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	315054	A. BUILDING _____ B. WING _____	C 12/31/2024

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F 000	INITIAL COMMENTS Complaint #: NJ00179819 Survey Date: 12/23/2024 Census: 171 Sample: 34 with 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide reasonable accommodation of a resident, specifically by having the resident's call device on the floor while the resident was in bed. The deficient practice was identified for 1 of 4 residents (Resident # 320) reviewed under the Environmental Task. A review of Resident # 320's Admission Record located in the Electronic Medical Record revealed a diagnoses of but not limited to, NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) [redacted].	F 558	F558- Reasonable Accommodations What corrective action will be accomplished for those residents affected by the deficient practice? Unit Manager ensured resident's call bell was placed in close proximity to the resident #320 on 12/16/2024 and 12/20/2024. How will the facility identify other residents having the potential to be affected by the	2/11/25

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

Electronically Signed | 01/17/2025

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F 558	Continued From page 1 On 12/16/2024 at 10:15 AM, the surveyor observed Resident # 320 in bed. At that time, their call device was on the floor, outside of reach of Resident # 320. On 12/20/2024 at 9:40 AM, the surveyor observed Resident # 320 in bed. At that time, their call device was on the floor, outside of reach of Resident # 320. On 12/23/2024 at 9:15 AM during an interview with the surveyor, the U.S. FOIA (b) (6) [redacted] said the facility provided education regarding call devices to the Certified Nurse Aide that was assigned to Resident # 320. A review of the facility-provided policy titled, "Call Bell System" with an effective date of 03/2020 revealed that, "Facility utilizes a call bell system to allow residents to call for staff assistance." N.J.A.C. 8:39- 31.8 (c)(9)	F 558	same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. Unit Managers completed an audit and if a call bell was not in close proximity of the resident, the call bell was moved toward the resident. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Call bell policy was reviewed. Clinical staff were educated on the importance of ensuring residents' call bells are in reach of residents. Unit managers will monitor call bells to ensure they are in close proximity of residents. How will the corrective action be monitored to ensure the deficient practice will not recure? Director of Nursing or designee will complete an audit of the location of resident call bells to ensure they are in close proximity of the resident. The Audit will be completed once a week for 30 days, then monthly x3. The results of the audit will be reviewed at the monthly QAPI team chaired by the facility administrator.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		2/11/25

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F 584	Continued From page 2	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

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F 584	Continued From page 3 sound levels. This REQUIREMENT is not met as evidenced by: Complaint # 179819 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to keep all areas clean, in good repair and, a [NJ Ex Order 26.] in place. The deficient practice was identified for 3 of 4 residents reviewed under the Environmental Task and 4 out 4 nourishment rooms. The deficient practice was evidenced by the following: On 12/16/2024 at 10:01 AM during the initial tour of the facility, the surveyor # 1 observed Resident # 11's bathroom. At that time, surveyor # 1 observed a toilet paper dispenser mounted to the wall that was crooked and appeared loose. There were also stains located on the floor near the resident's window. Lastly, surveyor # 1 observed stains on the wall outside the bathroom door. On the same date at 10:09 AM during the initial tour of the facility, surveyor # 1 observed Resident # 319's room. At that time, surveyor # 1 observed the [NJ Ex Order 26.] on the left side disconnected from the [NJ Ex Order 26.4(b)(1] and left on the floor along with the bed remote control. On 12/17/2024 at 11:17 AM during observation of the smoking area grounds, surveyor # 1 observed over a dozen discarded, used cigarettes on the ground in the grass areas and sidewalks. During the same observation, surveyor # 1 observed an outdoor bench that was cracked.	F 584	F584 Homelike Environment What corrective action will be accomplished for those residents affected by the deficient practice? The following residents were identified as being affected by the deficient practice: resident #11, resident #319, and resident #20. " Resident #11 toilet paper dispenser in the bathroom was secured to the wall. The bedroom walls were repainted, and the floor was stripped and buffed. " Resident #319 [NJ Ex Order 26.] on the left side was immediately reconnected to [NJ Ex Order 26.4] . The bed remote control was immediately picked up, wiped clean, tested to be in working condition and placed within resident□s reach. " Resident #20 room was immediately swept and mopped discarding the medication cup, straw and liquid on the floor. The unidentified tablet was discarded via drug buster. The clean [NJ Ex Order] left bedside were put away per residents request. The following areas were identified as being affected by the deficient practice: " The cigarettes on the ground in the grass and sidewalk area of the designated smoking area were discarded. " The cracked outdoor bench in the	

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F 584	Continued From page 4 On 12/18/2024 at 9:37 AM, the surveyor visited Resident # 20, surveyor # 1 observed a discarded medication cup, liquid, and a straw on the floor. The resident was unsure of what the liquid was. On the same date at 11:14 AM while visiting Resident # 11 in their room, surveyor # 1 observed one, loose, unidentified tablet under the bed and an opened package of NJ Ex Order 26.4(b)(1) [redacted] left on the bed side table. At that time, Resident # 11 confirmed that he/she has visitors from time to time and he/she does not want the NJ Ex Order 26.4(b)(1) left out. He/She stated, "They should be put away." A review of the facility policy titled, "Cleaning of Resident Rooms" with an effective date of 3/20 revealed under, "General Guidelines" that "Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled." A review of the facility policy titled, "Smoking" revealed that, "11. The designated area will be closed for a short duration for regular cleaning." § 8:39-31.4 (a) On 12/16/2024 at 10:08 AM during initial tour surveyor # 2 observed pillowcases tucked in the window of the bathroom on unit B room 8. Also observed on unit B in room 4 A-side, surveyor # 2 observed the wall next to the bed with scratches and peeling paint. On 12/19/2024 at 09:54 AM during a tour of the Unit C and D nourishment room surveyor # 2	F 584	courtyard was removed and discarded. " The pillowcases in room B8 bathroom window were removed. The window was checked by maintenance and is in good working order. " Room B4 (A) wall was repainted. " The water bottle with blue substance and sponge were immediately removed from Unit C/D nourishment room. " The white stains on the ice machine were removed and the rust was removed off the rack. " The stack of 3 paper cups observed facing up and open to room air were discarded. " The nourishment room cabinet On Unit G/H was discarded and a new cabinet was installed. " Cabinet doorknobs were placed on the Unit B nourishment room cabinet doors under the counter. " The tied plastic bag with a mop head in it was immediately removed and discarded. " The open bag of clothes on the chair was removed. " The inside of the upper cabinets in Unit E/F nourishment room were cleaned. " The bottom cabinets on Unit E/F nourishment room were replaced. " The counter tops in Unit E/F nourishment room were cleaned. " Six tied bags of clothes on the counters in Unit E/F nourishment room were removed. " The missing paint around the soap dispenser in Unit E/F nourishment room was repainted. " The layer of dirt and debris behind the	

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F 584	Continued From page 5 observed the following: 1. Under the sink there was a water bottle with a blue substance not labeled and a sponge open to air. 2. The ice machine was observed with white stains on the front and the tray was filled with water and rust was noted on the rack in the tray. 3. A stack of 3 paper cups were observed facing up and open to air. During an interview on 12/19/2024 at 09:57 AM with surveyor # 2, Registered Nurse/Unit manger #1 (RN/UM) said that the cups should be facing down to keep germs out. The RN/UM #1 also said that the blue substance was his/her own personal dish soap and that it should not have been in there. She removed the bottle and sponge. On 12/19/2024 at 10:02 AM during a tour of the Unit G and H nourishment room surveyor # 2 observed the following: 1. The kitchen cabinet if poor condition with a missing drawer, missing knob on one of the drawers and the cabinet doors missing knobs and attached paperclips used as a way to open the cabinet doors. 2. Peeling and chipped paint at the bottom of the cabinet. During an interview on 12/19/2024 at 10:08 AM with surveyor # 2, the RN #2 said the cabinet had been like that for about a month and that she thinks a new one was ordered.	F 584	sink in Unit E/F nourishment room was cleaned. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A facility audit was conducted to identify rooms/areas with the following: " Resident bathroom toilet paper dispensers were audited for secure placement. " The condition of resident bedroom walls and floors were audited. " Resident bed rails were audited to ensure proper placement. " Unit ice machines were audited for descaling and cleanliness. " Unit nourishment rooms were audited for repairs. " Nourishment rooms were audited for employee personal belongings. " Resident wearing briefs were identified and asked regarding their preference of storing incontinence products. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Housekeeping Director began re-education on January 6,2025, to the housekeeping staff reviewing the following: " Resident room cleaning procedures. " Nourishment room cleaning procedures.	

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F 584	Continued From page 6 On 12/19/2024 at 10:10 AM during a tour of Unit and B nourishment room surveyor # 2 observed the following: 1. Cabinet doors under the counter with missing knobs and attached paper clips in their place. 2. A tied plastic bag with a mop head in it left in one of the cabinets. 3. An open bag with what appeared to be clothes in it left on a chair. During an interview on 12/19/2024 at 10:12 AM with surveyor # 2 the RN/UM #3 said she didn't know the mop got into the cabinet and removed it. She also said that the bag of clothes was a staff members jacket. On 12/19/2024 at 10:22 AM during a tour of the Unit E and F nourishment room surveyor # 2 observed the following: 1. The upper cabinets were open and empty with visible dirt and a dead bug in them. 2. The bottom cabinets were all nailed shut. 3. A layer of dust noted on the counter tops. 4. Six tied plastic bags of clothes on the counters that were identified as staff belongings. 5. Missing paint around the soap dispenser where it had been moved. 6. A layer of dirt and debri behind the sink.	F 584	" Smoking area cleaning procedures. The Housekeeping Director or Designee will conduct random audits of the following areas: " Resident rooms for cleanliness of floors and walls by rounding and visually observing 5 resident rooms 5 days a week x4 weeks, then 3 rooms 5 days a week x4 weeks and then 2 rooms 5 days a week x4 weeks. " Nourishment rooms for cleanliness of counter tops, cabinets and sinks by rounding and visually observing all nourishment rooms 5 days a week x4 weeks, then all nourishment rooms 3 days a week x4 weeks and then all nourishment rooms 2 days a week x4 weeks. " Smoking area for cleanliness and removal of cigarettes by rounding and visually observing the smoking area 5 days a week x4 weeks, then 3 days a week x4 weeks and then 2 days a week x4 weeks. The Director of Maintenance began re-education on January 6, 2025, to the maintenance staff reviewing the following: " Resident room repairs and preventative maintenance " Resident bathroom repairs and preventative maintenance " Nourishment room repairs and preventative maintenance " Equipment repairs and preventative maintenance ie. Bed rails, ice machines The Director of Maintenance and or	

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F 584	Continued From page 7 During an interview on 12/20/2024 at 10:22 AM with surveyor # 2, the U.S. FOIA (b) (6)) said they start with room cleanings after breakfast, they empty all the trash, multiple microfibers are used per room. One for the bathroom and one for the rest of the room. They sweep the floors then mop their way out. He said they clean the nourishment rooms daily. They wipe the counters, empty trash and clean the floor. The unit hallway floors, and the nourishment rooms get a deep cleaning monthly, nursing staff empty the cabinets and drawers then house keeping goes in and wipes them out. The U.S. FOIA said that the bottle of dish soap should not have been left under the counter, and that counters and floors should be clean. During an interview on 12/20/2024 at 10:30 AM with the surveyor, the U.S. FOIA (b) (6)) said that maintenance does rounds on rooms and hallways daily. They prioritize what is most important for the residents and handle those issues as soon as possible. The U.S. FO agreed that the counters and lower cabinets in the nourishment needed replacing and said they have started the process by ordering a new one for one of the units. The U.S. FO was unsure of the time frame when they would all be replaced. During and interview on 12/20/2024 at 12:58 PM with surveyor # 2, the U.S. FOIA (b) (6)) said there should be appropriate ways of opening the drawers and doors to the cabinets in the nourishment, they are working on replacing them. The U.S. FOIA (b) also said that staff does have lockers and that is where their belongings should be kept. Lastly the U.S. FOIA (b) said they were aware the cabinets in the panty need replacing and they are working on it.	F 584	Designee will conduct random audits of the following areas: " Resident rooms for identified maintenance repairs by rounding and visually observing 5 resident rooms 5 days a week x4 weeks, then 3 rooms 5 days a week x4 weeks and then 2 rooms 5 days a week x4 weeks. " Resident bathrooms for identified maintenance repairs by rounding and visually observing 5 resident bathrooms 5 days a week x4 weeks, then 3 bathrooms 5 days a week x4 weeks and then 2 rooms 5 days a week x4 weeks. " Nourishment room for identified maintenance repairs by rounding and visually observing all nourishment rooms 5 days a week x4 weeks, then all nourishment rooms 3 days a week x4 weeks and then all nourishment rooms 2 days a week x4 weeks. " Bed rails to ensure proper placement on the bed frame by rounding and visually observing 5 resident rooms 5 days a week x4 weeks, then 3 rooms 5 days a week x4 weeks and then 2 rooms 5 days a week x4 weeks. " All Unit Ice machines to ensure descaling and tray maintenance by rounding and visually observing the ice machines 5 days a week x4 weeks and then 3 days a week x4 weeks. The Unit Managers began re-education on January 6, 2025, to the nursing staff on proper storage location of personal items and resident preference of location to store incontinent products.	

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F 584	Continued From page 8 A review of a facility provided Policy dated 03/20 and titled "Homelike Environment" revealed under "Policy Statement" that, "Residents are provided with a safe, clean, comfortable and homelike environment ..." § 8:39-31.2 (e)	F 584	" The Unit Managers and or Designee will conduct random audits for employee personal belongings by rounding and visually observing nourishment rooms 5 days a week x4 weeks, then 3 days a week x4 weeks and then 2 days a week x4 weeks. " The Unit Managers and or Designee will conduct random audits of residents who use incontinence products for proper storage in rooms by rounding and visually observing 5 resident rooms 5 days a week x4 weeks, then 3 days a week x4 weeks and then 2 days a week x4 weeks. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Housekeeping and/or designee will report on all the audit results to the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. The Director of Maintenance and/or designee will report on all the audit results to the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. The Unit Managers and/or designee will report all the audit results to the Quality	

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F 584	Continued From page 9	F 584	Assurance Performance Improvement Committee (QAPI) meeting monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility A.) failed to maintain medication records that were complete with staff signatures according to professional standards of clinical practice. This was identified for 1 of 32 residents reviewed (Resident #23) and it was determined that the facility B.) failed to follow the physician orders with regard to medications (meds) with parameters for 1 of 34 residents (Residents #51) reviewed. This deficient practice was identified by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching,	F 658	F658- Services Provided Meet Professional Standards What corrective action will be accomplished for those residents affected by the deficient practice? A statement was obtained by the Director of Nursing from the nurse who completed the treatment for resident #23. Statement indicated the resident□s treatment was completed. Resident #23 Treatment administration record could not be retroactively updated to include the initial of the nurse who completed the treatment. The Medical Director was made aware of the residents□ parameters on the medication administration record for Midodrine. The Medical Director provided no new orders.	2/11/25

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F 658	Continued From page 10 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 states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A.) On 12/16/2024 at 11:37 AM, surveyor # 1 observed Resident #23 in the bed on a NJ Ex Order 26.4(b) mattress. Resident #23 was a resident in the facility and had diagnosis that included NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(A quarterly Minimum Data Set (qMDS) an assessment tool used to facilitate management of care, with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(b)(1), indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #23 scored NJ Ex out of 15, which indicated that the resident's NJ Exec Order 26.4(was NJ Ex Order 26.4(b)(1). On 12/19/2024 at 12:04 PM, the surveyor reviewed the NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR) for Resident #23. When treatments were ordered by the physician,	F 658	How will the facility 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 alleged deficient practice. Treatment Administration Records were reviewed by Unit Managers for residents and no concerns or blanks were identified. Unit Managers reviewed charts for residents on Midodrine and no concerns were noted for blood pressure. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? Medication administration policy was reviewed. Nurses were educated on the importance of documenting treatments on the treatment administration records. Nurses were also educated by the Educator on monitoring and following medication parameters. Unit Managers or designee will monitor Treatment and Medication Administration records to ensure nurses are documenting and following medication parameters. How will the corrective action be monitored to ensure the deficient practice will not recure? Director of Nursing will monitor	

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F 658	Continued From page 11 the order was placed on the TAR. When administered by the nurses, the nurse would sign their initials on the TAR indicating that they had completed the treatment. Surveyor # 1 observed the treatment for NJ Ex Order 26.4(b)(1)) ordered on NJ Ex Order 26.4(b)(1) to be applied to the NJ Ex Order 26.4(b)(1) daily. Surveyor # 1 observed blank areas, that is no nurse's initials which would indicate the completion of the treatment on 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) for the day shift. When interviewed on 12/19/2024 at 12:04 PM, the US FOIA (b)(6) stated that when the TAR is signed it means the treatment was completed. He stated there should not be blanks on the TAR. When interviewed on 12/19/2024 at 12:04 PM, the U.S. FOIA (b) (6) stated there should not be blanks in the TAR. She stated the treatments should be completed then signed out. When interviewed on 12/19/2024 at 12:46 PM, the U.S. FOIA (b) (6) stated there should not be blanks on the TAR. She stated if there are blanks, the nurse forgot to sign the TAR, or the nurses didn't complete the treatment. The surveyor reviewed the facility's "Administering Medications" policy with a revised date of 3/2020 which included the individual administering medication must initial the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next	F 658	Treatment/Medication Administration Records once a week for 30 days, then monthly x 3 to ensure nurses are documenting or following parameters. The results of the audit will be reviewed at the monthly QAPI team chaired by the facility administrator.	

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F 658	Continued From page 12 ones. B.) On 12/18/24 at 10:58 AM, surveyor # 2 did not see Resident #51 in their room. Resident's roommate informed the surveyor that the resident went out for NJ Ex Order 26.4(b)(1)). The surveyor reviewed Resident #51's hybrid (electronic and paper) medical records that revealed the following: The Admission Record reflected that Resident # 51 was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1)) NJ Ex Ord , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b) A quarterly Minimum Data Set (qMDS) an assessment tool used to facilitate management of care, with an Assessment Reference Date (ARD) of NJ Ex Order 26.4 , indicated the facility assessed the resident's NJ Exec Order 26.4(using a Brief Interview Mental Status (BIMS) test. Resident #51 scored NJ Ex out of 15, which indicated that the resident's NJ Exec Order 26.4(was NJ Ex Order 26.4(b)(1) . A review of the Order Summary Report (OSR) reflected that Resident #51 had an active physician order (PO) dated NJ Ex Order 26.4 for a med: "NJ Ex Order 26.4(b)(1)) Oral Tab NJ Ex Order Give 1 tablet by mouth before meals for NJ Ex Order 26.4(b)(1) hold for NJ Ex Order 26.4(b)(1) " The corresponding PO was transcribed into the NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) electronic Medication Administration Record (eMAR).	F 658		

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Further review of the NJ Ex Order 26.4(b)(1) eMARs for Resident #51 revealed that nurses signed and reflected a checkmark which means that the med was administered when the med should have been held for a NJ Ex Order 26.4(b)(1) according to the PO, for the following dates and times:

Date	Time
NJ Ex Order	4 PM
NJ Ex Ord	11 AM
NJ Ex Ord	4 PM
NJ Ex Ord	11 AM

During an interview with surveyor # 2 on 12/19/24 at 10:38 AM, the Licensed Practical Nurse (LPN #1) stated that the NJ Ex Order 26.4(b)(1) was given to NJ Ex Order 26.4(b) NJ Exec Order 26.4b1 when NJ Ex Order 26 The LPN further stated that if the NJ Ex Order 26.4(b)(1) then she would hold the med as per the holding parameters [directions in the PO] otherwise it would NJ Ex Ord the BP NJ Ex Order 26

During an interview with surveyor # 2 on 12/19/24 at 1:34 PM, the LPN #2 stated the check marks on the eMAR means the medication was administered. LPN #2 stated NJ Ex Order 26.4(b)(1) would be given when the NJ Ex was NJ Ex Or The LPN #2 further stated she would hold the medication if NJ Ex Order 26.4(b) as the NJ Ex was at a decent range. Surveyor # 2 reviewed the NJ Ex Order 26.4(b)(1) eMAR with LPN #2, LPN #2 confirmed it was her signatures for 2 entries where NJ Ex Order 26.4(b)(1) was administered and should have been held. The LPN #2 stated "it might be incorrect documentation and I know I did not give it." The LPN #2 checked progress notes for supporting documentation. The LPN #2 was not able to provide any additional information or explanation

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F 658	Continued From page 14 to the surveyor. During an interview with surveyor # 2 on 12/20/24 at 10:07 AM, the U.S. FOIA (b) (6)) stated NJ Ex Order 26.4(b)(1) was given for NJ Ex Order 26.4(b)(1)), and it would be held for NJ Ex Order 26.4(b) as per the PO and if given it would NJ Ex Orde the NJ Ex NJ Ex Order The surveyor notified the NJ Ex Orde of the above-mentioned concerns. A review of the facility policy titled "Administering Medications policy" revised 3/20 included under Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Under section Policy Interpretation and Implementations-3.) Medications must be administered in accordance with the orders, including any required time frame. NJAC 8:39-11.2(b), 27.1 (a), 29.2(d)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide NJ Ex O to a resident who was NJ Ex Order 26.4(b)(1) activities of daily living (ADLs). This deficient practice occurred for 1 of 3 residents (Resident #122) reviewed for NJ Ex Order 26.4(b and was evidenced by the following:	F 677	F677- ADL Care Provided for Dependent Residents What corrective action will be accomplished for those residents affected by the deficient practice? Resident #122 was provided with NJ Ex Order 26.4(b by the caretaker on 12/18/2024.	2/11/25

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F 677	Continued From page 15 On 12/17/24 at 12:38 PM, the surveyor observed Resident #122 sitting on the edge of their bed. The surveyor observed resident's NJ Ex Order 26.4(b)(1) [redacted], and their [redacted] were [redacted] with [redacted]. On 12/18/24 at 11:47 AM, the surveyor observed Resident #122 sitting in their bed. Resident #122's nails were [redacted] with [redacted]. Resident #122 stated "I don't remember when my NJ Ex Order 26.4(b)(1)", and further stated, "I am going to ask my family to bring me [redacted]." On 12/18/24 at 11:54 AM, during an interview with the surveyor, the Certified Nursing Assistant (CNA) stated his responsibilities [redacted] feeding, [redacted] and providing ADL care, such as [redacted] the resident, and [redacted] during morning care. The CNA further stated if he saw a resident with [redacted] he would ask the resident if they want their [redacted]. The CNA stated it was important to [redacted] to avoid bacteria and prevent infections because residents NJ Ex Order 26.4(b)(1) [redacted] The CNA stated he was familiar with Resident #122 and the resident had never refused care. The CNA observed Resident #122's nails in the presence of the surveyor, the CNA acknowledged that the resident's NJ Ex Order 26.4(b)(1), and he never provided [redacted] to Resident #122. The CNA further stated that he should have [redacted] resident's [redacted] because resident was not able to NJ Ex Order 26.4(b)(1) due to [redacted]. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which	F 677	How will the facility 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 alleged deficient practice. The Unit Managers checked all residents for nail care and if nail care was required, the resident care team provided nail care. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? Policy for resident hygiene was reviewed. Clinical staff were educated on the importance of providing routine hygiene practices for residents. Unit managers or designee will monitor resident hygiene routine to ensure care is being provided. How will the corrective action be monitored to ensure the deficient practice will not recure? Director of Nursing or designee will audit residents' nails to ensure they have been provided with nail care. The audit will be conducted once a week for one month, then monthly x3. The results of the audit will be reviewed at the facility QAPI meeting x3 months.	

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included 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 quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), reflected the Resident #122 had a brief interview for mental status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15, which indicated resident was NJ Ex Order 26.4(b)(1). Section NJ Ex Order 26.4(b)(1) documented that Resident #122 required NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1).

A review of the individualized comprehensive care plan (ICCP) included a focus area for an ADL care deficit related to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Interventions included assist with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) as needed. Further review of the ICCP did not include a focused area for refusal of ADLs.

On 12/19/24 at 10:20 AM, during an interview with the surveyor, the US FOIA (b)(6) stated if she saw a resident with NJ Ex Order 26.4(b)(1), she will ask them if they want their NJ Ex Order 26.4(b)(1). The US FOIA stated the NJ Ex Order 26.4(b)(1) was important for NJ Ex Order 26.4(b)(1) and to keep up with NJ Ex Order 26.4(b)(1). The US FOIA stated Resident #122's behavior was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and did not refuse any care. The US FOIA stated Resident #122 was NJ Ex Order 26.4(b)(1) and was asked on Friday and the resident did not want their NJ Ex Order 26.4(b)(1). The US FOIA further acknowledged that the resident was not able to NJ Ex Order 26.4(b)(1) because he/she was NJ Ex Order 26.4(b)(1).

On 12/20/24 at 10:07 AM, during an interview with the surveyor, the U.S. FOIA (b) (6))

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F 677	Continued From page 17 stated if a resident had [NJ Ex Order 26.4(b)(1)], it was important to [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA] further stated if a resident refuses [NJ Ex Order 26.4(b)(1)] then the staff should ask them again at a later time. A review of the facility policy titled "Resident Nail Care policy" dated 3/23 included: The Purpose of this procedure is to provide guidelines for the provision of care to a resident's nails. Under section Policy Explanation and Compliance Guidelines:1.) Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. A review of the facility policy titled "Activities of Daily Living policy" revised 3/2022 included under Policy Statement: The facility will ensure that ADLs are provided in accordance with accepted standards of practice ... Under section Policy Interpretation:1.) The facility nursing staff will provide the resident who is unable to carry out ADLs on their own necessary services to maintain good nutrition, grooming, and personal and oral hygiene. NJAC 8:39-27.1(a), 27.2(g)	F 677		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 698		2/11/25

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F 698	Continued From page 18 Based on observation, interview and record review, it was determined that the facility failed to ensure medication administration times were sequenced to accommodate a resident's NJ Ex Order 26.4(b)(1)) schedule in accordance with professional standards of practice. This deficient practice was identified for 1 of 2 residents reviewed on NJ Ex Order 26.4(b)(1) (Resident #43), and was evidenced by the following: On 12/18/2024 at 09:17 AM, the surveyor observed Resident #43 in their room. Resident #43 stated that the facility gets him/her to NJ Ex Order 26.4 on time. The surveyor reviewed the medical record for Resident #43. The medical reflected Resident # 43 had a primary diagnosis of but not limited to NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1). A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b)(1) which reflected that the resident had NJ Ex Order 26.4(b)(1) and that the resident received NJ Ex Order 26.4(b)(1) . The care plan reflected an intervention to confer with physician and/or NJ Ex Order 26.4 treatment center regarding changes in medication administration times/dosage NJ Ex Order 26.4(b)(1) as needed. A review of the order Summary Report with active orders as of NJ Ex Order 26.4(b) reflected physician orders for the following:	F 698	F698- Dialysis What corrective action will be accomplished for those residents affected by the deficient practice? Nurse Manager spoke to the Primary Care Physician clarified and changed Resident #43 medication times of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to coincide with NJ Ex Order 26.4 hours and days. Educated RN/LPN assigned to Resident #43 on the Policy for NJ Exec Order 26.4b1 Given specific instructions on scheduling meds to coincide with resident dialysis hours and days. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents on hemodialysis have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Dialysis Policy was reviewed. Nurse Educator conducted education to RN/LPN/Unit Manager/Nursing Supervisor on the Policy for Dialysis. Education on specific instructions regarding scheduling medications to coincide with resident dialysis hours and days. Unit Managers or	

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F 698	Continued From page 19 1. Resident receives dialysis on Tuesday, Thursday, and Saturday, 11am. 2. NJ Ex Order 26.4(b)(1) Give 1 tablet by mouth three times a day for NJ Ex Order 26.4(b)(1)) 3. NJ Ex Order 26.4(b)(1) Give 2 tablets by mouth three times a day for NJ Ex Order 26.4(b)(1) A review of the NJ Exec Order 2 communication sheets from NJ Ex Order 26.4(b through until NJ Ex Order 26.4(b)(1 resident did not receive NJ Ex Order 26.4(b or NJ Ex Order 26.4 while at NJ Ex Order 26.4 A review of the electronic Medication Administration Record (eMAR) for November and NJ Ex Order 26.4(b)(1), indicated that NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1) were not given to the resident on 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), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b and at 1:00 PM because the resident was off the unit NJ Ex Order 26.4(b)(1)": On 12/20/2024 at 09:36 AM, the surveyor interviewed the Licensed Practical Nurse who was familiar to Resident # 43. She stated Resident #43 attends NJ Ex Order 26.4 on Tuesdays, Thursdays, and Saturdays he/she leaves the facility around 9:30 AM and returns around 3:30 PM. The LPN and surveyor reviewed the NJ Ex Order 26.4(b)(1) MAR together. She stated that Resident #43 is not receiving NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1) while at NJ Ex Order 26.4(She stated the resident should be receiving the medication and will call the physician to clarify the orders.	F 698	designee will monitor dialysis residents medication orders to ensure times are scheduled around Dialysis days and hours. How will the corrective action be monitored to ensure the deficient practice will not recure? Audits will be conducted by Nursing Administration on medication schedules coinciding with dialysis hours and days. The audits will be completed weekly x4, then monthly x3. The results of the audit will be reviewed at the monthly QAPI Committee chaired by the facility administrator.	

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F 698	Continued From page 20 On 12/20/2024 at 09:45 AM, the surveyor interviewed the Nurse Manager. She stated Resident #43 should be receiving the medications as ordered. She stated she will speak with the doctor to clarify and change the medication times to coincide with dialysis. The surveyor reviewed the facility provided policy titled "Hemodialysis", with a revised date of 06/2024 which reflected that resident medications will be administered as ordered. Medication times may be altered based on dialysis times. NJAC 8:39-11.2(d), 27.1(a)(b)	F 698		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced	F 712		2/11/25

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F 712	Continued From page 21 by: Based on observations, interviews, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents A.) conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission, B.) were seen by the physician or nurse practitioner every thirty days with a physician visit at least every sixty days. This deficient practice was observed for 4 of 34 residents (Resident #51, #52, #119, and #122) reviewed for physician visits. This deficient practice was evidenced by the following: 1.) A review of Resident #51's hybrid (electronic and paper) medical records (MR) from NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b)(1) revealed the following: The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but weren't limited to 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) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) A review of the quarterly Minimum Data Set (qMDS) an assessment tool dated NJ Ex Order 26.4 , revealed the Resident #51 had a Brief Interview Mental Status (BIMS) of NJ Ex out of 15, which indicated that the resident's NJ Exec Order 26.4(was NJ Ex Order 26.4(b)(1) . A review of the Electronic Medical Record (EMR) revealed the U.S. FOIA (b) (6)) visit progress notes (PN) dated NJ Ex Order 26.4 , NJ Ex Order 26.4 , NJ Ex Order 26.4 , NJ Ex Order 26.4 , NJ Ex Order 26.4 , NJ Ex Order 26.4 , NJ Ex Order 26.4 , NJ Ex Order 26.4 ,	F 712	F712- Physician Visits What corrective action will be accomplished for those residents affected by the deficient practice? The Director of Nursing and Director of Clinical Services spoke with the Medical Director and advised of policy on Physician Visits. The Medical Records for identified residents could not be retroactively updated to include physician visits. How will the facility 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 deficient practice. Managers audited clinical records and contacted physicians with any findings. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Policy for Physician Visits was reviewed. The Director of Clinical Services, Director of Nursing and or the Medical Director began education on January 8th,2025 to the primary physicians on staff of the policy on Physician Visits. Unit Managers will monitor resident records to ensure	

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F 712	Continued From page 22 NJ Ex Order 26.4, NJ Ex Order 26.4(, NJ Ex Order 26.4 (Note Text - History and Physical [H&P]), NJ Ex Order 26.4, NJ Ex Order 26.4(b), NJ Ex Order 26.4(b). A further review of the PN did not reveal any PN from the attending physician from NJ Ex Order 26.4(b)(1 through NJ Ex Order 26.4(b)(1). A review of the EMR did not reveal a PN from the attending physician or the attending US FO for NJ Ex Or and NJ Ex Order 26.4(b)(1) or that the physician and US FO were consistently alternating monthly visits. On 12/19/24 at 1:52 PM, during an interview with the surveyor, the US FOIA (b)(6) stated that physicians made rounds everyday and documented in the EMR. For a new admission, the staff would call the doctor. The US FO further stated the expectation would be that the doctor would be in to see the resident for an H&P within 24-hours as per facility policy and write physician visit PN once a month. The US FOIA reviewed Resident #51's EMR in the presence of the surveyor and confirmed that there were no PN from the attending physician from NJ Ex Order 26.4(b). The US FOIA further stated Resident #51's attending physician did not come to the facility anymore. 2.) On 12/17/24 at 11:43 AM, the surveyor observed Resident #52 lying in their bed. The resident was watching television. A review of Resident #52's hybrid MR from NJ Ex Or - NJ Ex Order 26.4(b)(1) revealed the following: The AR reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1)), NJ Ex Order 26. , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the qMDS dated 11/15/24, revealed	F 712	physicians are making visits at appropriate intervals. How will the corrective action be monitored to ensure the deficient practice will not recure? Audits will be conducted by Nursing Administration on Physicians Visits/Frequency/Timeliness, weekly x4, then monthly x3. The results of the audit will be reviewed at the monthly QAPI Committee chaired by the facility administrator.	

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the Resident #52 had a BIMS of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted].

A review of the EMR revealed an attending physician PN dated [redacted] and [redacted]. Further review of the EMR revealed the Physician Assistant (PA)/ NP PN also documented visits for the resident on [redacted].

A review of the EMR did not reveal a PN from the attending physician or the attending NP for [redacted], and [redacted] or that the physician and NP were consistently alternating monthly visits.

3.) On 12/17/24 at 11:21 AM, the surveyor observed a [redacted] Resident #119 sitting in their bed. Resident had [redacted].] and was able to use [redacted] to communicate with the surveyor.

A review of Resident #119's hybrid MR from [redacted] revealed the following:

The AR reflected that the resident was admitted to the facility with diagnoses that included [redacted].

A review of the qMDS dated [redacted], revealed the Resident #119 had a BIMS of [redacted] out of 15, which indicated that the resident was [redacted].

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A review of the EMR revealed the [US FO] visit PN dated [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)]. A further review of the PN did not reveal any PN from the attending physician from [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)].

A review of the EMR did not reveal a PN from the attending physician or the attending [US FO] for [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)] or that the physician and NP were consistently alternating monthly visits.

4.) On 12/17/24 at 12:38 PM, the surveyor observed the Resident #122 sitting on the edge of their bed. Resident was [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)]

A review of Resident #122's hybrid MR from [NJ Ex Order 26.4(b)(1)] - [NJ Ex Order 26.4(b)(1)] revealed the following:

A review of the AR reflected the resident was admitted to the facility with diagnoses which included [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)].

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26.4(b)(1)], reflected the Resident #122 had a brief interview for mental status (BIMS) score of [NJ Ex Order 26.4(b)(1)] out of 15, which indicated resident was [NJ Ex Order 26.4(b)(1)]

A review of the EMR revealed the NP visit PN dated [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)], [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)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)]. A further review of the PN did not reveal any PN from the attending physician from [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)].

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F 712	Continued From page 25 A review of the EMR did not reveal a PN from the attending physician or the attending [US FO] for [NJ Ex Ord] or that the physician and [US FO] were consistently alternating monthly visits. On 12/20/24 at 10:26 AM, during an interview with the surveyor, the[U.S. FOIA (b) (6)]) stated attending physician would see their residents and write PN within 24-48 hours of admission other than if the resident was admitted on Friday, then attending physician would see the resident by Monday. The [U.S. FOIA] further stated that the attending physician would make rounds every month for first 90 days after that every 60 days and as needed. The surveyor notified the [U.S. FOIA] of the above-mentioned concerns. At 1:57 PM, the [U.S. FOIA (b)] provided an additional handwritten PN for Resident # 51 titled as "Doctor's Progress Note" dated [NJ Ex Order 26.4] indicated as [NJ Ex Order 26.4(b)(1)]). A review of the facility policy titled "Physician Services" dated 3/20 included under Policy Interpretation and Implementation section: Physician orders and progress notes shall be maintained in accordance with current OBRA regulations. All attending physician or physician groups will document physician orders, progress notes, and physician history or physicals in the facility health record .... Physician visits, frequency of visits, ... are provided in accordance with current OBRA regulations and facility policy. NJAC 8:39-23.2 (b), 23.2 (d)	F 712		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		2/11/25

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F 761	Continued From page 26 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure all medications and biologicals were stored and labeled properly in medication carts. The deficient practice was identified for 4 of 5 medication carts reviewed under the Medication Storage and Labeling Task. The deficient practice was evidenced by the following:	F 761	F761- Label/Store Drugs and Biologicals What corrective action will be accomplished for those residents affected by the deficient practice? • Destroy all loose pills in the drug buster that were found in D-Hall, B-Hall, A-Hall, G-Hall medication carts, the undated Lantus multi-dose vial and the undated Lispro.	

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F 761	Continued From page 27 On 12/16/2024 at 12:47 PM, the surveyor inspected the D-Hall medication cart. At that time, the surveyor observed two, loose tablets in the second drawer of the medication cart. Secondly, the surveyor observed one, multi-use vial of Insulin Lispro (fast-acting medication used to treat blood sugar levels) and one, multi-use vial of Lantus (long-acting medication used to treat blood sugar levels) undated. Lastly, the surveyor observed loose vials of Heparin (medication used to thin the blood) placed in a plastic basket with the insulins. At that time, during an interview with the surveyor, Licensed Practical Nurse (LPN) # 1 said they [insulins] should be dated. She also removed the Heparin vials and placed them in the 3rd drawer box of Heparin. On 12/17/2024 at 11:01 AM, the surveyor inspected the B-Hall medication cart. At that time, the surveyor observed five, loose tablets in the second drawer of the medication cart. At that time, LPN # 2 placed the loose tablets in the "drug-buster" (bottled solution used to disintegrate medications). On the same date at 11:07 AM, the surveyor inspected the A-Hall medication cart. At that time, the surveyor observed seven, loose tablets in the second drawer of the medication cart. At that time, during an interview with the surveyor, LPN # 3 replied, "I'm not sure. It happens on night shift." when the surveyor asked how often are carts cleaned. On the same date at 1:25 PM, the surveyor inspected the G-Hall low medication cart. At that time, the surveyor observed one, loose tablet in the second drawer of the medication cart. At that time, the nurse placed the tablet in the drug	F 761	• Place Heparin vial in the proper box labeled Heparin. • Educated US FOIA (b)(6) assigned in A-hall, B-Hall, D-Hall, G-Hall medication carts on the Policy for Treatment & Medication Cart Cleaning and Medication Storage. Given emphasis on checking for loose pills in their med carts and destroying loose pills using drug busters if found. • Educated US FOIA assigned in D-Hall cart the Policy on Medication Labeling of Multi-dose Vial. Given specific instructions on proper labeling expiration date of Lantus multi-dose vial once opened. How will the facility 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 alleged deficient practice. Unit Managers audited medication carts on their units and no further concerns were noted. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? Nurse Educator began education on December 17, 2025 to RN/LPN's on staff of policy on Treatment & Medication Cart Cleaning and Medication Storage. Given emphasis on checking for loose pills in their med carts and destroying loose pills	

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F 761	Continued From page 28 buster. A review of the facility policy titled, "Treatment & Medication Cleaning" dated 03/2020 revealed under, "Procedure" that, "3. Treatment and Medication carts are cleaned routinely." A review of the facility policy titled, "Medication Storage" dated 03/2020 revealed under "Policy Interpretation and Implementation" that, "1. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner." and that, "7. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents." A review of the facility policy titled, "Administration of Insulin" dated 03/2020 revealed under "Steps in the Procedure (Insulin Injections via Syringe)" that, "4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after openings)." N.J.A.C. § 8:39-29.4 (a)(b)2	F 761	using drug buster if found. Policy on Medication Labeling of Multi-dose Vial will be provided. Given specific instructions on proper labeling of multi-dose vials once opened. How will the corrective action be monitored to ensure the deficient practice will not recure? Audits will be conducted by the Nursing Administration for loose pills in med carts, expiration labels on multi dose vials, and proper storage of Heparin Vials, weekly x4, monthly x3. The results of the audits will be reviewed at the monthly QAPI Committee chaired by the facility administrator.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		2/11/25

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 30 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to use appropriate infection control practices specifically, by staff not wearing a NJ Ex Order 26.4(b)(1) while entering a room under NJ Ex Order 26.4(b)(1). The deficient practice observed for 1 of 2 residents (Resident # 320) reviewed for NJ Ex Order 26.4(b)(1) Precautions under the Infection Control task. The deficient practice was evidenced by the following: Reference: "Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that	F 880	F880- Infection Control What corrective action will be accomplished for those residents affected by the deficient practice? Educated RN #1 on the Policy for Transmission Based Precautions. With emphasis on wearing proper PPE when entering room and providing care on Resident #320 on NJ Ex Order 26.4(b)(1) Precautions. How will the facility identify other residents having the potential to be affected by the same deficient practice and what	

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F 880	Continued From page 31 may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens." https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html A review of Resident # 320 Admission Record located in the Electronic Medical Record (EMR) revealed a diagnoses of but not limited to, NJ Ex Order 26.4(b)(1) as of the NJ Ex Order 26.4(b)(1)). On 12/16/2024 at 12:56 PM, the surveyor observed Registered Nurse (RN) # 1 in Resident # 320's room. Resident # 320 was in his/her bed. RN # 1 was wearing gloves but NJ Ex Order 26.4(b). Outside of the room, the surveyor observed a sign that revealed, "NJ Ex Order 26.4(b)(1) Providers and Staff Must Also: Put on gloves before room entry. Discard gloves before room exit. Put on NJ Ex Order before room entry. Discard NJ Ex Order before room exit..." Outside of the doorway, the surveyor observed a plastic bin containing masks, gloves, and NJ Ex Order 26. At that time, during an interview with the surveyor, RN # 1 said she wasn't doing direct care except shutting off a pump alarm. On 12/17/2024 at 12:11 PM during an interview with the surveyor, the U.S. FOIA (b) (6) confirmed Resident # 320 was on NJ Ex Order 26.4 . When the surveyor asked if NJ Ex Order 26. is required to be worn upon entering the room, the U.S. FOIA (b) (6) replied that may be the expectation but we go by the policy.	F 880	corrective action will be taken? All residents on Contact Isolation Precautions have the potential to be affected by this alleged deficient practice. Unit managers checked other residents on Contact Precautions, and no concerns were identified. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The policy on Infection Prevention and Control was reviewed. Nurse Educator began education on December 16, 2024 to RN/LPN/CNAs/Therapists on policy for Transmission Based Precautions. The staff members were educated on importance of wearing proper PPE when entering and giving care for resident on Contact Isolation Precaution. How will the corrective action be monitored to ensure the deficient practice will not recure? Audits will be conducted by Nursing Administration on wearing proper PPE when entering and giving care for residents on Contact Isolation Precautions. Audits will be conducted weekly x4, then monthly x3. The results of the audit will be reviewed at the monthly QAPI Committee chaired by the facility administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315054	A. BUILDING _____ B. WING _____	C 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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F 880	Continued From page 32 On 12/23/2024 at 10:32 during an interview with the surveyor, the U.S. FOIA (b) (6)) said they gave the nurse education on entering rooms under NJ Ex Order 26.4(b)(1) and that she will have to wear a mask, NJ Ex Order 2 and gloves. The U.S. FOIA (b) concluded that they are going to give all staff re-education. A review of the facility policy titled, "Transmission Based Precautions" revised 4/2024 revealed, "In addition to Standard Precautions, implement contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident - care items in the resident's environment. The decision on whether precautions are necessary will be evaluated on a case by case basis." Secondly, the policy revealed, "p. Wear a gown whenever anticipating that clothing will have direct contact with the resident or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient-care environment." N.J.A.C. § 8:39-19.4 (a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060106	A. BUILDING: _____ B. WING _____	C 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEAL	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for 12 of 14 day shifts as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: 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	S 560	S560 Staffing Levels What corrective action will be accomplished for those residents affected by the deficient practice? No residents were identified. How will the facility 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 systemic changes will be made to	2/11/25

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

Electronically Signed | 01/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060106	A. BUILDING: _____ B. WING _____	C 12/31/2024

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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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing prior to survey from 12/01/2024 to 12/14/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -12/01/24 had 13 CNAs for 178 residents on the day shift, required at least 22 CNAs. -12/02/24 had 15 CNAs for 178 residents on the day shift, required at least 22 CNAs. -12/03/24 had 17 CNAs for 176 residents on the day shift, required at least 22 CNAs. -12/04/24 had 18 CNAs for 175 residents on the day shift, required at least 22 CNAs. -12/05/24 had 20 CNAs for 175 residents on the day shift, required at least 22 CNAs. -12/06/24 had 21 CNAs for 175 residents on the day shift, required at least 22 CNAs. -12/07/24 had 16 CNAs for 175 residents on the day shift, required at least 22 CNAs.	S 560	ensure the deficient practice will not recur. On January 6, 2025, the Administrator provided re-education to the Director of Nursing, Assistant Director of Nursing and the Human Resources Director on the minimum staffing requirements by shift for certified nurse aides (direct care staff) by the Department of Health. The Administrator, Director of Nursing, Human Resources Director and or Staffing Coordinator will meet weekly to review staffing levels for the week, open positions, and recruitment efforts. The facility will focus on recruitment and retention including but not limited to, use of web-based recruitment advertising, contract utilization, sign on bonuses and referral bonuses, job fairs, shift differentials and employee moral incentives. The Human Resources Director will utilize the Recruitment Report to track and trend recruitment efforts weekly x4 weeks, then 2x a month for 2 months. How will the corrective action be monitored to ensure the deficient practice will not recur. The Human Resources Director and or Designee will review and report the audit results during the Quality Assurance Performance Improvement (QAPI) meeting monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director, and Department Heads.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060106	A. BUILDING: _____ B. WING _____	C 12/31/2024

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S 560	Continued From page 2 -12/08/24 had 15 CNAs for 175 residents on the day shift, required at least 22 CNAs. -12/09/24 had 18 CNAs for 173 residents on the day shift, required at least 22 CNAs. -12/10/24 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs. -12/13/24 had 20 CNAs for 169 residents on the day shift, required at least 21 CNAs. -12/14/24 had 19 CNAs for 169 residents on the day shift, required at least 21 CNAs. During an interview on 12/20/24 at 09:40 AM, the Staffing Coordinator (SC) stated that he is aware of the minimum staffing ratio requirement of direct care staff. He stated the facility is meeting the requirement. During an interview on 12/20/24 at 9:50 AM, the Director of Nursing stated she is aware of the minimum staffing ratio requirement of direct care staff. She stated the facility is meeting the requirement. The surveyor reviewed the facility provided policy titled, "Staffing", with a revised date of 4/2024. The policy reflected that our facility provides adequate staffing to meet care and services needs for our resident population and nursing assistants are available each shift to provide the needed care and services for each of our residents/patients.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of	S1680		2/11/25

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S1680	Continued From page 3 nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

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S1680	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of the Supplementary Nurse Staffing Report for the weeks of 12/01/2024 to 12/14/2024, it was determined that the facility failed to provide minimum staffing levels for licensed staff on 2 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 12/01/2024 Required Staffing Hours: 513 -12/01/24 had 480 actual staffing hours, for a difference of -33 hours. -12/02/24 had 504 actual staffing hours, for a difference of -9 hours. During an interview on 12/20/2024 at 9:40AM, the Staffing Coordinator (SC) stated that the facility relies on the facility census to know how many	S1680	S1680- Mandatory Nurse Staffing What corrective action will be accomplished for those residents affected by the deficient practice? No residents were identified. How will the facility 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 systemic changes will be made to ensure the deficient practice will not recur. On January 6, 2025, the Administrator provided re-education to the Director of	

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S1680	Continued From page 5 licensed staff to schedule. She stated the facility consistently meets the requirements. During an interview on 12/20/2024 at 9:50 AM, the Director of Nursing (DON)stated the facility had registered nurses twenty-four hours a day. The DON stated the facility is meeting the staffing requirements for nurses. During an interview on 12/20/24 at 11:53 AM, the Licensed Nursing Home Administrator stated that the facility staffs for acuities. She stated that the facility reviews the acuities and staffs the facility accordingly. She stated the facility is staffed correctly based on the acuities. The facility provided policy titled "Staffing", revised 4/2024, reflected our facility provides adequate staffing to meet care and services needs for our resident population. It reflected our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services.	S1680	Nursing, Assistant Director of Nursing and the Human Resources Director on the minimum staffing requirements by shift for professional nurses and certified nurse aides (direct care staff) by the Department of Health. The Administrator, Director of Nursing, Human Resources Director and or Staffing Coordinator will meet weekly to review professional nurse and certified nurse aides staffing levels for the week, open positions, and recruitment efforts. The facility will focus on recruitment and retention including but not limited to, use of web-based recruitment advertising, contract utilization, sign on bonuses and referral bonuses, job fairs, shift differentials and employee moral incentives. The Human Resources Director will utilize the Recruitment Report to track and trend recruitment efforts weekly x4 weeks, then 2x a month for 2 months. How will the corrective action be monitored to ensure the deficient practice will not recur. The Human Resources Director and or Designee will review and report the audit results during the Quality Assurance Performance Improvement (QAPI) meeting monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director, and Department Heads.	

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
315054 Y1	A. Building B. Wing Y2	2/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0658	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	02/11/2025	LSC	02/11/2025	LSC	02/11/2025
ID Prefix F0677	Correction	ID Prefix F0698	Correction	ID Prefix F0712	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.30(c)(1)-(4)	Completed
LSC	02/11/2025	LSC	02/11/2025	LSC	02/11/2025
ID Prefix F0761	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	02/11/2025	LSC	02/11/2025	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/31/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060106		2/14/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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 02/11/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 02/11/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
12/31/2024	☐ 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
	315054	A. BUILDING **01** B. WING _____	**12/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	**1100 CLEMATIS AVE** **PLEASANTVILLE, NJ 08232**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/27/24, 12/30/24 and 12/31/24, Our Lady's Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Our Lady's Center is a single (1) story, Type II unprotected construction, that was built in January 1963. The facility is divided into 12-smoke zones and has an exterior 125 KW diesel Generator that does approximately 80% of the facility. The building has a partial basement under the following areas and wings: A-wing, B-wing, C-wing, D-wing, areas-1&2(utilities) * the areas under A,B,C,& D wings have unfinished dirt floors. The census was 170 of 214 licensed beds.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101	K 281		2/11/25

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

Electronically Signed | 01/17/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	**1100 CLEMATIS AVE** **PLEASANTVILLE, NJ 08232**

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K 281	Continued From page 1 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/30/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 1 of 4 areas, had the potential to affect 25 residents and was evidenced by the following: An observation at 12:09 PM, revealed in the C-hall occupied dining room that 1 (one) wall light switch shutoff all 8 (eight) ceiling light fixtures. In an interview, the U.S. FO and U.S. FOIA both confirmed the findings at the time of observations. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code survey exit conference on 12/31/24 at 12:45 PM. NJAC 8:39-31.2(e)	K 281	K-0281 (E) NFPA 101- Illumination of Means of Egress 1. The facility is scheduled on January 24, 2025, to install emergency lighting in the dining room to illuminate the discharge path. The room has ambient lighting, and all residents were free from hazards. 2. All remaining egress path lights have been inspected and found at least one light that is on constant power. Fixtures have been tested and are in full operation as of 1/10/2025. All resident areas are free from hazards and all systems are operating as designed. 3. Education is completed with Maintenance staff to confirm proper function and maintenance of all egress path lighting on 1/10/2025. 4. Every quarter for a year the Maintenance Director or designee reviews random exit path lights for function. This information will then be entered on a log and will be presented to the QAPI meeting quarterly for one year. *emergency lighting was installed in the dining room- see attached photo*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315054	A. BUILDING **01** B. WING _____	**12/31/2024**

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K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 12/30/24 in the presence of the U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by	K 321	K-0321 (E) NFPA 101- Hazardous Areas Enclosure 1. Replacement of kitchen-rated doors were ordered on January 14, 2025 with installation prior to compliance date of	2/11/25

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	315054	A. BUILDING **01** B. WING _____	**12/31/2024**

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K 321	Continued From page 3 smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice had the potential to affect 25 residents in that identified area, was observed for 2 of 6 doors in the back of the facility, and was evidenced by the following: 1). An observation at 10:10 AM revealed the set of wooden doors to the kitchen, had a gap approximately 1/2-inch to 3/4-inch when in the closed position. 2). An observation at 10:21 AM revealed that the blue door from the kitchen to the resident dining room when would not fully close and latch due to positive air pressure from the kitchen forcing the door to remain in the open position approximately 6-inches. In an interview with the U.S. FO and U.S. FOIA (both confirmed the observations. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 12/31/24 at 12:45 PM.	K 321	February 11, 2025. New fire rated latching hardware will be installed as well. Residents are free from hazards. 2. All hazardous enclosure doors have been inspected, and confirmation of latching and free from gaps completed on 1/10/2025. 3. Education is completed with Maintenance staff to confirm proper door operation of doors on 1/10/2025 4. Every quarter for a year the Maintenance Director or designee review random doors throughout the building for proper operations. This information will then be entered on a log and will be presented to the QAPI meeting quarterly for one year. * See attached quote and receipt of payment for kitchen rated doors* * See attached photo of kitchen double door replacement*	
K 324 SS=F	NJAC 8:39-31.2 (e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324		2/11/25

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K 324	Continued From page 4 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/24 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 2 of 5 exhaust hood grease baffles were fully operational to protect against grease and fire from entering above the exhaust hood system in accordance with NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:32 AM revealed that 2 of 5 kitchen hood grease baffles were missing the interior channels of the #1 and #5 baffle, offering no protection in that area. The #1 grease baffle was observed over the main 4-burner natural gas	K 324	K-0324 (F) Cooking Facilities 1. Replacement of the 2 of the 5 kitchen hood grease baffles identified as missing the interior channels of the #1 and #5 baffle were ordered and installed on 1/9/2025. 2. All other areas have been inspected and comply. All resident areas are free from hazard and all systems are operating as designed. 3. The Maintenance Director provided education with the Maintenance staff to confirm proper gap penetration in kitchen equipment on 1/10/2025. 4. Every quarter for a year the Maintenance Director or designee review	

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K 324	Continued From page 5 cooking appliance. An interview was conducted at 10:34 AM, with the [redacted] and [redacted] where both confirmed the observations. The [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 12/31/24 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 10, 96	K 324	random areas for excess penetrations. This information will then be entered on a log and will be presented to the QAPI meeting quarterly for one year. *photo of replacement of kitchen baffles attached*	
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 observation, documentation review and interviews on 12/27/24 in the presence of the [redacted]) and [redacted], it was determined that the facility failed to ensure all components of the fire alarm system were fully operational in accordance with NFPA 70 and 72. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 09:00 AM with the [redacted] revealed that the main entrance fire alarm	K 345	K-0345 (E) NFPA 101- Testing and Maintenance 1. [redacted] has restored functionality to the fire alarm system by installing a new module on 1/14/2025. The system was always functioning, and all residents' areas are free from hazard. 2. All testing and maintenance paperwork has been completed and inspected on 1/14/2025 3. The Maintenance Director provided	2/11/25

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K 345	Continued From page 6 annunciator panel was in trouble mode: *the panel indicated Zone-4 [Brand Name] panel disconnected, trouble basement CO detector. A review of a document provided by the U.S. FOIA (b) (6) from the facility vendor dated: 12/13/24 stated the following: "The technician found a module for the CO detector and determined that it needed to be replaced, as it was causing the panel to boot cycle and was not changing status for the supervisory to return to normal, the panel was left with supervisory on until we get the monitoring module and programmer to correct the issue". In an interview at 10:10 AM, the U.S. FOIA (b) (6) stated the annunciator panel was in trouble mode due to the basement CO module needing to be replaced. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 12/30/24 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	education with Maintenance staff to confirm proper repairs on paperwork once deficiencies are found on 1/10/2025. 4. Every quarter for a year the Maintenance Director or designee review paperwork for proper paperwork and deficiency free reporting. This information will then be entered on a log and will be presented to the QAPI meeting quarterly for one year. *Invoice of service installation of fire alarm system module attached*	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		2/11/25

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K 355	Continued From page 7 by: Based on observation and interview on 12/30/24, in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), the facility failed to ensure fire extinguishers were ready for use in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition, Section 5.5.5.3(a). This deficient practice had the potential to affect approximately 75 residents and was evidenced by the following: An observation at 11:11 AM revealed in the E-hall exit/egress corridor, that access to the fire extinguisher was compromised by by a desk, computer monitor and a 3-tier paper tray. In an interview at 11:15 AM, the U.S. FO and U.S. FOIA both confirmed the observation. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 12/31/24 at 12:45 PM, NJAC 8:39-31.2(e) NFPA 10	K 355	K-0355 (E) Fire Extinguishers 1. The Fire Extinguisher compromised by the desk has been corrected by having the desk removed on 1/10/2025. All resident areas are free from hazard. 2. All Fire Extinguishers in the facility have been reinspected and are ready for use and the staff inspect the extinguisher areas to prevent this from happening in the future. All resident areas are free from hazard and all systems are operating as designed as of 1/10/2025. 3. The Maintenance Director provided education with Maintenance staff regarding monitoring Fire Extinguishers by Maintenance Staff on 1/10/2025. 4. Every quarter for a year the Maintenance Director or designee will check Fire Extinguishers throughout the facility to ensure they are ready for use. This information will then be entered on a log and will be presented to the QAPI meeting quarterly for one year. *desk was removed clearing access to fire extinguisher-see attached photo*	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled	K 920		2/11/25

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K 920	Continued From page 8 by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/30/24 in the presence of the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with NFPA 101: 2012, Sections 19.5, 19.5.1, 9.1 and 9.1.2, NFPA 70: 2011 Edition, Sections 400.8 and 590.3 (D), NFPA 99: 2012 Edition, Sections 10.2.3.6 and 10.2.4. This deficient practice was identified for 1 of 12 electrical wires observed, had the potential to affect all residents in the facility and was evidenced by the following: An observation at 10:00 AM in the basement boiler location revealed that a green extension cord was feeding power to a 120 gallon holding	K 920	K-0920 (E) Power Cords and Extensions. 1. The extension cord plugged into a circulator pump for the hot water system has been removed and replaced with a permanent circuit on 1/10/2025. All residents are free from hazard. 2. All areas are free from extension cords and have been inspected by 1/10/2025. 3. The Maintenance Director provided education with Maintenance staff regarding the need to maintain proper electrical connected with approved electrical connections. 4. Every quarter for a year the Maintenance Director or designee will check surge protectors throughout the facility to maintain logs of what they are	

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K 920	Continued From page 9 tank circulating pump. The green extension cord was plugged into a duplex wall outlet. In an interview at the time, the [redacted] and [redacted] both confirmed the observations. The [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 12/31/24 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 920	used for. This information will then be entered on a log and will be presented to the monthly QAPI meeting quarterly for one year. *extension cord was replaced with permanent circuit to the circulator pump-see attached photo*	

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
315054 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	02/11/2025	LSC K0321	02/11/2025	LSC K0324	02/11/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	02/11/2025	LSC K0355	02/11/2025	LSC K0920	02/11/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO