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 02/22/2024

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 Complaint #: NJ00171580 and NJ00171582 Survey Dates: 02/22/2024 Census: 101 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		3/31/24

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

Electronically Signed | 03/25/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00171580, NJ00171582 Based on interviews, medical record review, and review of other pertinent facility documents on 02/22/24, it was determined that the facility failed to develop a comprehensive person-centered care plan (CP) for a resident involved in two incidents of NJ Exec Order 26.4b1 The deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for CP and was evidenced by the following: According to the "Face Sheet," Resident #1 was	F 656	Resident #1 Care plan was updated. The center reviewed care plan goals and interventions of residents exhibiting NJ Exec Order 26.4b1. No other residents were affected. Facility Director of Nursing, Asst. Director of Nursing, Unit Managers and Interdisciplinary team members were provided education on timeliness of care plan goals and intervention updates.	

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	315210	A. BUILDING _____ B. WING _____	C 02/22/2024

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 656	Continued From page 2 admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted] Review of Resident #1's NJ Exec Order 26.4b Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated that Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident's NJ Exec Order 26.4b1 [redacted] Reviewed of Resident #1's incident reports (IR), provided by the facility revealed the following: -An IR, dated NJ Exec Order 26.4b [redacted] at 3:50 P.M., which indicated that while waiting for an event to start, Resident #2 stated, NJ Exec Order 26.4b1 [redacted] " Resident #1 responded, " NJ Exec Order 26.4b1 [redacted] " Resident #1 then NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted] of Resident #2. -An IR, dated 02/19/24 at 11:20 A.M., revealed that an activity aide witnessed Resident #1 NJ Exec Order 26.4b1 [redacted] Resident #3, while in the dining room. Resident #1 had NJ Exec Order 26.4b1 [redacted] Resident #3's [redacted] and NJ Exec Order 26.4b1 [redacted] Review of Resident #1's CP revealed a "Focus," initiated on NJ Exec Order 26.4b [redacted], that Resident #3 had NJ Exec Order 26.4b1 [redacted] related to the resident making NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted]. Under the "Interventions," section, revealed the following interventions:	F 656	Assistant Director of Nursing will audit care plan goals and interventions for 5 residents weekly for 4 weeks, 3 residents weekly for 4 weeks, then 3 residents monthly for one month. Audit findings will be reported by the Assistant Director of Nursing and or designee to the QAPI Committee monthly x3 months The QAPI Committee will determine the need for continuation of care plan audits and/or action plans.	

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F 656	Continued From page 3 -Set limits for acceptable behavior, initiated on NJ Exec Order 26.4b1 -Avoid type of conversation that could encourage or NJ Exec Order 26.4b1, initiated on NJ Exec Order 26.4b1. -Distract resident, if possible, initiated on NJ Exec Order 26.4b. -Initiate NJ Exec Order 26.4b1 consult, initiated on NJ Exec Order 26.4b. -NJ Exec Order 26.4b1 consult for medication review, initiated on NJ Exec Order 26.4b -Not to be seated NJ Exec Order 26.4b1 resident, initiated on NJ Exec Order 26.4b1 Further review of the CP showed no revision or updates to Resident #1's CP after the NJ Exec Order 26.4 resident to resident incident. The CP also failed to reveal a focus area for Resident #1's NJ Exec Order 26.4b1. On 02/22/24 at 2:03 P.M., the surveyor observed Resident #1 seated in wheelchair watching television at the bedside. The resident was NJ Exec Order 26.4 and did not express any NJ Exec Order 26.4b1. When questioned about the NJ Exec Order 26.4b and NJ Exec Order 26.4b incidents, Resident #1 NJ Exec Order 26.4b1 or having NJ Exec Order 26.4b1. During an interview with the surveyor on 02/22/24 at 1:01 P.M., the US FOIA (b)(6) stated the purpose of the CP was to keep the team updated on residents' goals and that the CP should be updated as soon as possible. The US FOIA (b)(6) further explained that the UM, Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON) were responsible for updating residents' CPs. The	F 656		

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	315210	A. BUILDING _____ B. WING _____	C 02/22/2024

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F 656	Continued From page 4	F 656		

US FOIA (b)(6) reviewed Resident #1's CP, in the presence of the surveyor and stated that "It [Resident #1's CP] should have been updated to reflect the resident's NJ Exec Order 26.4b1 [redacted]."

During an interview with the surveyor on 02/22/24 at 1:35 P.M., the US FOIA (b)(6) stated that any person on a resident's interdisciplinary team (IDT) could update CPs and that CPs were updated quarterly and/or when a new incident needed to be addressed. The US FOIA (b)(6) further stated that residents' CPs should be patient specific. The US FOIA (b)(6) reviewed Resident #1's CP, in the presence of the surveyor and stated that Resident #1's CP should have reflected the resident's NJ Exec Order 26.4b1 [redacted]

During an interview on 01/22/24 at 4:10 P.M., the US FOIA (b)(6) stated that CPs were created based on any problems identified by a resident's MDS and that focuses should be patient centered. The US FOIA (b)(6) reviewed Resident #1's CP, in the presence of the surveyor and stated that the CP had been updated for both incidents. The surveyor asked if Resident #1's CP reflected a "Focus" that Resident #1 had NJ Exec Order 26.4b1 [redacted] The US FOIA (b)(6) replied, "NJ Exec O[redacted]

Review of the facility's "Care Plans, Comprehensive Person-Centered" policy, revised March 2022, revealed that "11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The policy also revealed that the IDT reviewed and updated the CP "a. when there has been a significant change in the in the resident's condition ..."

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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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F 656	Continued From page 5 NJAC: 8:39-11.2(i); 27.1(a)	F 656		

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 02/22/2024

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 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 deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 11 of 14 day shifts. This deficient practice was evidenced by the following: 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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	The Staffing Coordinator, Human Resource Manager, DON and/or designee have reviewed staffing daily and continue to project CNA staff needs to ensure CNA staffing meets the staffing to resident ratios. Immediate education was provided to the Staffing Coordinator, Human Resource Manager, DON and/or designee to monitor CNA staffing daily. Staffing Coordinator/DON/designee will sign off on the schedule each day to ensure CNA staffing meets the staffing to resident ratios. No residents have been affected.	3/31/24

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

Electronically Signed | 03/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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. The surveyor requested staffing for the weeks of 02/04/2024 to 02/17/2024. The facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -02/04/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/05/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/06/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/07/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -02/08/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/09/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/12/24 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/13/24 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/14/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/15/24 had 11 CNAs for 93 residents on the	S 560	The facility continues a robust recruitment program. Monetary incentives and special shift accommodation have been made for in-house staff. The center continues with an on-call rotation for nursing management after hours and on weekends All efforts are made to fill open shifts due to scheduled staff not being able to attend their scheduled shift. Facility utilizes staffing agencies for open shifts. The Staffing Coordinator, Human Resource Manager and DON and/or designee will monitor projected and actual staffing ratios and HPPD, daily. Monitoring will be captured through daily audits every day for one month, then three times weekly for 4 weeks, weekly for 4 weeks. Results of the audits will be provided to the Administrator by the staffing coordinator. Results will be presented for review at the Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. 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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S 560	Continued From page 2 day shift, required at least 12 CNAs. -02/17/24 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs.	S 560		

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	4/1/2024

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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 04/01/2024	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
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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	
2/22/2024	☐ 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 (Y2)	DATE OF REVISIT (Y3)
060102	A. Building B. Wing	4/1/2024

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/01/2024	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
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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	
2/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO