b)(1) ." During an interview with Surveyor #1 on 06/09/22 at 09:42 AM, Certified Nursing Assistant (CNA) #1, stated that the signage outside the room of Resident #172 was for NJ Ex Order 26.4(b)(1) which meant that a NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order and gloves must be worn when entering the resident's room because the resident was NJ Ex Order 26.4(b)(1) . In the presence of the survey team, the U.S. FOIA (b) (6) , and the U.S. FOIA (b) on 06/10/22 at 11:06 AM, the U.S. FOIA confirmed that they are "standing" by their policy for NJ Ex Order 26.4(b)(1) new admissions NJ Ex Order 26.4(protocol as advised by their ID doctor that a NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Orde and	F 880	5. All Mandatory Infection Control in services will be incorporated in the Facility□s Annual Education Plan. 6. All Contractors will submit a list of all Contracted X-ray/Ultrasound/EKG technicians; Phlebotomists and Hospice Aides and Nurses who will be assigned to our Facility prior to providing services. 7. Facility will require all contractors to provide proof of completion of mandatory Infection Control In-services as stated above for employees that provide services requiring direct contact with residents. IV. CRITERIA IV: 1. Infection Preventionist/designee will continue to do random infection control rounds on each household weekly, and findings will be reported to the Director of Nursing/Administrator. 2. Assistant Director of Nursing/designee will audit proof of completion on infection control in services of contracted employees monthly for 6 months then quarterly there after. 3. Finding will be reported on the quarterly QAPI meeting.	

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F 880	Continued From page 30	F 880		

gloves was required in the room.

During an interview with Surveyor #1 on 06/13/22 at 11:06 AM, PT#1 stated that NJ Ex Order 26.4(b)(1) included a NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), gloves and NJ Ex Order 2 She stated that Resident #172 was NJ Ex Order 26.4(b)(1) and that a NJ Ex Order 26.4(b)(was not required in the resident's room.

b) On 06/08/22 at 10:02 AM, two surveyors observed a staff member inside of Resident #172's room. The surveyors observed that the staff member was wearing NJ Ex Order 26.4(b)(1), a NJ Ex Order 26.4(b)(1), and was standing within arm's length of the resident. The surveyors observed the outside of the room with signage that included NJ Ex Order 26 and NJ Ex Order 26.4(b)(1), stop see nurse, instructions to use hand hygiene, [PPE] NJ Ex Order and gloves required to enter the room, NJ Ex Order 26.4(b)(1) for potential body fluids splashes or sprays, and hand hygiene when exiting. There was a plastic bin which contained PPE NJ Ex Order 26 gloves, NJ Ex Order 26.4(b)(1) s, and disinfectant wipes, right outside the door.

At that time, a Licensed Practical Nurse (LPN) came to Resident #172's room to inform the staff member inside the room, that she was required to wear PPE while in Resident #172's room. The staff member was identified as a contracted U.S. FOIA (. The U.S. FOIA (b) (6) stepped out of the room into the hallway, donned a PPE gown and gloves, and re-entered the room. The U.S. FOIA informed the U.S. FOIA (b) (6) and surveyors that Resident #172 was on NJ Ex Order 26.4(b)(1) because he/she was NJ Ex Order 2 admission and was NJ Ex Order 26.4(b)(1) .

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F 880	Continued From page 31 On 06/08/22 at 10:07 AM, the two surveyors observed the door open, the U.S. FOIA (b) (6) move the resident's tray table and she proceeded to write information on paperwork. The U.S. FOIA [redacted] was observed to be in close proximity to the resident's face, and Resident #172 was unmasked. The U.S. FOIA (b) (6) discarded her PPE. The U.S. FOIA (b) (6) was still wearing the same NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). On 06/08/22 at 10:09 AM, during an interview with the two surveyors, the U.S. FOIA (b) (6) stated she did not know if she saw the precautionary signs on Resident #172's door. The U.S. FOIA [redacted] stated, "they are doing this because he/she is NJ Ex Order 26.4(b)(1) that is silly". Surveyor #2 asked about the required PPE and the U.S. FOIA [redacted] showed the surveyor her NJ Ex Order 26.4(b)(1) and stated that her company said, " NJ Ex Order 26.4(b)(1) [redacted] ". She acknowledged that according to the signage on Resident #172's door, that going into the room she should wear all PPE such as NJ Ex Order 26.4(b) [redacted], NJ Ex Order 2 NJ Ex Order 2 and gloves. The U.S. FOIA [redacted] further stated the facility never told her what PPE she should wear. On 06/08/22 at 10:15 AM, during an interview with the two surveyors, the NJ Ex Or [redacted] stated all staff would need to wear a NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and gloves to enter Resident #172's room because he/she was NJ Ex Order 26.4(b)(1) [redacted]. The U.S. FOIA [redacted] further stated that PPE was used to protect staff if a resident were to spit while talking. The U.S. FOIA [redacted] stated that if the U.S. FOIA [redacted] had followed the signage to "see nurse", she would have instructed the U.S. FOIA [redacted] what PPE she was required to wear.	F 880		

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F 880	Continued From page 32	F 880		

In the presence of the survey team on 06/08/22 at 11:47 AM, the U.S. FOIA (b) stated the hospital would have to do NJ Ex Order 26.4(b)(1) on residents being admitted to the facility. The U.S. FOIA (b) stated she could not say that all residents were in the hospital 10-14 days prior to admission and could not say if they were possibly NJ Ex Order 26.4(b) at the hospital or even by the transport company.

On 06/08/22 at 12:02 PM, during an interview with Surveyor #2, the U.S. FOIA (b) stated the U.S. FOIA [redacted] should have entered Resident #172's room wearing a NJ Ex Order 26.4(b)(1), gloves, and should have followed the signs on the resident doors regarding NJ Ex Order 26.4(b)(1) [redacted]. The U.S. FOIA (b) stated if there were no nurse around, the U.S. FOIA (b) (6) should have reported to the nurse's station. The U.S. FOIA (b) stated if the proper PPE was not worn, it would increase the risk of the spread of infection. The U.S. FOIA (b) further stated that contract staff would be told by the nurse on duty, to always see well residents first and the [redacted] or NJ Ex Ord residents last.

In the presence of the survey team on 06/10/22 at 11:10 AM, the U.S. FOIA [redacted] stated when the facility used contract workers they are expected to abide by standards of practice.

On 6/13/22 at 12:53 PM, during a telephone interview with Surveyor #3, the U.S. FOIA (b) (6) [redacted] who oversees the public health department, stated several weeks ago her department was asked to speak with Communicable Disease Service (CDS) and the facility on a phone call. The U.S. FOIA [redacted] stated that CDS informed the facility that they must follow the guidance (Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING _____ B. WING _____	06/14/2022

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 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	Continued From page 33 dated 2/25/22) including wearing the [NJ Ex Order 26.4(b)] which included an [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] stated the "guidance as written should be followed". A review of the "Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities" guidance dated 2/25/22, included but was not limited to: 5) New or readmitted asymptomatic patients/residents who are not up to date with all recommended COVID-19 vaccine doses and have a viral test negative upon admission or readmission, should be placed in quarantine and cared for using full PPE (gowns, gloves, eye protection that covers the front and sides of face, and NIOSH [National Institute for Occupation Safety and Health] approved N95 or equivalent or higher-level respirator), even if they have a negative test upon admission. A review of the facility provided Completed Development Opportunities in-services from the x-ray contracted company, dated 12/02/21, revealed that the x-ray technician had completed the Infection Control Practices course including infection prevention and control, standard and transmission-based precautions, barriers and use of personal protective equipment, and strategies for preventing the spread of infectious disease to healthcare workers and patients. A review of the facility provided Field Personnel COVID-19 Procedures/Use of PPE guidance from the x-ray contracted company, undated, included but was not limited to 3. PPE required for patient encounters with suspected or known positive COVID-19. a. mask; b. gloves; c. eye protection/shield; d. gown/approved covering; e. wash hands with soap and water or hand sanitizer; and f. for patient, covering for patient's	F 880		

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	315072	A. BUILDING _____ B. WING _____	06/14/2022

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F 880	Continued From page 34	F 880		

nose and mouth if the patient is symptomatic. These procedures are based on current CDC guidance/guidelines... All field personnel should routinely review the CDC's website for updates..

A review of the facility's policy, "[name redacted] COVID19-Resident Admission/Re admission Protocols" revised 5/10/2022, revealed For unvaccinated COVID19 residents they will be on contact and droplet precautions isolation for 10 days. When on isolation, full PPE will continue to be used. If no know exposure to COVID 19, an approved NIOSH N-95 will not be required.

A review of the facility's policy, "Application of Transmission-Based Precautions" revised 6/8/22, revealed Purpose: transmission-Based precautions are used for residents who are known or suspected to be infected or colonized with infectious agents, which require additional control measures to effectively prevent transmission. Cohorting: Readmissions/new admissions that are unvaccinated for COVID19 vaccine should be on droplet precautions and contact precautions for 10 days.

NJAC 8:39-19.4(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031402	A. BUILDING: _____ B. WING _____	06/14/2022

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 interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for 7 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	CRITERIA I. 1. Director of Nursing and Human Resources Director has been and continues to actively hire Certified Nursing Assistants and establish contracts with various Healthcare Staffing agencies to comply with State staffing ratios. 2. Administrator, Chief Executive Officer and Human Resources Director revamped retention strategies for all	7/30/22

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

Electronically Signed | 07/07/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031402	A. BUILDING: _____ B. WING _____	06/14/2022

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 5/15/22 and 5/22/22, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -05/15/22 had 8 CNAs for 74 residents on the day shift, required 10 CNAs. -05/19/22 had 8 CNAs for 73 residents on the day shift, required 10 CNAs. -05/20/22 had 9 CNAs for 73 residents on the day shift, required 10 CNAs. -05/22/22 had 9 CNAs for 77 residents on the day shift, required 10 CNAs.	S 560	new and existing employees by raising base and starting rates and enhanced benefit package for Full and part time positions. 3. Childcare services is offered at our Friendship Center located in campus at a 50% discounted rate for all employees. 4. 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 staffing ratio requirements on a daily basis. CRITERIA II: All residents have the potential to be affected by the deficient practice of new minimum staffing requirements for nursing homes. CRITERIA III: 1. Human Resources Director will continue to run ads to attract applicants. 2. Administrator/Chief Operating 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. 3. Administrator and Director of Nursing will reach out to Local schools to promote job opportunities.	

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	031402	A. BUILDING: _____ B. WING _____	06/14/2022

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S 560	Continued From page 2 -05/23/22 had 9 CNAs for 76 residents on the day shift, required 10 CNAs. -05/24/22 had 9 CNAs for 75 residents on the day shift, required 10 CNAs. -05/26/22 had 8 CNAs for 73 residents on the day shift, required 10 CNAs. -05/27/22 had 0 CNAs to 11 total staff on the evening shift, required 6 CNAs. On 6/9/22 at 11:56 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was aware of the required minimum direct care staff to resident ratios. The surveyor asked the SC if the facility was meeting the required minimum direct care staff to resident ratios. She stated that the facility was meeting the ratios to the best of her ability but that she could not prevent staff callouts. The surveyor then asked the SC if she informed anyone if she was unable to meet the required ratios. The SC stated that the Director of Nursing (DON) reviewed the schedules after she wrote them. On 6/13/22 at 10:27 AM, the surveyor interviewed the DON who stated that she was aware of the required minimum direct care staff to resident ratios. The surveyor asked the DON if she was aware of the scheduling that the SC does. She stated that she double checks the schedule after the SC makes it. The surveyor then asked the DON if the facility was meeting the required minimum direct care staff to resident ratios. She stated that the facility was meeting the required minimum direct care staff to resident ratios the majority of the time. On 6/14/22 at 10:44 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that she was aware of the required minimum direct care staff to resident	S 560	4. Human Resources Director and Department Heads have increased expedience on hiring process by providing orientation more frequently and conveniently for potential new employees. CRITERIA IV: 1. Staffing Coordinator will provide weekly report to Director of Nursing and Administrator regarding all efforts made in an attempt to comply with State Staffing ratios. 2. Human Resources Director will submit monthly reports on status of all recruitment and retention efforts to the QAPI committee for 6 months. 3. Quality Assurance and Performance Improvement Committee will then determine further action Plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031402	A. BUILDING: _____ B. WING _____	06/14/2022

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

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S 560	Continued From page 3 ratios. A review of the facility provided policy titled, "Staffing Protocol", with a revised date of 10/26/2020, included the following: Policy: [name redacted] will provide nursing services and licensed nursing and ancillary personnel at all times. Objective: To fully staff each unit as required by standards, acuity levels, and by skill level of staff to properly meet the needs of all residents. 1. To determine minimum staffing, multiply the total number of residents by 2.5 hours a day. 2. In addition, the acuity levels will be calculated and added to that total ... 4. Staffing coordinator/designee will log in to nj.gov to report staffing totals as per regulation. Staffing is reported for each shift for each day. 5. Nursing staffing is posted daily. Minimum staffing requirements 1. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in ...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; ... (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 ...	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315072 Y1	A. Building B. Wing Y2	8/8/2022 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 F0625	Correction	ID Prefix F0658	Correction	ID Prefix F0732	Correction
Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	07/30/2022	LSC	07/30/2022	LSC	07/30/2022
ID Prefix F0761	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	07/30/2022	LSC	07/20/2022	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	
6/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
031402 Y1	A. Building B. Wing Y2	8/8/2022 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	07/30/2022	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	
6/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING **01** B. WING _____	**06/14/2022**

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 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
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		
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 06/08/2022 and 06/10/2022, 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.	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K 351		7/6/22

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

Electronically Signed | 07/06/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 1 of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/08/2022, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the facility for 1 of 20 closets, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The evidence includes the following, On 6/08/2022 (day one of survey) during the survey entrance at 9:05 AM, a request was made to the U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. Starting at 9:31 AM, in the presence of facility's U.S. FOIA (a tour of the building was conducted. Along the tour the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: At 9:40 AM, an inspection inside the facility's Social Services Directors office was performed. The surveyor observed no evidence of a fire sprinkler coverage inside the four (4) feet six (6) inch wide by two (2) feet deep closet inside the office. At this time the surveyor asked the U.S. FOIA (b) do you	K 351	No sprinkler head in social service closet: Interim life safety closet will not be used for storage until sprinkler head is installed. Maintenance Director notified the Sprinkler Company on 6/8/22. On 6/9/22 Sprinkler Company verified sprinkler head was omitted from the drawings. 6/20/22 quote being prepared for installation of sprinkler head in Social Services Closet. On 6/21 6/24/22 Maintenance staff inspected all storage closets where residents could be affected and found sprinkler heads to be in place at the time of the inspection. Staff was instructed on the new change and form amended on 6/24/22. Maintenance Foreman, will monitor the work to be completed on 7/6/22 Monthly Inspection adjusted and dated will now include checking closets for required sprinkler head in accordance with NFPA. Maintenance Director or designee will report the results of the inspection audit at the quarterly Quality Assurance Performance Improvement meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 351	Continued From page 2 see a sprinkler inside the closet. The U.S. FOIA (look inside and said, no. The findings were verified and confirmed by the U.S. FOIA (during the observations. The surveyor informed the US FOIA (b)(6) of the deficiency at the Life Safety Code exit conference on 06/10/2022 at 12:20 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 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 observation, interview and review of facility provided documentation on 6/08/2022 and 6/10/2022, it was determined that the facility failed to provide a portable class "K-type" fire extinguisher in one (1) of eight (8) kitchen cooking areas and ready for use in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition, Sections 6.6, 6.6.1, 7.2, 7.2.1.2, 7.2.2, 7.2.4.3 and 7.2.4.4 and 7.2.4.5. This deficient practice was evidenced by the following: NFPA,	K 355	No Portable Class K fire extinguisher in ADL suite of the cook area located in the physical therapy room. Maintenance Director notified Fire Protection Company on 6/8/22 that a portable Class K Fire Extinguisher was missing from ADL Suite. On 6/10/22 new portable Class K Fire Extinguisher was hung in ADL Suite by Fire Protection Company. On 6/21 □ 6/24/22 Maintenance staff checked all pantries and other areas with cooking facilities to ensure portable Class K Fire Extinguishers were in place where residents could be affected. All areas	7/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING **01** B. WING _____	**06/14/2022**

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 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 355	Continued From page 3 - 6.6.1 Class K fire extinguishers shall be provided for hazards where there is a potential for fire involving combustible cooking media (vegetable or animal oils and fats). - 6.6.2 Maximum travel distance shall not exceed 30 feet from the hazard to the extinguishers. On 6/08/2022 (day one of survey) during the survey entrance at 9:05 AM, a request was made to the U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified that there are seven (7) cooking serving areas and one in the main kitchen of the facility. On 6/10/2022 (day two of the survey) starting at 10:54 AM, in the presence of facility's U.S. FOIA (the tour of the building continued. At 11:43 AM, an inspection inside the Physical Therapy area was performed. The surveyor observed no evidence of a portable class K-type fire extinguisher in the area (with in thirty feet) of the stove inside the Average Daily Living (ADL) Kitchen therapy area. At this time the surveyor asked the U.S. FOIA (b) do you have a class K-type fire extinguisher in the ADL kitchen area. The U.S. FOIA (said, no. The surveyor informed the U.S. FOIA (b) (6) of the deficiency at the Life Safety Code exit conference on 06/10/2022 at 12:20 PM. NJAC 8:39-31.2(e) NFPA 10	K 355	were found to be in order. Monthly Inspection will now include the inspection of the Class K fire extinguisher in all pantries and areas with cooking facilities. This was added to the In-House Life Safety Book. The Life Safety Book is evaluated by Assistant Director of Maintenance and Director of Maintenance. This action will be conducted monthly by the Maintenance staff. The results will be recorded in the in-house life safety book which is reviewed and evaluated by the Assist. Director of Maintenance and Director of Maintenance. The results of the audit will be reviewed at the quarterly Quality Assurance Performance Improvement Meetings.	

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	8/8/2022 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. #	Completed
LSC K0351	07/06/2022	LSC K0355	07/05/2022	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	
6/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO