STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 Standard Survey 09/13/2024 Census: 102 Sample Size: 26+ 3 closed records C/O # NJ 169501, 172145, 174170, 174299, 174603, 174640, 175080, 175844, 176089 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		10/15/24

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

Electronically Signed | 09/27/2024

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain resident dignity when staff were observed standing while [NJ Ex Order 26.4] residents [NJ Ex Order 26.4(b)(1)] on 1 of 2 Nursing units, [NJ Exec] floor, for 1 of 1 resident reviewed for dignity (Residents #20). This deficient practice was evidenced by the following: On 09/10/2024 at 12:13 PM, the surveyor observed a facility staff on the [NJ Exec] floor dining room at the lunch meal [NJ Ex Order 26.4(b)] Resident #20 [NJ E] The staff was standing next to the table [NJ E] the Resident #20 [NJ Ex Order] from a standing position. Resident #20 was seated in a wheelchair at a table in the center of the dining room facing the television. The staff did not attempt to get a chair while assisting Resident #20 to [NJ Exec] The staff continued [NJ Ex Order 26.4] Resident #20 from the standing position throughout the meal. On interview, the staff who identified herself as a Licensed Practical Nurse (LPN #1). The	F 550	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 20 was receiving [NJ Ex Order 26.4(b)(1)] and LPN #1 was not sitting while [NJ Ex Order 26.4(b)(] LPN#1 received one to one education regarding resident dignity and being seated during meal assistance. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who require assistance with feeding have the potential to be affected by the deficient practice. A review of the residents requiring meal	

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F 550	Continued From page 2 surveyor asked LPN #1 what the facility procedure is when NJ Ex Order 26.4(b) residents NJ Ex Order 26.4 LPN #1 stated to the surveyor, "Should I be seated?" According to the Admission Record, Resident #20 was admitted to the facility with the following but not limited to diagnoses: NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). According to section GG of the Minimum Data Set, an assessment tool, dated NJ Ex Order 26.4(b)(1), Resident #20 required NJ Ex Order 26.4(b)(1). On 09/13/2024 at 09:53 AM, during an interview with the facility administration, which included the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), the surveyor asked what the facility practice was for assisting residents who are unable to NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) told the surveyors, "Staff who NJ Ex Order residents who require NJ Ex Order 26.4(b)(1) should be seated at eye level." Thy surveyor then asked the U.S. FOIA (b) why staff should NJ Ex Order residents seated at eye level. The U.S. FOIA (b) responded, "We do it that way because it is a dignity issue." A review of the facility provided policy titled Assistance with Meals, revised March 2022, revealed the following under Policy Interpretation and Implementation: Dining Room Residents: 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting	F 550	assist was immediately reviewed and no other residents were affected by this deficient practice. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Staff that assist residents with feeding had an in-services initiated on dignity and the procedure for assisting with meals How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Unit Manager/ or designee will monitor 3-5 meals for residents requiring assistance to validate dignity is maintained for 4 weeks, then 2 x a month for one month, then monthly for an additional month. Results of the observation audit will be reviewed with at the monthly Quality Assurance Performance Improvement meetings. Revisions will be made and implemented as necessary	

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F 550	Continued From page 3 them with meals. NJAC 8:39 - 4.1(a)12	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview review of the Electronic Medical Record (EMR) and review of	F 609	What corrective action(s) will be accomplished for those residents found to	10/15/24

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F 609	Continued From page 4 other facility documentation, it was determined that the facility failed to report an [redacted], specifically a [redacted], as well as an [redacted] of [redacted] to the New Jersey Department of Health (NJDOH) in a timely manner for 2 of 26 sampled residents, (Resident #13 and Resident #257). This deficient practice was evidenced by the following: 1. During the initial tour of the unit, Resident #13 told Surveyor #1 that he/she had [redacted] due to a [redacted]. Resident #13 denied [redacted] and said he/she will be following up with the [redacted] on Thursday. A review of the EMR was conducted on 09/09/2024 at 01:05 PM and included the following: According to the Admission Record Resident #13 was admitted to the facility with diagnoses including but not limited to: [redacted] and [redacted]). A review of a the most recent comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate care dated [redacted], revealed Resident #13 had a Brief Interview for Mental Status score of [redacted]/15 indicating [redacted]. A review of the Clinical Orders revealed a physician order dated [redacted] for [redacted] D/C (discontinue) when completed. A further review of the Order Summary Report revealed a physician order dated [redacted] for [redacted]	F 609	have been affected by the deficient practice? Resident # 13 had a [redacted] The medical record of the resident was immediately reviewed and interventions for his/her care were confirmed by the [redacted] Family, Physician notified of event. Reportable event called into the NJDOHSS/Ombudsman as an [redacted]. Managers and licensed personnel were immediately in-serviced on the protocol and definition of a reportable event and timeliness of reporting. Resident #13 remains in the facility([redacted] was determined to be old and conclusion submitted to the DOHSS) Resident #257 no longer resides at the facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. A review of reportable events submitted timely as well as radiology reports have been audited for the prior 30 days and no other residents have been affected. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur?	

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F 609	Continued From page 5 (NJ Ex Order 26.4(b)(1) and treat. On 09/10/2024 at 10:45 AM, a review of the EMR progress notes for NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) did not include documentation of what had occurred that the physician would have ordered the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) and treat on NJ Ex Order 26.4(b)(1). On 09/11/2024 at 09:19 AM, a review of NJ Ex Orde dated NJ Ex Order 26.4 revealed a NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) within NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) noted NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) noted. Under the impression section NJ Ex Order 26.4(b)(1) involving the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) During an interview with Surveyor #1 on 09/11/2024 at 10:17 AM, the U.S. FOIA (b) (6) was asked what had occurred with Resident #13 having sustained a NJ Ex Order 26.4(b)(1) The U.S. FOIA replied "I don't know how the NJ Exec Order 26.4(b)(1) happened. The resident has a history of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)." The U.S. FOIA went on to say, "I would say this is an NJ Ex Order 26.4(b) and should have been reported to NJDOH." The U.S. FOIA said, "I know there's no documentation in EMR regarding his/her NJ Ex Order 26.4 and follow up NJ Ex Orde ordered and the NJ Exec Order 26.4(b) Surveyor #1 requested any information including reporting of this to the NJDOH from U.S. FOIA (b) On 09/11/2024 at 01:00 PM, Surveyor #1 reviewed a type written document from the U.S. FOIA (b) (6)) indicating the following; Resident name	F 609	The administrator and Director of Nursing immediately in-serviced dept managers on the definition of injury of unknown origin as well as the policy on timely reporting. Licensed staff were in-serviced on timely reporting and definition of what constitutes a reportable event. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? DON/designee will review 4-7 days of nursing communication report weekly x 4 weeks to review for potential reportable events and ensure timeliness. After 4 weeks, audits will continue bi-monthly for a period of 1 month, then monthly for another month. Results of the audits will be presented by the Director of Nursing to the Administrator at the monthly Quality Assurance Performance Improvement meetings for a period of three months. Revisions will be made and implemented as necessary.	

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F 609	Continued From page 6 Admission date NJ Ex Order 26.4 NJ Ex Order 26.4 Resident complained to family about NJ Ex O. Family contacted U.S. FOIA (b) (6)) and informed of NJ Ex Orde U.S. FO communicated family concern to clinical team. NJ Ex Order 26.4 NJ Ex Orde ordered. NJ Ex Orde completed. NJ Ex Orde results received. NJ Ex Order 26.4(b)(1) reviewed by US FO documented on NJ Ex Orde results NJ Ex Order 26.4 order received for NJ Ex Order 26.4(b)(1) and treat. NJ Ex Order 26.4 Resident interviewed by U.S. FOIA (b) (6). Resident noted sitting in wheelchair in NJ Ex O room. NJ Exe is NJ Ex Order 26.4 NJ Ex Orde and NJ Ex Order 26.4(b)(1) NJ Exe shows no signs or symptoms of NJ Ex Orde or NJ Ex Order 26.4(b)(1) at the time of the interview. Resident stated that NJ Ex has had NJ Ex Order 26.4(b)(1) for years. NJ Exe denies any NJ Ex Orde while here in the facility. NJ Exe denies anyone NJ Ex Order 26.4(b)(1) to NJ Ex O. NJ Exe stated that he does not think NJ Ex has ever had any NJ Ex Order 26.4 or NJ Ex Order 26.4 previously on NJ Ex Order 26.4. NJ Ex Order 26.4 Reportable called into the NJDOH. Notified Office of U.S. FOIA (b) (6) The U.S. FOIA (b) confirmed this was called into the NJDOH after surveyor inquiry. During an interview with Surveyor #1 on 09/11/2024 at 1:26 PM, the U.S. FOIA (b) said the facility became aware of resident's NJ Exec Order 26 when the surveyor inquired about the investigation. The U.S. FOIA (b) said the staff should have informed administration at the time they knew resident had NJ Ex Order 26.4(b)(. It was a communication problem.	F 609		

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During an interview with Surveyor #1 on 09/12/2024 at 09:24 AM, the [U.S. FOIA (b) (6)] was asked what her expectations were regarding being notified of [NJ Ex Order 26.4(b)(1)], resident [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)]. She replied "my expectations are when I come in, I ask what is going on and what is new from both nurses and aides. I call in on weekends and staff knows I am available by phone. [U.S. FOIA (b) (6)] said staff knows to call me with [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 2] or [NJ Ex Order 26.4(b)(] If I become aware of [NJ Ex Order 2], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4] it is instant call to [U.S. FOIA (b) (6)], [U.S. FOIA (b)] and [U.S. FOIA (b) (6)]

During an interview with Surveyor #1 on 09/12/2024 at 09:35 AM, Licensed Practical Nurse (LPN #1) was asked what the facility policy was when there was a [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], or a resident was found to [NJ Ex Order 26.4(b)(1)] with [NJ Ex] [U.S. FOIA (b)] [U.S. FOIA (b) (6)]), Family. We ask the resident what happened, risk management form on computer (incident report) we would make a note in medical record of the incident or [NJ Ex Order 26.4(b)(1)] We would call [U.S. FOIA] on her cell phone if she were not here. We would also notify supervisor on duty. We do have supervisors on and would tell them as well. We would write and get statements from assigned aides that day and nurse who had them as well as prior nurse and cnas. LPN #1 went on to say Yes, one of the first things we would do was assess the resident for pain, injury, and vitals. We would get statements from residents involved as well. We would do this

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immediately.

On 09/12/2024 at 08:34 AM, a review of a facility policy titled "Facility Responsibilities for Reporting Allegations" with a revised date of September 2022 revealed the following addresses facility responsibilities for reporting allegations/occurrences involving staff to resident abuse; resident to resident altercations; injuries of unknown source; and misappropriation of resident property/exploitation.
Under the Injuries of Unknown Source Required to report incudes but not limited to: Unobserved/unexplained fractures, sprains or dislocations.... The policy did not include timeframes for reporting or steps for facility to take once the allegation/injury.

On 09/12/2024 at 09:48 AM, a review of the above facility policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" with a revised date of April 2021, revealed under the Policy Statement, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.
Under the Policy Interpretation and Implementation section "Reporting Allegations to the Administrator and Authorities" 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to the other officials according to state law. 2. The Administrator or the individual making the

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allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; ...3. Immediately is defined as: within 2 hours of the allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

2. A review of a facility reported event involving an [NJ Ex Order 26.4] incident of NJ Ex Order 26.4(b)(1) revealed that Resident #257 [NJ Ex Order 26.4] that Certified Nursing Assistant (CNA #1) was talking to a co-worker on the 11 PM - 7 AM shift on [NJ Ex Order 26.4(b)(1)]. Resident #257 alleged that CNA #1 was NJ Ex Order 26.4(b)(1), and Resident #257 went to their door threshold and [NJ Ex Order 26.4(b)] CNA #1 for [NJ Ex Order 26.4(b)(1)]. Resident #257 then NJ Ex Order 26.4(b)(1) . According to Resident #257, who no longer resides at the facility, CNA #1 [NJ Ex Order 26.4] Resident #257's [NJ Ex Ord] and spoke to him/her [NJ Ex Ord] telling Resident #257 that he/she could not NJ Ex Order 26.4(b)(1) and they could pull their privacy curtain for privacy before exiting the room. This event was noted to have occurred "late" on the 11 Pm - 7 AM shift, however the Reportable Event Record/Report indicated that the event occurred on [NJ Ex Order 26.4(b)(1)] at a11:45 PM.

Review of the facility investigation summary dated [NJ Ex Order 26.4(b)] revealed that the facility [U.S. FOIA (b) (6)]) was not made aware of the NJ Ex Order 26.4(b)(1) until 9:30 AM on [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] documented on the investigation summary that "it was a presumed delay in reporting the matter to the appropriate management. The incident occurred on the

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evening of NJ Ex Order 2 but was not reported until the morning of NJ Ex Order 2. The reporting nurse will receive a NJ Ex Order 26.4(b)(1) education on reporting events in a timely manner."

On 09/12/2024 at 02:54 PM the surveyor conducted an interview with the NJ Exec Floor Registered Nurse/Unit Manager (RN/UM #1). The surveyor asked RN/UM #1 what the facility practice was when NJ E NJ Ex Order 26. event of NJ Ex Order 26 was NJ Ex Order 26.4 RN/UM #1 told the surveyor, "I would immediately report it to the U.S. FOIA (b) (6) U.S. FOIA (b) and the U.S. FOIA (b) (6) . I would then assist in getting any information that those people would require of me. I would also notify the physician and I would notify the family afterwards. I also assess the involved resident."

On 09/12/2024 at 03:22 PM the surveyor conducted an interview with the facility U.S. FOIA and U.S. FOIA (b) (6)) concerning the NJ Ex Order 26.4(b)(1) investigation of Resident #257. The surveyor asked the U.S. FOIA and U.S. FOIA (b) what the facility practice was for NJ Ex Order 26.4(b)(1). The U.S. FOIA told the surveyor, "Nursing should report to the facility U.S. FOIA and U.S. FOIA (b) any NJ Ex Order 26.4(b)(1) ." The surveyor asked what the time frame was for reporting an NJ Ex Order 26.4(b)(1) to the New Jersey Department of Health. The U.S. FOIA stated, "An NJ Ex Order 26.4(b)(1) should be reported to the NJDOH within 2 hours and for residents over the age of 60 it should also be reported to the U.S. FOIA (b) (6)

On 09/12/2024 at 09:48 AM, a review of the above facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and

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	315210	A. BUILDING _____ B. WING _____	C 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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F 609	Continued From page 11 Investigating with revised date of April 2021.revealed under the Policy Statement, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Under the Policy Interpretation and Implementation section "Reporting Allegations to the Administrator and Authorities" 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to the other officials according to state law. 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; ... 3. Immediately is defined as: within 2 hours of the allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. NJAC 8:39-9.4(f)	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		10/15/24

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F 656	Continued From page 12	F 656		

objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.

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F 656	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives, timelines, and interventions to meet resident's medical and nursing needs specifically by failing to implement a care plan for an [NJ Ex Order 26.4(b)] that was [NJ Ex Order 26.4] through a NJ Ex Order 26.4(b)(1) used to [NJ Ex Order 26.4(b)(1)], and 2.) a resident diagnosed with [NJ Ex Order 26.4(b)(1)]) on admission. The deficient practice was identified for 2 of 26 sampled residents, (Resident #86 and Resident #99). The deficient practice was evidenced by the following: 1.) On 09/09/2024 at 08:28 AM, during the initial tour, Resident #86 was identified by the nurse preparing an NJ Ex Order 26.4(b)(1)), as being ordered an [NJ Ex Order 26.4(b)(1)] for an [NJ Ex Order 26.4(b)] A review of Resident #86's Admission Record revealed that he/she had a diagnosis that included but not limited to: NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated [NJ Ex Order 26.4(b)(1)], under Section N-Medications: [NJ Ex Order 26.4(b)(1)] Classes: Use and Indication: indicated that Resident #86 is taking an [NJ Ex Order 26.4(b)(1)] Under Section O-Special Treatments, Procedures, and Programs: [NJ E	F 656	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #86 care plan did not include the [NJ Ex Order 26.4(b)(1)] used for [NJ Ex Order 26.4(b)] was immediately reviewed and updated. Resident #99 has been discharged from the facility. Facility failed to develop a comprehensive person centered care plan for residents #86 and #99. Care plans were immediately reviewed and updated as appropriate. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with a comprehensive care plan have the potential to be affected. An audit was completed for residents with a diagnosis of PTSD and residents with a PICC line used for IV abt and no other residents were affected. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Social services and licensed nursing staff were educated by the MDS Coordinator and DON on developing the comprehensive care plan that is patient	

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F 656	Continued From page 14 NJ Ex Order 26.4(b)(1) NJ Ex Or A review of the Physician Orders revealed the following: Change NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) weekly every night shift every Tuesday; NJ Ex Order 26.4(b)(1) , use NJ Ex Order 26.4(b)(1) two times a day for NJ Ex Order 26.4(b)(1) . A review of Resident #86's Care Plan did not include a care plan that addressed that Resident #86 had a NJ Ex Order 26.4(b)(and was receiving NJ E During an interview with the surveyor on 09/12/2024 at 3:15 PM, the U.S. FOIA (b) (6)) was asked what the expectations for a comprehensive person-centered Care Plan to include that a NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b) should be included in the residents Care Plan. The U.S. FOIA said yes it should be included. 2. On 09/09/2024 at 08:43 AM, the surveyor conducted an interview with Resident #99 on the initial tour of the facility. Resident #99 told the surveyor the he/she was a NJ Exec Order 26 and stated to the surveyor that he/she had NJ Ex Order 26.4(b)(1) . Resident #99 was observed to be NJ Ex Order 26.4 on interview and told the surveyor that they were medicated for NJ Ex Order 26 On 09/09/2024 at 12:16 PM, the surveyor conducted a record review for Resident #99. According to the Admission Record, Resident #99 was admitted to the facility with the following but not limited to diagnoses: NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) .	F 656	centered How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? DON/ or designee will audit up to 5 resident records that have a PICC line and validate the care plan is in place weekly for 4 weeks, then bi-monthly for two months, then monthly for one month. DON/designee will audit up to 5 resident records that contain a diagnosis of PTSD and validate the care plan is in place weekly for 4 weeks, then bi-monthly for two months, then monthly for one month. Results of the audits will be presented by the Director of Nursing to the Administrator at the monthly Quality Assurance Performance Improvement meetings for a period of three months. Revisions will be made and implemented as necessary.	

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F 656	Continued From page 15 A review of the comprehensive Minimum Data Set (MDS) an assessment tool, dated [redacted], revealed Resident #99 had a Brief Interview for Mental Status score of [redacted]/15, indicating [redacted]. According to Section [redacted] of the MDS, Resident #99 had feelings of [redacted] and [redacted], [redacted] or [redacted] on a frequency of [redacted]. A review of Section [redacted] of the MDS revealed Resident #99 had active diagnoses of [redacted], [redacted] and [redacted]. Section N of the MDS revealed Resident #99 received daily [redacted] medication. A review of the Order Summary Report revealed Resident #99 had the following physician order: [redacted]) Oral Tablet [redacted]) [redacted]) Give 2 tablet by mouth one time a day for [redacted].: Order Date: [redacted]. A review of Resident #99's comprehensive care plan did not include a care plan for [redacted] On 09/12/2024 02:38 PM, the survey team conducted an interview with the [redacted] and [redacted]. On interview both the facility [redacted] and [redacted] agreed that, "[redacted] is a diagnosis that should be care planned." On 09/13/2024 at 10:40 AM, the surveyor conducted an interview with the [redacted] of the [redacted] floor. The [redacted] was responsible for developing care plans for Residents on the [redacted]	F 656		

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F 656	Continued From page 16 floor of the facility where Resident #99 resided. The surveyor then asked the U.S. FOIA (b) (6) if Resident #99 should have been care planned for a diagnosis of NJ Ex Order 2 U.S. FOIA (b) (6) told the surveyor, "I'm really not sure if it should have been care planned, but yes, I should've care planned Resident #99 for NJ Ex Order 2 I have to be honest I never had anybody with a diagnosis of NJ Ex Order 2 before. I'm glad that I know now." A review of a facility policy on 09/12/2024 at 12:10 PM, titled "Care Plans, Comprehensive Person-Centered," with a revised date of March 2022, Policy Statement as follows: "A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident." Under #7, "The Comprehensive, Person-Centered Care Plan:" reflects currently recognized standards of practice for problem areas and conditions. a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; e. reflects currently recognized standards of practice for problem areas and conditions. NJAC 8:39-11.2(f)	F 656		
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,	F 658		10/15/24

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F 658	Continued From page 17 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: C/O #NJ 174603 Based on observation, interview, review of the Electronic Medical Record (EMR) it was determined that the facility nursing staff failed to document in the progress notes (PN) unusual incidents, specifically regarding a.) a [redacted], b.) NJ Ex Order 26.4(b)(1) and c.) a NJ Ex Order 26.4(b)(1) [redacted]. This deficient practice was identified for 4 of 26 sampled residents (Resident #13, Resident #5, Resident #48 and Resident #257) and 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 stated, "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 regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family	F 658	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #13 had a summary progress note entered into the medical record. that also included the outcome of the NJ Ex Order 26.4(b)(1) which indicated the [redacted] is old. Residents #5 and 48 had late entry progress notes entered into their medical record to reflect the NJ Ex Order 26.4(b)(1) with resolution regarding the NJ Ex Order 26.4(b)(1) of [redacted]. Resident #257 no longer resides at the center and a late entry is unable to be entered. A narrative late entry note has been attached to the closed hybrid record. C.N.A. #1 no longer is employed at the center. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected. Director of Nursing Immediately initiated inservicing to licensed staff on reporting in	

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F 658	Continued From page 18 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." 1. During the initial tour of the unit, Resident #13 told Surveyor #1 that he/she had NJ Ex Or due to a NJ Ex Order 26.4(b)(1). Resident #13 denied having NJ Ex Order and said he/she will be following up with the NJ Ex Order 26.4(b)(1) physician on Thursday. A review of the EMR was conducted on 09/09/2024 at 01:05 PM and included the following: According to the Admission Record Resident #13 was admitted to the facility with diagnoses including but not limited to: NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) A review of the most recent comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate care dated NJ Ex Order 26.4(b)(1), revealed Resident #13 had a Brief Interview for Mental Status score of NJ E/15 indicating NJ Ex Order 26.4(b)(1). A review of the Clinical Orders revealed a physician order (PO) dated NJ Ex Order 26.4(b)(1) for NJ Ex O to r/o (rule/out) NJ Ex Order 26.4(b)(1). D/C (discontinue) when completed. A further review of the Order Summary Report revealed a physician order dated NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1)) and treat. On 09/10/2024 at 10:45 AM, a review of the EMR	F 658	a timely manner. Audits will be completed to monitor timely entry of progress notes related to injury of unknown origin and resident altercations. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Director of Nursing immediately initiated in-service to licensed nurses and social services on the definition of documenting in progress notes and completing an incident report for unusual occurrences. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? DON/designee will review up to 5 progress notes to validate nursing communication of unusual incidents or changes in a residents status have been captured in the progress notes for 4 weeks , then twice monthly for one month, then monthly for one month.. Director of Social Service and Administrator will do a weekly review of up to 5 progress notes related to reportable events that involve residents for 4 weeks to validate the progress captures the events that occurred and any follow up required, then twice monthly for one month, then monthly.	

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F 658	Continued From page 19 progress notes for NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) did not include documentation of what had occurred that the physician would have ordered the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) and treat on NJ Ex Order 26.4(b)(1). On 09/11/2024 at 09:19 AM, a review of NJ Ex Orde dated NJ Ex Order 26.4 revealed a fracture of NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) noted NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) noted. Under the impression sectio NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) During an interview with Surveyor #1 on 09/11/2024 at 10:17 AM, the U.S. FOIA (b) (6)) was asked what had occurred with Resident #13 having sustained a NJ Ex Order 26.4(b)(1) The U.S. FOIA replied "I don't know how the NJ Ex Order 26.4 happened. The resident has a history of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)." The U.S. FOIA went on to say, "I would say this is an NJ Ex Order 26.4 and should have been reported to NJDOH." The U.S. FOIA said, "I know there's no documentation in EMR regarding his/her NJ Ex Order 26.4 and follow up NJ Ex Order ordered and the NJ Ex Order 26.4(b)(Surveyor #1 requested any information including reporting of this to the NJDOH from U.S. FOIA (b On 09/12/2024 at 02:58 PM, a review of a facility policy titled "Charting and documentation" with a revised date of July 2017 revealed under the Policy Statement section All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical	F 658	Results of the audits will be reviewed at the monthly Quality Assurance Performance Improvement meetings for a period of three months. Revisions will be made and implemented as necessary	

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F 658	Continued From page 20 record. Under the Policy "Interpretation and Implementation" section 2. d. any changes in the resident's condition; e. events, incidents or accidents involving the resident. 2. On 9/10/2024 at 10:00 AM, the surveyor reviewed the facility provided Facility Reported Event (FRE) dated [NJ Ex Order 26.4] which was an [NJ Ex Order 26.4] involving two residents over the NJ Ex Order 26.4(b)(1), Resident #5 and Resident #48. On 9/11/2024 at 1:45 PM, the surveyor interviewed Resident #5's and Resident #48's nurse, LPN #3, who stated she was unaware of any NJ Ex Order 26.4(b)(1) between the two residents. LPN #3 stated that Resident #5 could be NJ Ex Order 26.4(b)(1) at times but was [NJ Ex Order] On 9/11/2024 at 1:51 PM, the surveyor interviewed LPN #3 regarding Resident #48, who stated the resident got along with both the staff and residents but would become NJ Ex Order 26.4(b)(1) if he/she felt their needs weren't satisfied in a timely manner. When asked the facility process for reporting NJ Ex Order 26.4(b)(1) between two residents LPN #3 stated the residents would be NJ Ex Order 26.4(b)(1) then she would let management either the [U.S. FO] or the U.S. FOIA (b) (6) or the [U.S. FOIA] know about the incident. Then there would be a risk management report entered into the resident's medical record including a Situation, Background, Assessment and Recommendation (SBAR) a tool used in nursing for communication with other healthcare professionals regarding patient information, notification to resident's physician, and family the	F 658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 21 incident would be discussed at a morning meeting of department heads On 9/12/2024 at 12:24 PM, the surveyor reviewed the medical record for Resident #48. A review of the Admission Record reflected the resident was admitted to the facility with diagnoses which included [redacted] and [redacted]). A review of the most recent quarterly Minimum Data Set (MDS) an assessment tool dated [redacted], reflected the resident had a brief interview for mental status score of [redacted] out of 15, which indicated a [redacted]. A review of the individualized person-centered care plan reflected a focus area initiated [redacted], for a [redacted] related to [redacted] staff. Interventions included caregivers to provide opportunity for [redacted] with him/her as passing by. Educate [Resident #48] ...on [redacted] and [redacted]... A review of the resident Progress Notes (PN) for [redacted] did not reveal any notes or references to the FRE incident reported to the New Jersey Department of Health (NJDOH) regarding the [redacted] event on [redacted]. On 9/12/2024 at 2:28 PM, the surveyor reviewed the medical record for Resident #5.	F 658		

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A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included [redacted], [redacted] and [redacted].

A review of the most recent quarterly Minimum Data Set (MDS), and assessment tool dated [redacted], reflected a brief interview for mental status (BIMS) score of [redacted] out 15, which indicated [redacted].

A review of the individualized person-centered care plan reflected a focus area initiated [redacted], for [redacted] related to his/her diagnosis of [redacted] and history of [redacted] and [redacted] evident by occasional [redacted], [redacted] and expressions of [redacted]. Interventions included to allow time for [redacted] and attempt to resolve [redacted]. Attempt to [redacted] [Resident #5's] [redacted] to something [redacted] when [redacted].

A review of the resident Progress Notes (PN) for [redacted] did not reveal any notes or references to the FRE incident reported to the New Jersey Department of Health (NJDOH) regarding the alleged event on [redacted].

3. A review of a Facility Reported Event, dated [redacted], revealed that Resident #257 [redacted] that Certified Nursing Aide (CNA #1) [redacted] him/her on the 11 PM - 7 AM shift on [redacted]. Resident #257 alleged that CNA #1 was [redacted]. Resident #257

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F 658	Continued From page 23	F 658		

stated that he/she went to the threshold of their door and NJ Ex Order 26.4(b) CNA #1 for NJ Ex Order 26.4(b)(1) y and then NJ Ex Order 26.4(b)(1). Resident #257 then stated that CNA #1 opened the door to the room and spoke to him/her in NJ Ex Order 26.4(b)(1). Resident #257 stated that CNA #1 told him/her that they could not have their NJ Ex Order 26.4(b)(1) and that they could pull the privacy curtain if they wanted privacy.

According to Resident #257's Admission Record they were admitted to the facility with the following but not limited to diagnoses: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

According to a review of the Minimum Data Set (MDS) an assessment tool, Resident #257 had a Brief Interview for Mental Status score of NJ Ex /15, indicating NJ Ex Order 26.4(b)(1). According to Section D of the MDS, Resident #257 had NJ Ex Order 26.4 , or NJ Ex Order 26.4(b)(1) for several days in the observation period.

Review of the comprehensive care plan for Resident #257 revealed a care plan Focus: "Adjustment to new environment & involvement in activity interests NJ Ex Order 26.4b1 . New admission. Date Initiated: NJ Ex Order 26.4(b)(1)." The following was observed under Interventions/Tasks: My usual bed time is NJ Ex Order 26. Date Initiated: NJ Ex Order 26.4(b)(1)"

On 09/11/2024 at 02:34 PM, a review of the PN from NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) did not include documentation of the NJ Ex Order 26. incident between Resident #257 and CNA #1.

On 09/12/2024 at 02:40 PM the surveyor

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F 658	Continued From page 24 conducted an interview with the U.S. FOIA (b) (6) [redacted]. The surveyor asked the U.S. FOIA (to briefly describe what she would do concerning a report of NJ Ex Order 26.4(b)(1) in the facility. The U.S. FOIA (stated, "I would find out from the resident what the actual event was from their perspective and would meet in private with the resident." The surveyor then asked the U.S. FOIA (if she would document the interview/meeting in the EMR. The U.S. FOIA (responded, "Of course, I would document the encounter with NJ Ex Order 26.4(b)(1) in the social service progress notes in PCC (Point Click Care, an electronic medical record). The surveyor told the U.S. FOIA (that he was unable to find any documentation of the U.S. FOIA (b) (interview with Resident #257 concerning the NJ Ex Order 26.4(b)(1). The surveyor asked if the encounter should have been documented in the EMR. The U.S. FOIA (responded, "Yes, I would have documented and should have documented the event in the progress notes for the NJ Ex Order 26.4(b)(1) that occurred on NJ Ex Order 26.4(b) with Resident #257." On 09/12/2024 at 02:58 PM, a review of a facility policy titled "Charting and documentation" with a revised date of July 2017 revealed under the Policy Statement section All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. Under the Policy "Interpretation and Implementation" section 2. d. any changes in the resident's condition; e. events, incidents or accidents involving the resident. On 9/13/2024 at 9:23 AM the survey team met with facility Administration. The U.S. FOIA told the	F 658		

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F 658	Continued From page 25 surveyor's that a summary of the [NJ Ex Order 26.] incident would be expected to be documented in the resident's progress notes. The [U.S. FOIA] further acknowledged that an FRE should have been documented in the resident's progress notes. NJAC 8:39-11.2(b); 27.1(a)	F 658		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and review of Nurse Staffing Report sheets, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 6 days of 10 weeks reviewed. This deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the weeks of 11/05/2023, 12/31/2023 thru 01/06/2024 revealed the facility had no RN coverage for 8 consecutive hours for all shifts on 11/05/2023, 11/08/2023, 11/11/2023,	F 727	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility is unable to retroactively address the dates noted for RN hours. [NJ Ex Order 26.4b1, US FOIA (b)(6)] immediately educated to proactively alert DON and LNHA of any days without an RN at least 8 hours a day/7 days a week..	10/15/24

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F 727	Continued From page 26 12/31/2023, 01/01/2024, and 01/06/2024. On 09/12/2024 at 03:15 PM, the surveyors conducted an interview with the facility U.S. FOIA (b) (6) [redacted] and the surveyor said she reviewed the facility staffing sheets which indicated that the facility had days without a Registered Nurse (RN) for at least 8 consecutive hours. When asked should there be an RN on duty for at least 8 consecutive hours daily the U.S. FOIA [redacted] replied, "Yes, we should have 8 hours minimum for RN on duty per day. A review of the facility provided policy titled Staffing, revised October 2017, revealed the following under Policy Statement: Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. The following was revealed under the heading Policy Interpretation and Implementation: 5. Efforts are made to fill open shifts as well as call-outs utilizing incentive programs and agency. Staffing is monitored daily. NJAC 8:39-25.2(h)	F 727	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected by this. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? The Health Center at Galloway has contracted with several staffing agencies for assistance with staffing. Flexible schedules offered, incentive bonuses, increases in online recruitment postings. Additional RN staff are in the process of being hired to ensure coverage will comply with requirement. RN unit manager, RN MDS cordinator or RN designee will be required to cover for 8 hours if no other alternatives are available. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? The DON and LNHA proactive by monitoring the staffing projected for upcoming days to assure staffing meets census and ratio of one RN 8 hours/daily for seven days.	

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F 727	Continued From page 27	F 727	DON will review staffing levels and will report monthly at the Quality Assurance Performance Improvements (QAPI) committee	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		10/15/24

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F 758	Continued From page 28 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to follow up on a NJ Ex Order 26.4(b)(1) recommendation to discontinue an NJ Ex Order 26.4(b)(1) medication, failed to monitor residents' NJ Ex Order 26.4(b) for the use of the NJ Ex Order 26.4(b)(1) and failed to develop a care plan for the use of an NJ Ex Order 26.4(b)(1) This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications, (Resident #74) and was evidenced by the following: On 9/10/2024 at 08:58 AM, the resident was observed lying in bed with his/her eyes closed. On 9/10/2024 at 12:30 PM, the resident was observed in his/her room with a NJ Ex Order 26.4(b) eating lunch. There were no NJ Ex Order 26.4(b)(1) exhibited. On 9/11/2024 at 08:39 AM, the resident was observed lying in bed with his/her eyes closed.	F 758	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #74 had a NJ Ex Order 26.4(b)(1) recommendation to discontinue NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b)(1). Physician notified that order had not been discontinued and order was discontinued on 9-12-24. Nursing Education included retrieval of NJ Ex Order recommendations from the progress notes and reviewing recommendation with primary physician to obtain new orders if approved. Resident #74 Medication Administration Record (MAR) did not include monitoring for NJ Ex Order 26.4b1 . The nursing team updated the MAR for NJ Ex Order 26.4b1 has been discontinued.	

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F 758	Continued From page 29 On 9/12/2024 at 12:00 PM, the resident was observed NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(Resident was smiling, replied fine when asked how he/she was today. No NJ Ex Order 26.4(b)(1 were exhibited. On 9/09/2024 at 12:19 PM, a review of the Electronic Medical Record was done and revealed the following: According to the Admission record, Resident #74 was admitted with diagnoses including but not limited to: NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) A review of the most recent comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate care dated NJ Ex Order 26.4(b)(1 revealed Resident # 74 had a Brief Interview for Mental Status (BIMS) of NJ /15 score indicating NJ Ex Order 26.4 . The MDS further revealed Resident #74 had NJ Ex Order 26.4(b)(1), and was taking an NJ Ex Order 26.4(b)(1) medication. A review of the Care Area Assessment (CAA's) revealed to proceed to care plan for NJ Ex Order 26.4(b)(1). A review of the Order Summary Report with active orders as of NJ Ex Order 26.4(b)(1 revealed a physician order dated NJ Ex Order 26.4(b)(1 for NJ Ex Order 26.4(b)(1) oral tablet NJ Ex Order 26.4(b)(1)) NJ Ex Order 26.4(b)(1) Give NJ Exe tablet by mouth at bedtime for NJ Ex Order 26.4(b)(1). A review of the Medication Administration Record (MAR) for NJ Ex Ord NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) did	F 758	Resident #74 did not have a care plan to address the use and monitoring for NJ Ex Order 26.4(b)(1) Care plan was immediately reviewed and as the NJ Ex Order 26.4(b)(1) was discontinued, no care plan to address was initiated How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents that have psychiatric recommendations have the potential to be affected. A review of psychiatric consults and residents with psychotropic drug orders was completed and no other residents were affected. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Licensed nurses will be re-educated by Director of Nursing (DON)/ or designee on following up on consulting physician recommendations, and behavior monitoring at the start of and discontinuation of psychotropic drugs. Unit managers will be educated on care plans necessary for residents on psychotropic drugs by 9/23/24 How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality	

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F 758	Continued From page 30 not include monitoring for NJ Ex Order 26.4(b)(1) or the use of NJ Ex Order 26.4(b)(1). A review of a Progress note dated NJ Ex Order 26.4(b)(1) revealed a NJ Ex Order 26.4(b)(1) Progress Note which indicated a Chief Complaint: Pt (patient) was re-evaluated today for follow-up, and med (medication) management. Under the HPI (history of present illness): Patient with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) seen for follow up, and med management. Per chart has a NJ Ex Order 26.4b1, admitted to the hospital for NJ Ex Order 26.4(b)(1) and discharged on NJ Ex Order 26.4(b)(1) Patient seen in room, NJ Ex Order 2, NJ Ex Order NJ Ex Order 26.4(b) NJ Ex Order 26.4(b) at baseline, and in no apparent NJ Ex Order 26.4(Reports NJ Ex Order 26.4(b)(1)". Under the MONITORED NJ Ex Order 26.4 MEDICATIONS (with DIAGNOSES) section ...4. NJ Ex Order 26.4(b)(1) QHS (every bedtime time) for NJ Ex Order 26.4(b)(1) Under the PLAN section: 1. Always consider supportive and individualized non-pharmacologic interventions, including: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4 , NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), family involvement. Treat medical issues including NJ Ex Ord NJ Ex On NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(Encourage participation in activities, social engagement as tolerated and as possible for NJ Ex Order 26.4(b)(1). 2. Recommend D/C (discontinue) NJ Ex Order 26.4(b) ; B>R (benefits>risk). A Dose Reduction (GDR) (gradual dose reduction) is: D/C NJ Ex Order 26.4(b)(1). A review of Resident #74's progress Notes from	F 758	assurance programs will be established? DON/designee will review five records for patients on an antipsychotic to have behavior monitoring and side effect monitoring on the MAR. Weekly for a period of four weeks, then bi-monthly for one month, then monthly for an additional month. DON/designee will review five residents that are receiving antipsychotics for an active care plan in place weekly for a period of four weeks, then bi-monthly for one month, then monthly for an additional month. Results of the audits will be presented by the Director of Nursing at the monthly Quality Assurance Performance Improvement meetings. Revisions will be made and implemented as necessary.	

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F 758	Continued From page 31 NJ Ex Order 26.4(b)(1) thru NJ Ex Order 26.4(b)(1) did not include documentation that the physician was notified of the NJ Ex Order 26.4(b)(1) recommendation to discontinue the NJ Ex Order 26.4(b)(1) A review of the care plan for Resident #74 did not include the care and monitoring for the use of NJ Ex Order 26.4(b)(1) During an interview with the surveyor on 9/11/2024 at 12:37 PM, Licensed practical Nurse (LPN#3) was asked what the facility policy was regarding follow up by nurses with consultations. LPN #3 replied It depended on which physician. The dentist and eye doctor give us their orders. The psychiatrist gives us a paper for recommendations and once we get physician approval we put the new orders in the computer. We can read their (consultant's) notes but most of the time they give us a paper with the recommendations for all their residents on the unit. The surveyor questioned what the facility policy was on monitoring of NJ Ex Order 26.4(b)(1) medications, and LPN #3 replied "We do monitor for different s/s (signs/symptoms), any reactions, an increase in behaviors and we document that on the MAR. The surveyor asked if that was for all NJ Ex Order 26.4(b)(1) medications, and she stated yes, for any NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) We have to put in the monitoring of NJ Ex Order 26.4(b) on order sheets." The surveyor asked what was expected to be on a resident care plan and LPN #3 stated she was not too familiar with care plans. She stated she knew it would contain the resident's transfer requirements, their diet, and whatever assistance was needed to care for the resident. LPN #3 further stated that nurses didn't usually handle care plans.	F 758		

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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
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During an interview with the surveyor on 9/13/2024 at 9:18 AM, the U.S. FOIA (b) (6)) was asked what the facility's policy was regarding following-up on consultant recommendations by nurses. The U.S. FOIA stated that the nurses were to reach out to the physician, make them aware of the recommendation, and record their decisions whether they agree or disagree in the EMR. The U.S. FOIA was then asked what the facility's policy was on monitoring of NJ Ex Order 26.4(b)(1) medications? The U.S. FOIA replied residents were supposed to be monitored for 14 days when a new medication was initiated. The surveyor then asked should there be NJ Ex Order 26.4(b monitoring for a resident who was receiving NJ Ex Order 26.4(b)(1) The U.S. FOIA replied yes, they should have NJ Exec Order 26.4 monitoring documented in the EMAR (electronic medication administration record). The U.S. FOIA was then asked what was expected to be on a resident care plan and she replied things that were going on with them, what their goal would be, any NJ Ex Ord any NJ Ex Order 26.4(b)(1), and use of any NJ Ex Order 26.4(b)(1) medications. The surveyor questioned should there be a care plan for a resident on NJ Ex Order 26.4(b)(1) and the U.S. FOIA confirmed, if a resident was on NJ Ex Order 26.4(b)(1) there should be a care plan.

The surveyor reviewed the following policies:
On 9/12/2024 at 12:28 PM, a facility policy titled "Guidelines for Notifying Physician of Clinical Problems" with a revised date of September 2017 revealed under Non-immediate Notification Situations Non-immediate implies that the physician should be informed of the problem or event at the time of the next routine communication or the next time he/she is making rounds (whichever is sooner). Under 3. Other Consultant reports not involving a life-threatening

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or unstable medical or psychiatric situation.

On 9/12/2024 at 12:45 PM, a facility policy titled "Care Plans, Comprehensive Person-Centered" with revised date of March 2022 revealed under the Policy Statement section A comprehensive, person-centered care plan that include measurable objectives and timetables to meet the residents psychosocial and functional needs is developed and implemented for each resident. Under the Policy Interpretation and Implementation section 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy also indicated 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychological well-being, e. reflects currently recognized standards of practice for problem areas and conditions.

On 9/13/2024 at 10:37 AM, a facility policy titled Psychotropic Medication Use with revised date of July 2022 revealed under the Policy Interpretation and Implementation section 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Antipsychotics.... 3. Residents, families, and/or the representative are involved in the medication management process. Psychotropic medication management includes: ...d. adequate monitoring for efficacy and adverse consequences. 10. Nonpharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for

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F 758	Continued From page 34 discontinuation of medications when possible. 13. Residents receiving psychotropic medications are monitored for adverse consequences, including: anti cholinergic effects, flushing, blurred vision, dry mouth, altered mental status....b. cardiovascualar {sic} [cardiovascular] effects-irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath...c. metabolic effects...d. neurologic effects-agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinson's, tardive dyskinesia, e. psychosocial effects-inability to perform ADL's or interact with others, withdrawal or decline from usual social patterns, ... NJAC 8:3927.1(a)	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		10/15/24

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F 812	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 09/09/2024 from 7:39 to 8:23 AM, the surveyors, accompanied by the cook and the U.S. FOIA (b) (6)), observed the following in the kitchen: 1. Prior to entering the walk-in refrigerator and freezer the surveyors reviewed the temperature logs. Review of the September 2024 Refrigerator Temperature log revealed that no AM or PM temperatures were recorded on 9/7, 9/8, and 9/9/2024. On interview the U.S. FOIA stated that the aide was responsible for recording the refrigeration temperatures and that the aide had not worked on those days. 2. On a lower shelf in the walk-in freezer, a sheet pan contained frozen hamburger patties. The hamburger patties were covered with plastic wrap. There were no dates labeled on the pan or plastic wrap. 3. On a middle shelf in the walk-in refrigerator, a plastic milk crate contained NJ Ex Order 1 Ready Care supplements (A frozen nutritional supplement for people with unintended weight loss). Approximately 20 vanilla shakes were in the crate. No dates were observed on the crate or supplements. The U.S. FOIA told the surveyor that the shakes are good for 14 days once pulled from frozen storage.	F 812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Temperature logs not complete. Dining service director immediately checked temperatures re in- serviced staff on temp log requirement for freezer and refrigerator Food not dated, food not covered completely, and nutritional supplements used for unintended or unavoidable weight loss were discarded immediately. Immediate confirmation by the Dining service director confirmed both freezer and walk-in refrigerator confirmed no other items were unlabeled and/or not covered. Re-education was initiated immediately. Dessert plates and pots/colander not inverted for drying were rewashed immediately. Dining service director immediately re in- serviced staff on ware washing procedures and storage procedures Freezer Temp logs in 3rd floor pantry are unable to be retroactively addressed. The freezer temp was checked immediately and in range and Dining service director immediately re inserviced staff on temp-log requirements for freezer and refrigerator. 3rd floor Pantry was immediately cleaned	

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F 812	Continued From page 36 4. On a lower shelf in the kitchen prep area (under toaster) a clear plastic container contained cleaned and sanitized dessert plates. The plates were uncovered and were not in the inverted position leaving the eating surface exposed to contamination. 5. Four (4) pans and a colander on a middle shelf of the pot and pan drying/storage rack were not in the inverted position and were not covered. The food contact surface of the pans and colander were exposed, and the pan contained a clear liquid substance on the interior of the pan. [redacted] removed to be rewashed and sanitized. On 09/11/2024 from 08:58 to 09:12 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN #2), observed the following on the 3rd Floor resident pantry: 1. Observation of the temperature log revealed that the facility was only monitoring refrigerator temperatures and there was no monitoring of the freezer temperatures. 2. The lower glass shelf and lower storage drawers of the refrigerator were covered with an off white unidentified substance. All foods are labeled and dated, however sign on outside of refrigerator stated that all foods were to only be held for "24 hours" after the labeled date and then would be discarded. A gray plastic bag on the lower shelf contained unidentified resident food. The bag was labeled "Rec 9/9/24 Discard 9/15/24." In addition, on the same shelf a plastic [redacted] style container contained unidentified resident food. The container was labeled with resident name and room number. The container	F 812	and food brought in from families discarded if not within date range. Dirty Refrigerator in 3rd floor pantry. Food Service Director immediately cleaned refrigerator Tray line Temperature logs are unable to retroactively be addressed. The tray line temperature log was reviewed immediately and temperatures were validated. The . Dining service director immediately re in- serviced staff on temp log requirement for steam table prior to service How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents that eat have the potential to be affected. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Mandatory in-services to dietary personnel will be provided by the Food Service Director on the following items: Completing temperature logs for walk-in refrigerator and freezer, dating and labeling food as well covering food products, pantry temperature log maintenance that includes both refrigerator and freezer, cleaning	

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F 812	Continued From page 37 had no dates. On 09/11/2024 from 09:47 to 09:53 AM, the surveyor, accompanied by LPN #3, observed the following on the 2nd Floor resident pantry: 1. Observation of the temperature log revealed that temperatures were being recorded in the AM and PM for the refrigerator. No monitoring of freezer temperatures was conducted. On 09/11/2024 at 09:57 AM, the surveyor conducted an interview with the food service U.S. FOIA (b) (6) The surveyor asked the U.S. FO who was responsible for maintaining the facility resident pantries. The U.S. FO explained that "It' a concerted effort between food service and nursing (no housekeeping). We (food service) are responsible for cleaning the refrigerator and freezer. The surveyor then questioned what the use by date should be when a food from out of the facility is stored in the pantry refrigerator. The US FOIA told the surveyor the use by date should be 72 hours. 24 hours is too short. The U.S. FO further told the surveyor I will get with the U.S. FOIA (b) (6)) and get on the same page with dates today. The surveyor then asked the U.S. FO why there was no monitoring of freezer temperatures on the facility pantry's The U.S. FO stated, "I might have to ask the U.S. FOIA about freezer temps. The freezer temperatures on the pantry's should be monitored, yes." The U.S. FO agreed that the facility policy for food brought from family/visitors was inconsistent with the posted signage on the 3rd floor refrigerator door indicating that food was to be discarded after 24 hours and the dietary policy of 3 days. The U.S. FO assured the surveyor that they would meet with facility administration to establish a consistent policy for use by dating related to	F 812	schedule for pantries, process of food brought in from family members and kept in in the panty, and maintenance of temperatures during tray line activity and documenting. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? The Food Service Director will complete weekly random audits for dating and labeling and tray line temp log adherence 1 x a week x 4 weeks. Then 1 x a month x 2 months. FSD will conduct weekly random audits for 2nd and 3rd floor unit cleanliness and temperature log adherence 1 x a week x 4 weeks. Then 1 x a month x 2 months. FSD will conduct weekly random audits for proper ware-washing and storage procedures 1 x a week x 4 weeks. Then 1 x a month x 2 months. Results of the audits will be provided to the Administrator by the Food Service Director and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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food brought by visitors/family.

On 09/12/2024 from 10:33 to 10:57 AM, the surveyors, accompanied by the [redacted] and the [redacted] observed the following in the kitchen:

1. The surveyors requested to see the tray line temperature monitoring logs from the [redacted] Observation of the "TService Line Checklist" (Food temp log) revealed that "Item names and temperatures for all hot and cold foods should be taken prior to service and recorded in the boxes below." Review of the Service Line Checklists provided to the surveyor by the facility [redacted] revealed the following: On 8/17/2024 the cook failed to record hot and cold food temperatures at the breakfast and lunch meal, on 8/18/2024 the cook failed to record food temperatures for the breakfast, lunch, and dinner meals, on 8/22/2024 the cook failed to record hot and cold food temperatures for the lunch and dinner meals, on 8/25/2024 the cook failed to record hot and cold food temperatures for the dinner meal, on 8/26/2024 the cook failed to record hot and cold food temperatures at the dinner meal, On 9/2/2024 the cook failed to record hot and cold food temperatures at the lunch and dinner meal, on 9/3/2024 the cook failed to record hot and cold food temperatures at the dinner meal, on 9/4/2024 the cook failed to record hot and cold food temperatures at the dinner meal, on 9/5/2024 the cook failed to record hot and cold food temperatures at the dinner meal, and on 9/7/2024 the cook failed to record hot and cold food temperatures at the dinner meal. When interviewed the [redacted] and [redacted] told the surveyor, "It's our responsibility to make sure that the food temperatures are being done correctly. It's important to monitor to ensure that food is not in

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the danger zone (41-134 degrees Fahrenheit (F)). The surveyor asked why it was important to monitor food temperatures for hot and cold foods. The U.S. FOIA and U.S. FO explained, "People (residents) could potentially get food poisoning if food is in the danger zone." The surveyor asked who was responsible for taking food temperatures of hot and cold foods prior to meal service. The U.S. FOIA stated, "The cooks are in charge/responsible for checking temperatures prior to tray line."

The surveyor reviewed the facility policy titled Food: Preparation, [company name] Policy 016, revised 2/2023. The following was revealed under the heading Procedures:

4. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F, or per state regulation.

13. All foods will be held at appropriate temperatures, greater than 135 F (or as state regulation requires) for hot holding, and less than 41 F for cold holding.

14. Temperature for TCS (time/temperature control for safety) will be recorded at time of service and monitored periodically during meal service periods.

The surveyor reviewed the facility policy titled Receiving, [company name] Policy 017, revised 2/2023. The following was revealed under the heading Procedures:

5. All food items will be appropriately labeled and

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dated either through manufacturer packaging or staff notation.

The surveyor reviewed the facility policy titled Food Storage: Cold Foods, [company name] Policy 019, revised 2/2023. The following was revealed under the heading Procedures:

4. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded.

The surveyor reviewed the facility policy titled NJ Ex Order 26.4(b)(1) [company name] 022, revised 2/2023. The following was revealed under the heading Procedures:

4. All dishware will be air dried and properly stored.

The surveyor reviewed the facility policy titled Foods Brought by Family/Visitors, revised March 2022. The following was revealed under Policy Interpretation and Implementation:

5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food.
b. Perishable foods are stored in re-sealable containers with tight-fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the "use by" date.

NJAC 18:39-17.2(g)

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 1.) For the week of Complaint staffing from 11/05/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 2.) . For the week of Complaint staffing from 12/31/2023 to 01/06/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 3.) . For the 2 weeks of Complaint staffing from 02/18/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts, and deficient in total staff for residents on 1 of 14 overnight shift , 4.) For	S 560	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility to ensure and maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey The health center at Galloways management team will monitor Certified Nursing Assistant (CNA) staffing ratios and offer incentives to current direct care staff.	10/15/24

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

Electronically Signed | 09/27/24

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S 560	Continued From page 1 the week of Complaint staffing from 04/21/2024 to 04/27/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts , 5.) For the 2 weeks of Complaint staffing from 05/19/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts , 6.) For the week of Complaint staffing from 06/09/2024 to 06/15/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 7.) For the 2 weeks of staffing prior to survey from 08/25/2024 to 09/07/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 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. 1. For the week of Complaint staffing from 11/05/2023 to 11/11/2023, the facility was	S 560	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? residents have the potential to be affected by this. Staffing coordinator immediately educated to proactively alert DON and LNHA of any days that do not meet minimum staffing requirements. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? The Health Center at Galloway has contracted with several staffing agencies for assistance with staffing. Leadership to hold weekly staffing strategy meetings to continue the development of recruitment retention and attraction. Weekend Shift differentials are implemented. Flexible schedules offered, incentive bonuses, increases in online recruitment postings. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? The DON and LNHA proactive by monitoring the staffing projected for upcoming days to assure adequate staffing. DON will review staffing levels and will	

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HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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S 560	Continued From page 2 deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -11/05/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -11/06/23 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -11/07/23 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -11/08/23 had 9.75 CNAs for 104 residents on the day shift, required at least 13 CNAs. -11/09/23 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -11/10/23 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -11/11/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. 2. For the week of Complaint staffing from 12/31/2023 to 01/06/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -12/31/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -01/01/24 had 6 CNAs for 107 residents on the day shift, required at least 13 CNAs. -01/02/24 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -01/03/24 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -01/04/24 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -01/05/24 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/06/24 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. 3. For the 2 weeks of Complaint staffing from 02/18/2024 to 03/02/2024, the facility was	S 560	report monthly at the Quality Assurance Performance Improvements (QAPI) committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060102	A. BUILDING: _____ B. WING _____	C 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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S 560	Continued From page 3	S 560		

deficient in CNA staffing for residents on 13 of 14 day shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows:

-02/18/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs.
-02/19/24 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs.
-02/19/24 had 6 total staff for 103 residents on the overnight shift, required at least 7 total staff.
-02/20/24 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs.
-02/21/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs.
-02/22/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.
-02/23/24 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.
-02/24/24 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.

-02/25/24 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-02/26/24 had 6 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-02/27/24 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-02/28/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-02/29/24 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-03/02/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs.

4. For the week of Complaint staffing from 04/21/2024 to 04/27/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:

-04/21/24 had 10 CNAs for 108 residents on the

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	060102	A. BUILDING: _____ B. WING _____	C 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4	S 560		

day shift, required at least 13 CNAs.
-04/22/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs.
-04/23/24 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-04/26/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-04/27/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs.

5. For the 2 weeks of Complaint staffing from 05/19/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows:

-05/19/24 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-05/20/24 had 6 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-05/21/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-05/22/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-05/24/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-05/25/24 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs.

-05/26/24 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-05/27/24 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-05/28/24 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs.
-05/29/24 had 7 CNAs for 104 residents on the day shift, required at least 13 CNAs.
-05/30/24 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs.
-05/31/24 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060102	A. BUILDING: _____ B. WING _____	C 09/13/2024

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HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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S 560	Continued From page 5 -06/01/24 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. 6. For the week of Complaint staffing from 06/09/2024 to 06/15/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -06/09/24 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -06/10/24 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -06/11/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -06/12/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -06/13/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -06/14/24 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -06/15/24 had 7 CNAs for 98 residents on the day shift, required at least 12 CNAs. 7. For the 2 weeks of staffing prior to survey from 08/25/2024 to 09/07/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -08/25/24 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/26/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/27/24 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/28/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -08/29/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -08/30/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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S 560	Continued From page 6	S 560		

-09/01/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-09/02/24 had 7 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-09/03/24 had 7 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-09/04/24 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-09/05/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-09/07/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.

On 09/12/2024 at 03:15 PM the surveyors conducted an interview with the facility Director of Nursing (DON) and the surveyor said she reviewed the facility staffing sheets which indicated that the facility had days without a Registered Nurse (RN) for at least 8 consecutive hours. When asked should there be an RN on duty for at least 8 consecutive hours daily the DON replied, "Yes, we should have 8 hours minimum for RN on duty per day. When questioned whether the facility was aware of the state mandated CNA ratios for residents the DON replied, "We are trying to meet the minimum requirements." The DON was able to confirm to the survey team that she knew that they were 7-3 shift is 1 to 8, 3-11 shift is 1 to 10 and 11-7 shift is 1 to 14.

A review of the facility policy titled Staffing, revised October 2017, revealed the following under the heading Policy Statement: Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. In addition, the policy revealed the following under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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S 560	Continued From page 7 Policy Interpretation and Implementation: 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, in addition to State and Federal requirements.	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
315210 Y1	A. Building B. Wing Y2	10/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0609	Correction	ID Prefix F0656	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	10/15/2024	LSC	10/15/2024	LSC	10/15/2024
ID Prefix F0658	Correction	ID Prefix F0727	Correction	ID Prefix F0758	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed
LSC	10/15/2024	LSC	10/15/2024	LSC	10/15/2024
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060102		10/21/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/13/2024	☐ 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
	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

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E 000	Initial Comments The Health Center at Galloway was not 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		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004		10/15/24

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

Electronically Signed | 09/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents on 9/11/24, the facility failed to establish and maintain the facility contracts and agreements at least annually in accordance with Appendix Z, §483.73(a): Emergency Plan. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility documents at 10:05 AM, revealed that facility contracts and transfer agreements were not updated at least annually. The following contracts and transfer agreements not annually updated: 1. Facility to Facility Mutual Transfer Agreement with Barnegat Rehabilitation and Nursing Center indicates the date of August 31, 2017 and will renew automatically unless cancelled by either party in writing. 2. Facility to Facility Transfer Agreement with	E 004	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility failed to maintain contracts and agreements at least annually in accordance with Appendix Z 483.73 (a) Maintenance director immediately reviewed the EP and began the requests for all updated transfer agreements, pharmacy service provider, food purveyor emergency plan and preparedness. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected by the deficient practice.	

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	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

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E 004	Continued From page 2 Southern Ocean Center titled Evacuation/Emergency Transfer agreement was dated April 17, 2014. 3. The Facility to Facility Transfer Agreement with Seacrest Village titled Evacuation Transfer agreement was dated March 5, 2015. 4. The Pharmacy Services Provider agreement was dated 10/16/20. 5. The food purveyor's Emergency Plan & Preparedness document was dated 1/3/17. In an interview at the time of document review, the U.S. FOIA (b) (6) verified the findings. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference at 12:45 PM. NJAC 8:39-31.2(e), 31.6(i)	E 004	What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Maintenance Director will Review all contracts for updated agreements weekly for 4 weeks. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPIAny revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting x 3 months.	
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 9/9/24, 9/10/24, and 9/11/24. The Health Center at Galloway 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 Occupancy	K 000		

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	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 3 The Healthcare Center at Galloway is a three-story building that was built in the 60's. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The exterior diesel generator does approximately 60% of the building as per the Maintenance Director. The facility is licensed for 120 certified beds and is currently occupying 102. *The facility has a Pediatric Day Care wing that was closed. The Maintenance Director and Regional Plant Operations Director indicated in the near future, that area, will be constructed into a 10-bed long term care wing. The Administrator indicated all proper notification to DCA and Department of Health was being submitted.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 9/9/24 and 9/10/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to a) ensure all components of the fire alarm system were fully operational in accordance with NFPA 70 and 72, and b) sensitivity testing of smoke detectors was	K 345	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility failed to ensure all components of the fire alarm system were fully operational and that the fire alarm	10/15/24

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	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(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 345	Continued From page 4 conducted every alternate year in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: a) A documentation review on 9/9/24, revealed that the 3/21/24 fire alarm vendor report indicated the RTU-4 smoke detector was removed due to it causing trouble in the system and was not replaced. In an interview at the time, the U.S. FO confirmed that the RTU-4 duct smoke detector was removed and not replaced as of 9/11/24. b) A documentation review also revealed there was no current documentation of sensitivity testing for smoke detectors. In an interview on 9/9/2024 at 09:30 AM, the U.S. FO stated the facility was unable to provide any documentation of a recent inspection of the fire alarm sensitivity testing of smoke detectors. The U.S. FO indicated the last sensitivity testing was conducted by the facility fire alarm vendor on 9/9/20. The facility's U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 9/11/24 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	sensitivity testing of smoke detectors complied with life safety codes Maintenance Director immediately contacted vendor and issue to be rectified on Oct 1, 2024 An RTU-4 duct smoke detector was removed and not replaced. Maintenance Director immediately contacted vendor who inspected on 9/12/24 and will rectify the RYU-4 smoke detector replacement on October 1, 2024 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents that have the potential to be affected What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Inspection my maintenence Dir of all fire alarm systems quarterly. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly x 3 months	

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K 345	Continued From page 5	K 345	Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee monthly meeting	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or	K 363		10/15/24

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K 363	Continued From page 6 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/10/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101: 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 4 of 38 resident rooms observed, had the potential to affect 4 resident rooms and was evidenced by the following: Observations from 9:15 AM to 12:45 PM in the presence of the U.S. FO and U.S. FOIA (b) T, revealed resident room doors did not operate properly as follows: 1. The resident room #201 door would not latch into its frame (hardware-issue). 2. The resident room #205 door would not latch into its frame (hardware-issue). 3. The resident room #304 door would not latch into its frame (hardware-issue). 4. The resident room #331 door got stuck into its frame. In an interview at the time of observations, the	K 363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Corridor doors failed to ensure they were able to resist the passage of smoke. Maintenance director reviewed the NFPA Life safety code requirements for maintenance, Inspection and testing of doors. Non-latching doors and door that got stuck on frame were immediately corrected on 9/11/2024 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Inspection of all fire doors and tags will be completed utilizing the NFPA door	

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K 363	Continued From page 7 U.S. FOIA (b) (6) confirmed the findings. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 9/11/24 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	checklist tool. Monitoring will be captured thru life safety rounds completed monthly How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly x 3 months.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced	K 531		10/15/24

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K 531	Continued From page 8 by: Based on record review and interview on 9/9/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to conform with Firefighter's Service Requirements of ASME/ANSI A17.3 and NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. This included firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation for 2 of 2 devices. This deficient practice had the potential to affect and was evidenced by the following: In an interview at 11:02 AM, the surveyor asked the U.S. FO and U.S. FOIA (b) for the Phase I and Phase II firefighters monthly recall documentation. The U.S. FO stated that currently the required monthly testing was not being performed. The NJ Ex Order 26.4(b)(1) was informed of the findings at the Life Safety Code exit conference on 9/11/24 at 12:45 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility failed to conform with the firefighter Service Requirements which includes monthly inspection and testing of elevators. Both facility elevators were immediately tested for phase 1 and phase 2 and no issues found to exist. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected by the deficient practice. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Inspection of elevators for phase 1 and phase 2 requirements will be inspected monthly. Elevator Monitoring will be captured thru life safety rounds completed monthly. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Results of the audits will be provided to	

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K 531	Continued From page 9	K 531	the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly x 3 months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		10/15/24

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K 741	Continued From page 10 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/10/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101: 2012 Edition, Section 19.7.4 by failing to prohibit the practice of mixing cigarette butts and ash in trash cans with other combustibles. This deficient practice had the potential to affect 20 residents and was evidenced for 1 of 1 smoking areas observed by the following: Observations at 11:39 AM in the presence of the U.S. FO and U.S. FOIA (b) (6 revealed the occupied smoking courtyard had a combustible beige dome top plastic garbage filled with 10 plus cigarette butts and combustible cups, paper and cigarette boxes. The area was observed to have 3-Oasis style cigarette receptacles. The smoking area was not provided with an approved self-closing covered metal container for the disposal of cigarette butts and ashes in the area. The U.S. FO provided a resident smoking policy that indicated: "Metal containers, with self-closing cover devices, are available in smoking areas". In an interview at the time of observation, the U.S. FO and U.S. FOIA (b) both confirmed the findings in the resident smoking courtyard. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 9/11/24 at 12:45 PM.	K 741	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility failed to conform to the requirement of Maintenance director ensuring the mixing of combustibles and cigarettes does not occur. Maintenance Director immediately removed the garbage can that did not meet NFPA requirements Approved smoking area did not provide a self-closing metal container for the disposing of cigarette butts and ashes. Maintenance Director purchased the appropriate metal trash receptacle. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents that have the potential to be affected by the deficient practice. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Maint dir or designee will Inspect smoking area will occur daily x 4 weeks and monthly x 2 months	

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K 741	Continued From page 11 NJAC 8:39-31.2(e)	K 741	How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly for 3 months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		10/15/24

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K 918	Continued From page 12 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 9/10//24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) , it was determined that the facility failed to ensure a remote manual stop station for the exterior 250 KW diesel generator was installed in accordance with the requirements of NFPA 110: 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice had the potential to affect all residents in the facility and was evidenced for 1 of 1 generators by the following: Observations at 10:45 AM in the presence of the U.S. FOI and U.S. FOIA (b) (6 revealed there was no remote manual stop station outside the area of the generator location. In an interview at the time of the observation, the U.S. FO and U.S. FOIA (b) both confirmed that the generator	K 918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility failed to comply with ensuring a remote manual stop station for the 250 KW diesel generator was installed. Maintenance Director immediately contacted vendor and stop station was installed 9/23/24. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected by the deficient practice.	

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K 918	Continued From page 13 did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover. The U.S. FOIA (b) (6) was informed of the finding at the Life Safety Code exit conference on 9/11/24 at 12:45 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? Maint Dir/designee will review function of emergency stop x 2 months. All staff will be in-serviced on the emergency function of the stop station. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly for 3 months Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6	K 921		10/15/24

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HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

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K 921	Continued From page 14 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 9/9/24 and 9/10/24, in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) intervals were established with policies and protocols for Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1 and 10.3.5.4. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's maintenance records on 9/9/2024, revealed there was no documentation regarding ITM for PCREE.	K 921	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility failed to inspect, test and document all patient care related electrical equipment (PCREE). Maintenance Director immediately began to inventory and inspect, test, and document all PCREE. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(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 921	Continued From page 15 In an interview on 9/10/2024 at 9:30 AM, the [U.S. FO] and [U.S. FOIA (b)] both stated there was no ITM documentation for PCREE that included patient beds, air mattresses, oxygen concentrators, nebulizer and similar items that were used for patient care. The facility's [U.S. FOIA (b) (6)] was informed of the findings at the Life Safety Code exit conference on 9/11/2024 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	All Residents have the potential to be affected by the deficient practice. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? maintenance Dir or designee will monitor PCREE for residents 1x a week for 4 weeks, then 2 x a month for one month to ensure system is in place for accurate communication and timely inspection. All Staff will be in-serviced on requirement to inspect PCREE. How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Results of the audits will be provided to the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting monthly x 3 months	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		10/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(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 923	Continued From page 16 Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/10/24 in the presence of the U.S. FOIA (b) (6))	K 923	What corrective action(s) will be accomplished for those residents found to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(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 923	Continued From page 17 and U.S. FOIA (b) (6)), it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice had the potential to affect 51 residents, was identified for 1 of 12 portable oxygen cylinders observed, and was evidenced by the following: Observations at 10:18 AM in the presence of the U.S. FO and U.S. FOIA (b) (6) revealed on floor #2 in the B-wing oxygen storage closet, that 1 of 12 portable oxygen cylinders was freestanding and stored unprotected against tipping, rupture and damage. The portable oxygen cylinder was at approximately 400 PSI when observed. In an interview at the time of observation, U.S. FO and U.S. FOIA (b) both stated that the oxygen cylinder must be secured from tipping, rupture and damage at all times in the facility. The U.S. FOIA (b) (6) was informed of the finding at the Life Safety Code exit conference on 9/11/24 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 923	have been affected by the deficient practice? Facility failed to store Cylinders of compressed oxygen in accordance with NFPA 99. Maintenance Director immediately rectified all oxygen issues by securing them in the appropriate holders. Immediate staff education begun on 9/11/2024 to all licensed staff and additional signage in oxygen storage areas provided How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected by the deficient practice. What measures will be put into place or what system changes will you make to ensure the deficient practice does not recur? maintenance Dir or designee will monitor oxygen cylinders are being stored appropriately 1x a week for 4 weeks, then 2 x a month for one month to ensure system. Inservices will continue to all staff How the corrective action will be monitored to ensure that that the deficient practice will not recur, i.e., what quality assurance programs will be established? Results of the audits will be provided to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING **01** B. WING _____	**09/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	**66 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

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K 923	Continued From page 18	K 923	the Administrator by the Maintenance director and/or designee and will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly x 3 months Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315210	A. Building B. Wing	10/21/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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 E0004 Reg. # 483.73(a) LSC	Correction Completed 10/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315210 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0345	10/15/2024	LSC	K0363	10/15/2024	LSC	K0531	10/15/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0741	10/15/2024	LSC	K0918	10/15/2024	LSC	K0921	10/15/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0923	10/15/2024	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO