STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING _____ B. WING _____	C 06/21/2024

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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F 000	INITIAL COMMENTS Complaint #: NJ162616, NJ162614, NJ172611, NJ171657, NJ162574 Survey Date: 6/13/24 through 6/21/24 Census: 106 Sample: 22 + 2 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		7/5/24

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

Electronically Signed | 07/05/2024

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: NJ#162614 Based on observations, interviews, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to report as required to the New Jersey Department of Health (NJDOH) within two hours an allegation of [redacted] for one (1) of two (2) residents (Resident #156) reviewed for [redacted]. This deficient practice was evidenced by the following: On 6/13/24 at 11:20 AM, the surveyor reviewed a Reportable Event Record (RER) for a [redacted] that indicated the RER was submitted to the NJDOH by the facility's [redacted] at that time, on [redacted]. A review of the RER included the following: Today's Date: [redacted] Date of Event: [redacted] Time of Event: 11:00 PM The section that the facility can document if the incident was a significant event and if the event was called in was blank. Further review of the RER indicated that Resident #156 [redacted] by an unsampled resident on [redacted]	F 609	Resident #156 was discharged from the facility on [redacted]. The Director of Nursing and Licensed Nursing Home administrator of record at the time of the [redacted] are no longer at the fResidents involved in allegations of [redacted] have the potential to be affected. The current [redacted] and [redacted] were educated on the requirement to report allegations of abuse within 2 hours of the allegation. Allegations of abuse for the last 90 days have been reviewed. All reporting requirements have been completed per NJ Guidelines. acility.Staff were educated on the requirement to report allegations of abuse including resident to resident altercations to the Administrator and Director of Nursing as soon as it is reported. The [redacted] and [redacted] were educated to report allegations of abuse including resident to resident altercations to the New Jersey Department of Health and Office of the	

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F 609	Continued From page 2 On 6/13/24 at 12:30 PM, the surveyor requested from the U.S. FOIA (b) (6) the facility's complete documentation of the RER for Resident #156. On 6/14/24 at 9:39 AM, the surveyor reviewed the facility provided Full QA (Quality Assurance) Report (facility's incident report) for Resident #156 which included the following: Incident Date/Time: NJ Ex Order 26.4(b)(1) 11:00 PM Conclusion: Resident #156 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)) ...Resident woke up, while NJ Ex Order 26.4(b)(1) by roommate, unsampled resident, who was a NJ Ex Order 26.4(b)(1) resident and has NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) No NJ Ex Order noted. Resident #156 verbalized, "I am NJ Ex Order I am NJ Ex Order 26.4(b)(1) ." Patient transferred to another room immediately. Notifications: U.S. FOIA (b) (6) NJ Ex Order 26.4 11:00 PM (phone) U.S. FOIA (b) (6) NJ Ex Order 26.4 11:00 PM (phone) U.S. FOIA (b) (6) NJ Ex Order 26.4 3:00 PM (phone) NJDOH NJ Ex Order 26.4(b) 3:00 PM (phone) Further review of the above information, the facility did not report the allegation of NJ Ex Order 2 within two hours. Resident #156 and the unsampled resident no longer resided at the facility. On 6/17/24 at 11:03 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding an allegation of NJ Ex Order 26 The U.S. FOIA stated that any allegation of NJ Ex Order 2 should be reported within two hours whether the NJ Ex Order 2 was substantiated or not. The surveyor then asked the U.S. FOIA about the	F 609	Ombudsman within the required two hours of the allegation. Regional Director of Clinical Services or designee will review Allegations of Abuse to ensure they are reported per required regulation. The Regional Director of Operations will audit Allegations of abuse for 90 days to ensure they are reported per New Jersey Department of Health Regulation. The Audit will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.	

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F 609	Continued From page 3	F 609		

incident between Resident #156 and the unsampled resident and when it should have been reported. The [U.S. FOIA] stated that she had been at the facility for only [NJ Ex Order 26.4(b)(1)]. She added that the incident should have been reported within two hours.

On 6/17/24 at 12:47 PM, in the presence of the survey team, the surveyor notified the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)], the concern that the facility did not report an allegation of [NJ Ex Order 2] within two hours of the incident.

On 6/18/24 at 10:00 AM, in the presence of the survey team and [U.S. FOIA (b) (6)] the [U.S. FOIA] stated that the incident should have been immediately, within two hours reported and that she inserviced everyone in the facility about [NJ Ex Order 2] reporting.

The facility did not provide any additional information.

A review of the facility provided policy titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" with a revised date of September 2022, included the following:
Policy Statement
All reports of resident abuse ...are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management.
Policy Interpretation and Implementation
Reporting Allegations to the Administrator and Authorities
1. If resident abuse ....is suspected, the suspicion must be reported immediately to the administrator

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F 609	Continued From page 4 and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; ... 3. "Immediately" is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. N.J.A.C. 8:39-5.1(a)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ171657	F 610	Resident # 157 [NJ Ex Order 26.] on [NJ Ex Order 2]. Residents with [NJ Ex Order 26.] of [NJ Exec Order 26.4b1]	7/5/24

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F 610	Continued From page 5 Based on interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to thoroughly investigate an [NJ Ex Order] NJ Exec Order 26.4b1 This deficient practice was identified for one (1) of two (2) residents reviewed, Resident # 157. This deficient practice was evidenced by the following: On 6/17/24 at 12:10 PM, the surveyor in the company of another surveyor interviewed the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) who explained that the investigation involves a look back of 48 hours, including statements from staff who cared for the resident. The surveyor reviewed the medical records of Resident #157 and revealed the following: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not 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] A review of the Significant change in status Minimum Data Set, an assessment tool used to facilitate the management of care, dated [NJ Ex Order 26.4(b)], reflected that Resident #157 had a Brief Interview for Mental Status (BIMS) score of [NJ] out of 15, which indicated that Resident #157 had	F 610	have the potential to be affected. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were educated The administrator reviewed Incident reports for last 90 days for current residents to ensure investigations were complete. No discrepancies were identified. staff were educated on the policy and procedure for Abuse, including reporting and investigating injuries of unknown origin. The U.S. FOIA (b) (6) was educated on ensuring statements are obtained for each staff working for the 48 hours prior to the date the injury of unknown origin was discovered. The Administrator will review each investigation for injuries of unknown Origin to ensure statements for each shift and each discipline are obtained for the 48 hours prior to the date the injury of unknown origin was discovered. The Regional Risk team will scrub progress notes daily for key words to monitor for injuries of unknown origin and completion of incident reports. The Regional Director of Clinical Services will audit each injury of unknown origin for 90 days and then quarterly for 4 quarters to ensure statements are obtained from staff on all shifts prior to the date the injury of unknown origin was discovered. The results of the audits will be submitted	

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F 610	Continued From page 6	F 610		

NJ Ex Order 26.4(b)(1).

The facility reportable event (FRE) documenting an NJ Ex Order NJ Exec Order 26.4b1 to Resident #157 on NJ Ex Order 26.4(b) . The FRE described that Resident #157 was identified by a family member as having a NJ Ex Order 26.4(b)(1) . The family member informed a facility staff member (nurse) of the resident's NJ Ex Order

The surveyor reviewed the Employee Statement (ES), provided by U.S. FOIA (b) (6) , which was an incident investigative form used to document 48 hours of staff interviews prior to any incident. The Employee Statement form included interviews from NJ Ex Order 26.4(b) shift 3-11 to NJ Ex Order 26.4(b) 7-3 shift when the NJ Ex Order was identified.

Further review of the above provided ES, there were two blank interview spaces marked for NJ Ex Order 26.4(b) 11-7 Nurse and NJ Exec Order 26.4 11-7 U.S. FOIA) (the shift prior to the identified injury) missing any documented statements.

On 6/18/24 at 12:09 PM, the surveyor interviewed the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) who acknowledged that they could not find any interviews from the shift prior to the incident being identified for NJ Exec Order 26.4 11-7 shift. The U.S. FOIA (b) (6) stated that staff interviews were important factors to completing an investigation of NJ Exec Order 26.4b1 . The U.S. FOIA (b) (6) acknowledged that the facility should have interviewed and gotten a written statement from the NJ Ex Order 26.4(b) 11-7 NJ Ex Ord and nurse, who had cared for Resident #157 prior to the shift in which the NJ Ex Order was identified.

A review of the facility's undated policy titled

monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate.

The Quality Assurance Committee will make recommendations based upon the results of the audits.

Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.

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F 610	Continued From page 7	F 610		

"Investigating Resident Injuries" included: 7. If the nursing and medical assessment determines an "injury of unknown source," interviews/ statements from staff over the prior 48 hours will be obtained and the investigation will follow the protocols set forth in our facility's established abuse reporting and investigation guidelines.

A review of the facility policy titled "Accidents and Incidents- Investigating and Reporting" was revised on 7/2017, under Policy Statement included: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator.

A review of the facility policy titled "Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating" was revised on 9/2022, under Policy Statement included:
All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.

Under Section Investigating Allegations of "Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating" included: 7e.) interviews any witnesses to the incidents; h.) interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incidents; i.) interviews the resident's roommate, family members, and visitors. 8d.) Witness statements are obtained in writing, signed, and dated. The witness may write his/her statement, or the investigator may obtain a

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F 610	Continued From page 8 statement. On 6/18/24 at 01:09 PM, the surveyor interviewed the U.S. FOIA (b) (6) who acknowledged that the investigation of Resident #157's NJ Ex Order of NJ Exec Order 26.4b1 was incomplete and should have included the staff interviews missing from the 11-7 shift on NJ Ex Order 26.4(b). No further information was provided. NJAC 8:39-5.1(a)	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		7/5/24

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F 625	Continued From page 9 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that the facility failed to provide the resident or resident representative appropriate written notification of the facility's bed hold and reserve payment policy upon transfer to the hospital for two (2) of two (2) residents (Resident #69 and #85) reviewed for hospitalizations. The deficient practice was evidenced by the following: 1. A review of Resident #69's hybrid (combination of paper and electronic) medical record revealed the following: Resident #69's two discharge assessment-return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, reflected that the resident was transferred to the hospital. A review of Resident's hybrid medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative (RR) prior to the transfer to the hospital. On 6/14/24 at 10:24 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the facility's written notification of the bed hold policy process. The U.S. FOIA (stated that she would leave a message and mail a letter. She showed the surveyor a copy of the facility's bedhold policy and stated that she mailed out a copy of the	F 625	Residents #69 and #85 were given the room rates for bed holds on NJ Exec Order 26 Administrator educated the U.S. FOIA (b) (6) on ensuring the room rates are given to the resident with the bed hold policy upon transfer.Residents being transferred out have the potential to be affected. An audit was conducted for the residents that had transferred in the last month and they were given the room rates. The Administrator educated the U.S. FOIA (b and U.S. FOIA (b) (6) to ensure the facility rate will be included in the bed hold policy when resident/responsible party are being notified of transfer. Bed Hold Policy was updated to include the room rates. The Business office manager will log transfers out daily and ensure bed hold policy notice to residents/ responsible parties are being done upon transfer including the bed hold reserve rate. The Administrator/ designee will audit resident transfers weekly X4 weeks and then Monthly to ensure bed hold notice with rate was provided to the resident/ responsible parties. Any discrepancies will	

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F 625	Continued From page 10 policy. She then showed the surveyor a binder and stated that she kept a list of the residents that she mailed the policy to. On that same date and time, the surveyor asked if any additional information was provided each transfer to the hospital. The [redacted] stated that no additional information was given and that all residents were given the daily rate of the bed within 24-48 hours of their initial admission. The surveyor reviewed the document titled "Bed Hold & Emergency Transfer Policy." The document included Date, Resident, To and Payor. The first three sections were filled out and the fourth section labeled Payor was blank. On 6/17/24 at 12:46 PM, in the presence of the survey team, the surveyor notified the [redacted], the concern that the facility did not provide Resident #69 written notification of the bed hold policy which included the reserve bed payment and other information. On 6/18/24 at 9:50 AM, in the presence of the survey team and the [redacted] the [redacted] stated that she inserviced the [redacted] to include the rate on the information given to the resident and to include it on her log. The facility did not provide any additional information. 2. On 6/14/24 at 11:50 AM, the surveyor reviewed the hybrid medical records for Resident #85 which revealed the following:	F 625	be addressed. The results of the audits will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.	

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According to the Admission Record (an admission summary), Resident #85 had diagnoses that included but were not limited to, [redacted]), [redacted] , and [redacted]).

A New Jersey Universal Transfer Form and nurse progress notes documented Resident #85 was transferred to an [redacted] hospital on [redacted].

A physician's order dated [redacted] read: "Transfer to [redacted]) for eval (evaluation)."

On 6/14/24 at 12:12 PM, the surveyor interviewed the [redacted]) who stated the business office provided bed hold policy notifications to residents and/or RR.

On 6/14/24 at 12:57 PM, the surveyor interviewed the [redacted] who confirmed she mailed the facility's bed hold policy and would also call RR. The [redacted] provided a list of residents in which bed hold policy notification was provided. Resident #85 was on the list. The [redacted] confirmed the facility's "Bed-Holds and Returns" bed policy was what was sent to all the residents or RR upon a resident's transfer.

A review of the undated facility provided policy titled, "Bed-Holds and Returns", included the following:
1. Residents may return to and resume resident in the facility after hospitalization or therapeutic leave as outlined in this policy.
2. The current bed-hold and return policy established by the state (if applicable) will apply to Medicaid resident in the facility.

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 12 3. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. the rights and limitations of the resident regarding bed-holds; b. the reserve bed payment policy as indicated by the state plan (Medicaid residents); c. the facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. the details of the transfer (per the notice of transfer). 4. Medicaid residents who exceed the state's bed hold limit and/or non-Medicaid residents who request a bed-hold are responsible for the facility's basic per diem rate while his or her bed is held .... N.J.A.C. 8:39-5.1 (a); 5.2 (a)	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for three (3) of twenty four (24) residents, Resident #69, Resident #105 and Resident #306 reviewed for accuracy for MDS coding.	F 641	The MDS Coordinator corrected the MDS assessment for Resident #69 on [redacted]. The MDS Coordinator corrected the MDS assessment for Resident #105 on [redacted]. The MDS Coordinator corrected the MDS assessment for Resident #306 on [redacted]. Residents receiving [redacted] have	7/5/24

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F 641	Continued From page 13 This deficient practice was evidenced by the following: 1. On 6/13/24 at 10:31 AM, Surveyor #1 (S#1) observed Resident #69 seated in a wheelchair calling for the nurse. The U.S. FOIA (b) (6) stated to the surveyor that Resident #69 had just returned from NJ Ex Order 26.4(On 6/13/24 at 01:00 PM, S#1 reviewed Resident #69's medical record. A review of Resident #69's Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)). The Discharge assessment-return anticipated Minimum Data Set (DRAMDS), dated NJ Ex Order 26.4 , did not indicate Resident #69 received NJ Ex Order 26.4 treatment. On 6/13/24 at 01:42 PM, S#1 requested the U.S. FOIA (to print Resident #69's DRAMDS dated NJ Ex Order 26.4 section NJ E which indicated if a resident received NJ ex Order 26.4 treatments. The printed copy did not indicate the resident received NJ Ex Order 26.4 treatment. On 6/14/24 at 10:09 AM, S#1 interviewed the	F 641	the potential to be affected. Residents receiving NJ Exec Order 26 have the potential to be affected. Residents being discharged to home have the potential to be affected. The U.S. FOIA (b) (6) was educated on 6/13/24 to ensure MDSs are coded correctly. The Regional MDS coordinator educated staff completing MDS assessments on ensuring accurate coding for residents receiving Dialysis or hospice and residents being discharged home with return not anticipated. The Regional MDS coordinator will audit Discharge MDS Assessments for accuracy prior to submission. The Regional MDS Coordinator will audit the MDS assessments for residents receiving Dialysis for accuracy prior to submission. The Regional MDS Coordinator will audit the MDS assessments for residents receiving Hospice services for accuracy prior to submission. The MDS Coordinator, or designee, will keep a log of Discharge MDS assessments, assessments for residents receiving hospice and residents receiving Dialysis x 20 weeks.	

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F 641	Continued From page 14 U.S. FOIA (b) (6) regarding Resident #69's DRAMDS. The U.S. FOIA (b) (6) stated that she had modified the DRAMDS after surveyor inquiry. She added that the DRAMDS should have been coded to indicate Resident #69 received NJ Ex Order 26.4 treatment. She added that she followed the RAI (Resident Assessment Instrument) manual. On 6/17/24 at 12:46 PM, in the presence of the survey team, S#1 notified the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6)) and NJ Ex Order 26.4(b)(1)), the concern that the Resident #69's MDS was coded incorrectly. On 6/18/24 at 10:09 AM, in the presence of the survey team and U.S. FOIA (b) the U.S. FOIA (b) confirmed that the MDS not coded correctly and that the US FOIA (b) (6) was inserviced and modified the MDS. 2. On 6/13/24 at 01:41 PM, S#2 reviewed the closed medical records for Resident #105 and revealed the following: The quarterly MDS and the modified MDS with an assessment reference date of NJ Ex Order 26.4 did not identify the resident as a NJ Exec Order 26 resident, and the NJ Ex Order 26.4(b)(1) was offered and NJ Exec Order 26.4(b) The NJ Ex Order 26.4(b)(1) record showed that Resident #105 received the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1 The Universal Transfer Form dated NJ Ex Order 26.4 revealed that the resident had NJ Ex Order 26.4(b)(1) on NJ Exec Order 26.4(A review of the physician's order showed an order for NJ Ex Order 26.4 on NJ Ex Order 26.4(	F 641	The log will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits.	

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F 641	Continued From page 15	F 641		

On 6/14/24 at 02:13 PM, S#2 in the presence of two other surveyors interviewed the NJ Ex Order 26 and the NJ Ex Order 26.4(b)(1) The NJ Ex Order 26 stated that the facility followed the RAI Manual for MDS and there was no separate policy for MDS. The surveyor notified the facility management of the above findings and concerns regarding the accuracy of coding the MDS for NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) Both facility management stated that they would get back to the surveyor.

On 6/17/24 at 10:49 AM, Surveyor #3 interviewed the U.S. FOIA (b) (and the U.S. FOIA (b) (6). The U.S. FOIA (b) (stated that it was missed to check off and indicated that the resident was under NJ Ex Order 26.4(b care.

3. On 6/17/24 at 11:53 AM, S#3 reviewed the discharge medical records for Resident #306 and revealed the following:

The DRAMDS for Resident #306 dated NJ Ex Order 26.4(b which revealed that the resident was discharged to NJ Ex Order 26.4(b hospital.

The Interdisciplinary Progress Notes dated NJ Ex Order 26.4(b which documented that Resident #306 was discharged NJ Ex Order 26.4(b

On 6/17/24 at 12:56 PM, the survey team met with the facility's U.S. FOIA (b) (U.S. FOIA (b) U.S. FOIA (b) (6), and U.S. FOI S#3 discussed the above concern.

A review of the facility provided policy titled, "Discharge Assessments" dated October 2023, included the following:
1. A discharge assessment is completed when:
a. a resident is admitted to an acute care hospital;

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F 641	Continued From page 16 b. a resident has a hospital observation stay greater than 24 hours; ... A review of the facility provided policy titled, "Electronic Transmission of the MDS" with a revised date of November 2019, included the following: 1. All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the MDS RAI Instruction Manual .... 4. The MDSC is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes. On 6/18/24 at 9:46 AM, the facility's [U.S. FOIA (b)] stated that the MDS was coded in incorrectly and acknowledged that Resident #306 was discharged[NJ Ex Order 26.4(b)]. No further information was provided. NJAC 8:39-11.1, 11.2(e)(1)	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 645		7/5/24

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F 645	Continued From page 17	F 645		

performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in

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F 645	Continued From page 18 the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined that the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for one (1) of one (1) resident (Resident #3) reviewed for PASRR. This deficient practice was evidenced by the following: On 6/13/24 at 10:20 AM, the surveyor observed Resident #3 lying in bed in their room. The resident was NJ Ex Or and NJ Ex Order 26.4(b The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #3 which revealed the following: According to the Admission Record (AR, an admission summary), Resident #3 had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1)	F 645	Social Worker completed PASARR level NJ screen for resident # 3 on NJ Exec Order 2. The resident did not require a PASARR Level NJ E All residents being admitted to the facility have the potential to be affected. Social Worker conducted and audit of all current residents to ensure PASARR level 1 was completed. All current residents had PASARR level 1 screen in the electronic medical record. The Administrator educated the US FOIA (b)(6) and the US FOIA (b)(6) on ensuring that residents being admitted to the facility have a PASARR screening in place prior to admission. The admission Director will keep a log of residents being admitted to the facility and	

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F 645	Continued From page 19 (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) . Further review of the AR revealed the diagnosis of NJ Ex Order 26.4(b)(1) had an onset date of NJ Ex Order 26.4(b) during the stay of the resident at the facility. A quarterly Minimum Data Set (qMDS) assessment, a tool used to facilitate the management of care, dated NJ Ex Order 26.4, indicated the facility assessed the resident's NJ Exec Order 26.4(b) using a Brief Interview for Mental Status (BIMS) test. Resident #3 scored a score of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). The qMDS in Section NJ Active Diagnosis for Resident #3 included NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) There was no documentation found in the hybrid medical records of a PASRR (is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) level I screen being completed for Resident #3 during their time at the facility. On 6/14/24 at 12:12 PM, the surveyor interviewed the U.S. FOIA (b) (6)) in the presence of the U.S. FOIA (b) (6)) about PASRR processes. The U.S. FO stated a PASRR level I screen was completed for residents prior to admission to screen for NJ Exec Order 2 to ensure a resident received appropriate care and services.	F 645	the date their PASRR was completed. The Administrator will audit the admission PASRR log weekly for 4 weeks and then monthly for 6 months to ensure compliance of PASRR being obtained prior to Admission to the facility. Findings of the audits will be submitted to the Quality Assurance Committee monthly for 6 months. The Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.	

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F 645	Continued From page 20 On that same date and time, the U.S. FO further stated that if a Level I screen indicated a resident may meet the criteria, they would be referred for a PASRR Level II evaluation screening to determine if specialized services were needed. The U.S. FO stated a resident who had a new onset of a possibly NJ Exec Order 26.4b1 during their stay at the facility, a PASRR screen should be completed. The U.S. FO confirmed NJ Ex Order 26.4(b)(1) would be considered a NJ Exec Order 26.4b1. At that time, the surveyor notified the U.S. FO that there was no PASRR found for Resident #3. The U.S. FO stated she would review and provide the surveyor with further information. On 6/14/24 at 01:44 PM, the U.S. FOIA (b) (6) provided the surveyor with a PASRR Level II for Resident #3. The U.S. FOIA stated the PASRR provided was done today after surveyor inquiry and the resident did not trigger for requiring a PASRR Level II. She further stated that any prior PASRR for Resident #3 could not be found in their medical record or in the facility records. The U.S. FOIA stated Resident #3 when admitted to the facility in NJ Exec Ord had a diagnosis of NJ Ex Order 26.4(b)(1) and the PASRR should have been completed previously. On 6/17/24 at 10:45 AM, the surveyor interviewed the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) about the resident's medical diagnoses. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) stated the resident was admitted with NJ Ex Order 26.4(b)(1) and on NJ Ex Order 26.4(b)(the diagnosis was updated to NJ Ex Order 26 the resident's NJ Ex Order 26.4(b)(1) diagnosis to NJ Ex Order 26.4(b)(1). Both the facility management acknowledged a PASSR should have been completed for the resident at	F 645		

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F 645	Continued From page 21 the time of their admission. On 6/17/24 at 12:45 PM, the surveyor informed the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) , and the U.S. FOIA (b) (6) of the above concerns. The surveyor reviewed the facility provided policy titled "Behavioral Assessment, Intervention and Monitoring", with a revised date of 3/2019. Under Policy Interpretation and Implementation, Assessment, it read: " ...a. All residents will receive a Level I PASRR screen prior to admission ...b. If the level I screen indicates that the individual may meet the criteria for a mental disorder, intellectual disability, or related condition he or she will be referred to the state PASRR representative for the Level II (evaluation and determination) screening process ..." The surveyor reviewed the facility provided policy titled "Admission Criteria", with a revised date of 3/2019. Under Policy Interpretation and Implementation, it read: " ...8. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process ...a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD ..." On 6/18/24 at 10:10 AM, the U.S. FOIA (and U.S. FOIA (b) met with the survey team. There was no additional information provided by the facility. NJAC 8:39-11.2(i), 27.1(a)	F 645		

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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 the facility failed to consistently follow standards of clinical practice with regards to accurately: a) documenting medication administration for one (1) of 24 residents, Resident #18, reviewed for NJ Ex Order 2 medications, b) complete NJ Ex Order 26.4 post assessment forms for one (1) of one (1) resident, Resident #69, reviewed for NJ Ex Order 26.4(and c) complete NJ Ex Order 26.4(b monitoring sheets for one (1) of five (5) residents, Resident #50, reviewed for unnecessary medications. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	The nurses responsible for not signing the Medication administration record for Resident # 18 were counseled by Director of Nursing on 6/14/24. The physician and Resident representative were notified on 6/14/24. The Nurses responsible for completing the NJ Exec Order 26.4b1 for Resident # 69 were educated on 6/14/24. The physician and Resident representative were notified on 6/14/24. The nurses responsible for not signing the NJ Exec Order 26.4(and Side Effect monitoring for Resident # 50 were counseled by Director of Nursing on 6/14/24. The physician and Resident representative were notified on 6/17/24. All residents have the potential to be affected. Director of Nursing audited Medication administration Records, Behavior and Side Effect Monitoring Records and Dialysis Communication logs for June 2024 for blanks. Variances were addressed.	7/5/24

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 23 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 casefinding; 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." 1. On 6/13/24 at 01:40 PM, the surveyor observed Resident #18 sitting in a wheelchair (w/c) in their room. The Resident was NJ Ex Orde NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1). Resident #18 stated they were NJ Ex Order 26.4 and had no concerns with their care. The Surveyor reviewed the electronic health record (EHR) of Resident #18 which revealed the following: According to the Admission Record (AR, an admission summary), Resident #18 had diagnoses that included but were not limited to, 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 quarterly Minimum Data Set (qMDS) assessment, a tool used to facilitate management of care, dated 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 #18 scored a NJ Ex out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1).	F 658	US FOIA (b)(6) were educated on ensuring documenting on behavior and side effect monitor forms, medication administration record and dialysis communication form per policy. Director of Nursing or designee will print and review Medication Administration Audit Report daily for previous day to check for blanks on the Behavior and Side effect Monitoring Form and Medication administration record. Director of Nursing or designee will review each residents dialysis forms three times per week to ensure completion. Director of Nursing or designee will conduct audits on 10 residents Medication Records and Behavior Monitoring records weekly to ensure Behavior Monitoring records are completed per policy and procedure for 4 weeks and then monthly to monitor for completed records. Director of Nursing or Designee will Audit 2 Dialysis residents Dialysis Binders weekly for 4 weeks and then Monthly to ensure post dialysis documentation is complete. The audits will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits.	

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F 658	Continued From page 24 Resident #18 had a care plan with a focus that read "I have NJ Ex Order 26.4(b)(1)," initiated on [redacted]. An intervention of the care plan read "[redacted] medication as ordered by doctor. Monitor and document side effects and effectiveness." A physician's order (PO) dated [redacted] read: NJ Ex Order 26.4(b)(1) ([redacted]) NJ Ex Order 26.4(b)(1) before meals for NJ Ex Order 26.4(b)(1)]. A PO dated [redacted] read: "NJ Ex Order 26.4(b)(1) checks AC/HS [before meals and at bedtime], document in [EHR], no NJ Exec Order 26.4b1 AC and at HS for NJ Ex Order 26.4(b)(1)]." A PO dated [redacted] read: "[brand name] NJ Ex Order 26.4(b)(1) Miscellaneous [redacted] AC and at HS for [redacted]" A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed [redacted] entries were not signed by the nurses and left blank on [redacted] at 1600 [4 PM] and [redacted] at 1600. A review of the NJ Ex Order 26.4(b)(1) MAR revealed [redacted] check entries were not signed by the nurses and left blank on: [redacted] at 1600, [redacted] at 2100 [9 PM], [redacted] at 1600, [redacted] at 2100, and [redacted] at 2100. A review of the NJ Ex Order 26.4(b)(1) MAR revealed [redacted] entries were not signed by the nurses and left blank on [redacted] at 1600, [redacted] at 2100, [redacted] at 1600, [redacted] at 2100, and [redacted] at 2100.	F 658	Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.	

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Further review of the NJ Ex Order 26.4(b)(1) MAR revealed the following medication (med) entries had no nurse signature and were left blank:

- "NJ Ex Order 26.4(b)(1)) Give 1 tablet by mouth at HS for NJ Ex Order 26.4(b)(1)," on NJ Ex Order 26.4 at 2100.
- "NJ Ex Order 26.4(b)(1)) Apply to NJ Ex Order 26.4(b)(1) one time a day for NJ Ex Or remove at HS and remove per schedule", which was scheduled for removal on NJ Ex Order 26.4 at 2100.
- "NJ Ex Order 26.4(b)(1)) Apply to NJ Ex Order 26.4(b)(1) one time a day for NJ Ex Order remove at HS and remove per schedule", which was scheduled for removal on NJ Ex Order 26.4(at 2100.
- NJ Ex Order 26.4(b)(1) Give NJ Ex Order 26.4(b) by mouth two times a day for NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 and NJ Ex Order 26.4 at 1600.
- "NJ Ex Order 26.4(b)(1) Give 1 capsule by mouth two times a day for NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 and NJ Ex Order 26.4 at 1700 [5 PM].
- "NJ Ex Order 26.4(b)(1) Give 1 tablet by mouth two times a day for NJ Ex Order 26.4(b)(1) ", on NJ Ex Order 26.4 at 1700.
- "NJ Ex Order 26.4(b)(1) two times a day for NJ Ex Order ", on NJ Ex Order 26.4 and NJ Ex Order 26.4 at 1700.

A review of the NJ Ex Order 26.4(b)(1 MAR revealed NJ Ex Order 2 entries were not signed by the nurses and left blank on NJ Ex Order 26.4 at 1100 [11 AM], NJ Ex Order 26.4 at 1100, and NJ Ex Order 26.4 at 1600.

A review of the NJ Ex Order 26.4(b)(1 MAR revealed NJ Ex Order

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NJ Ex Order check entries were not signed by the nurses and left blank on NJ Ex Order 26.4 at 1100, NJ Ex Order 26.4 at 1100, NJ Ex Order 26.4 at 1600, NJ Ex Order 26.4 at 2100, and NJ Ex Order 26.4 at 2100.

A review of the NJ Ex Order 26.4(b)(1 MAR revealed NJ Ex Order 26 entries were not signed by the nurses and left blank on NJ Ex Order 26.4 at 1100, NJ Ex Order 26.4 at 1100, NJ Ex Order 26.4 at 1600, NJ Ex Order 26.4 at 2100, and NJ Ex Order 26.4 at 2100.

Further review of the NJ Ex Order 26.4(b)(1 MAR revealed the following med entries had no nurse signature and were left blank:

- 'NJ Ex Order 26.4(b)(1) Give 1 tablet by mouth at HS for NJ Ex Order 26.4(b)(1)", which was scheduled for NJ Ex Order 26.4 and NJ Ex Order 26.4 at 2100.
- 'NJ Ex Order 26.4(b)(1)) Apply to NJ Ex Order 26.4(b)(1) one time a day for NJ Ex Or remove at HS and remove per schedule", which was scheduled for application on NJ Ex Order 26.4 at 0900 and NJ Ex Order 26.4 at 0900; and scheduled for removal on NJ Ex Order 26.4 at 2100.
- 'NJ Ex Order 26.4(b)(1)) Apply to NJ Ex Order 26.4(b)(1) one time a day for NJ Ex Order remove at HS and remove per schedule", which was scheduled for application on NJ Ex Order 26.4 at 0900 and NJ Ex Order 26.4 at 0900; and scheduled for removal on NJ Ex Order 26.4 at 2100.
- NJ Ex Order 26.4(b)(1) Give NJ Ex Order 26.4(b) by mouth two times a day for NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(at 1600.
- 'NJ Ex Order 26.4(b)(1) Give 1 capsule by mouth two times a day for NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 at 1700.
- 'NJ Ex Order 26.4(b)(1) Give 1 tablet by mouth two times a day for NJ Ex Order 26.4(b)(1)", which was scheduled for NJ Ex Order 26.4 at 1700.

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- "NJ Ex Order 26.4(b)(1) two times a day for NJ Ex Order [redacted]", which was scheduled for NJ Ex Order 26.4 [redacted] and NJ Ex Order 26.4([redacted] at 1700.

A review of the NJ Ex Order 26.4(b)(1) MAR revealed an NJ Ex Order 26.4(b)(1) entry was not signed by the nurse and left blank on NJ Ex Order 2 [redacted] at 1100.

A review of the NJ Ex Order 26.4(b)(1) MAR revealed a NJ Ex Order [redacted] entry was not signed by the nurse and left blank on NJ Ex Order 26 [redacted] at 1100.

A review of the NJ Ex Order 26.4(b)(1) MAR revealed an NJ Ex Order 26.4(b)(1) entry was not signed by the nurses and left blank on NJ Ex Order 2 [redacted] at 1100.

Further review of the NJ Ex Order 26.4(b)(1) MAR revealed the following med entries had no nurse signature and were left blank:

- "NJ Ex Order 26.4(b)(1) [redacted]) Apply to NJ Ex Order 26.4(b)(1) one time a day for NJ Ex Or [redacted] remove at HS and remove per schedule", which was scheduled for application on NJ Ex Order 2 [redacted] at 0900.
- "NJ Ex Order 26.4(b)(1) [redacted]) Apply to NJ Ex Order 26.4(b)(1) one time a day for NJ Ex Order [redacted] remove at HS and remove per schedule", which was scheduled for application on NJ Ex Order 2 [redacted] at 0900.

On 6/14/24 at 11:16 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 about documentation of med administration. LPN #1 stated the MAR should be signed by the nurses at the time of med administration. LPN #1 further explained entries should not be left blank, nurses were to document when a med was administered and to document the reason why a med was not

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administered to a resident.

On 6/14/24 at 11:20 AM, the surveyor informed the U.S. FOIA (b) (6)) of the concerns for missing signatures of nurses on the NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) MARs. The U.S. FOIA stated she would review and provide further information.

On 6/17/24 at 11:25 AM, the U.S. FOIA met with the surveyor. The U.S. FOIA acknowledged there were unsigned entries on the MARs of Resident #18. The U.S. FOIA could not respond to why there were blank entries and was following up with the nurses to determine what happened. The U.S. FOIA stated it was expected for the nurses to complete their MAR documentation at the time medications (meds) were administered and there should be no unsigned entries. The U.S. FOIA further explained if meds were administered or not, nurses had to sign the MAR and document the reason why a med was not administered.

On 6/17/24 at 12:45 PM, the surveyor informed the U.S. FOIA (b) U.S. FOIA (b) (6) , U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), about the concerns of the missing nurse signature for the NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order MARs of Resident #18.

The surveyor reviewed the facility provided policy titled "Administering Med", with a revised date of 04/2019. Under Policy, it read: "Meds are administered in a safe and timely manner, and as prescribed." Under Policy Interpretation and Implementation, it read: " ...4. Meds are administered in accordance with prescriber orders, including any required time frame ...22.

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The individual administering the med initials the resident's MAR on the appropriate line after giving each med and before administering the next ones ..."

On 6/18/24 at 9:47 AM, the [U.S. FOIA] and [U.S. FOIA (b)] met with the survey team. The [U.S. FOIA] stated she was following up with nurses regarding the unsigned MAR entries and was providing education to nursing staff. There was no additional information provided by the facility.

2. On 6/13/24 at 10:31 AM, the surveyor observed Resident #69 seated in a w/c calling for the nurse. The Licensed Practical Nurse (LPN #2) stated to the surveyor that Resident #69 had just returned from [NJ Ex Order 26.4(b)]

On 6/13/24 at 01:10 PM, the surveyor asked the U.S. FOIA (b) (6)) to view Resident #69's [NJ Ex Order 26.4] NJ Exec Order 26.4b1 ([NJ Ex Ord]), which is a binder that contains documents that was filled out in three sections; by the facility prior to going to [NJ Ex Order 26.4] facility, by the [NJ Ex Order 26.4] facility post treatment and lastly by the facility when the resident returned to the facility.

On 6/13/24 at 01:12 PM, the LPN #2 provided the binder to the surveyor and stated that she had not filled out the document post return yet but that she had assessed the resident and taken vital signs.

On 6/13/24 at 01:20 PM, the surveyor reviewed Resident #69's [NJ Ex Ord] which included the following: [NJ Ex Order 26.4(b)(1)] NJ Exec Order 26.4b1 [NJ Ex Order]) dated [NJ Ex Order 26.4] Section 3. Completed by facility upon return from [NJ Ex Order 26.4] was blank. [NJ Ex Ord] dated [NJ Ex Order 26.4] Section 3 was blank.

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F 658	Continued From page 30 NJ Ex Ord dated NJ Ex Order 26.4 Section 3 was blank. NJ Ex Ord dated NJ Ex Order 26.4 Section 3 was blank. There was a handwritten note dated NJ Ex Order 26.4 in the front of the NJ Ex Ord which included the following: Section 3-Completed by facility (Facility nurse) upon return. On 6/13/24 at 01:22 PM, the surveyor showed the LPN #2 Resident #69's NJ Ex Order 2 that were blank. LPN #2 confirmed that Section 3 was blank and that they should have been filled out. On 6/13/24 at 01:30 PM, the surveyor interviewed the U.S. FOIA (b) (6) regarding Resident #69's NJ Ex Order 26 The U.S. FOIA (b) (6) stated that the NJ Ex Ord should be filled out by the nurse and that it was an assessment that was done by the nurse when the resident returned from NJ Ex Order 26.4 treatment. She added that she usually checked the NJ Ex Order 2 to make sure they were filled out before she moved them to a larger binder. On 6/13/24 at 01:40 PM, the surveyor reviewed Resident #69's medical record. Resident #69's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) [redacted] ,NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) [redacted]. On 6/17/24 at 12:46 PM, in the presence of the	F 658		

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F 658	Continued From page 31 survey team, the surveyor notified the [redacted] and [redacted] the concern that the Resident #69's [redacted] communication record post [redacted] assessment upon return to the facility was not completed. On 6/18/24 at 9:58 AM, in the presence of the survey team and [redacted] the [redacted] stated that the resident's communication log appeared to be incomplete. She added that she educated the nurses on completing communication log in its entirety. The facility did not provide any additional information. A review of the facility provided policy titled, "Dialysis Communication" with an adopted date of June 2021, included the following: Policy Statement The facility and dialysis center will establish a communication and reporting mechanism to promote situational awareness between both facilities. The policy did not contain information on the facility's HCR document. 3. On 6/13/24 at 10:52 AM, the surveyor observed Resident #50 seated in a w/c in his/her room. On 6/14/24 at 12:39 PM, the surveyor reviewed Resident #50's medical record. Resident #50's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]	F 658		

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F 658	Continued From page 32 [NJ Ex Order 26.4(b)] NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . Resident #50's [NJ Ex Order 26.4(b)(1)] MAR/Treatment Administration Record (TAR)/[NJ Ex Order 26.4(b)] Monitoring included the following orders: [NJ Ex Order 26.4(b)(1)/INTERVENTION] Monitor for (NJ Ex Order 26.4(b)(1)) ...every evening and night shift; 3 of 15 evening shifts were blank. [NJ Ex Order 26.4(b)(1)/INTERVENTION] Monitor for [NJ Ex Order 2] ...every shift; 9 of 15 day shifts were blank; 3 of 15 evening shifts were blank. [NJ Ex Order 26.4(b)(1)/INTERVENTION] Monitor for (NJ Ex Order 26.4(b)(1)) ...every shift; 9 of 15 day shifts were blank; 3 of 15 evening shifts were blank. [NJ Ex Order 26.4(b)(1)/INTERVENTION] Monitor for (NJ Ex Order 26.4(b)(1)) ...every shift; 9 of 15 day shifts were blank; 3 of 15 evening shifts were blank. [NJ Ex Order 26.4(b)(1)/INTERVENTION] Monitor for (NJ Ex Order 26.4(b)(1)) ...every shift; 9 of 15 day shifts were blank; 3 of 15 evening shifts were blank. [SIDE EFFECTS] Monitor for Side Effects of [NJ Ex Order 26.4(b)(1)] Meds every shift; 9 of 15 day shifts were blank; 3 of 15 evening shifts were blank. [SIDE EFFECTS] Monitor for Side Effects of [NJ Ex Order 26.4(b)] Meds every shift; 9 of 15 day shifts were blank; 3 of 15 evening shifts were blank. On 6/17/24 at 11:46 AM, the surveyor interviewed LPN #2 regarding [NJ Ex Order 26.4(b)] monitoring and side effect monitoring. LPN #2 stated that there was a PO for monitoring in the computer. She added	F 658		

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that each shift would document a yes or no if there was [NJ Exec Order 26.4b] or side effects. The surveyor showed LPN #2 Resident #50's blanks for [NJ Ex Order 26.4(b)] monitoring and side effect monitoring. LPN #2 stated that there should not be blanks. The surveyor asked what the importance of [NJ Ex Order 26.4(b)] monitoring was. LPN #2 stated that it was to know if a med was necessary or if it needed to be changed.

On 6/17/24 at 12:02 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] regarding [NJ Ex Order 26.4(b)] monitoring and side effect monitoring. The [U.S. FOIA (b) (6)] stated that every shift should have documentation and should not see blanks. She added that if the resident was not in the building the nurse should document a code to indicate that.

On 6/17/24 at 12:09 PM, the surveyor interviewed the [U.S. FOIA] regarding Resident #50's blank [NJ Ex Order 26.4(b)] monitoring and side effect monitoring. The [U.S. FOIA] stated that it should not be blank.

On 6/17/24 at 12:48 PM, in the presence of the survey team, the surveyor notified the [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] and [U.S. FOIA] the concern that the Resident #50 had multiple blanks on the [NJ Ex Ord] MAR/TAR for multiple PO for [NJ Ex Order 26.4(b)] monitoring and side effect monitoring.

On 6/18/24 at 10:07 AM, in the presence of the survey team and [U.S. FOIA (b) (6)] the [U.S. FOIA] stated that there was missing [NJ Ex Order 26.4(b)] monitoring.

The facility did not provide any additional information.

A review of the facility provided policy titled, "Behavioral Assessment, Intervention and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 34 Monitoring" with a revised date of March 2019, included the following: Monitoring 1. If the resident is being treated for altered behavior or mood, the IDT (Interdisciplinary Team) will seek and document any improvements or worsening in the individual's behavior, mood, and function. NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of facility policies, it was determined	F 692	Resident # 27□s physician and family were notified on [redacted].	7/5/24

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	315497	A. BUILDING _____ B. WING _____	C 06/21/2024

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F 692	Continued From page 35 that the facility failed to identify and accurately address an NJ Ex Order 26.4(b)(1)) order discrepancy. This deficient practice was identified for one (1) of two (2) residents reviewed for NJ Ex (Resident #27). The deficient practice was evidenced by the following: On 6/13/24 at 10:24 AM, the surveyor interviewed Resident #27 in the resident's room. The resident stated he/she does not take NJ Ex Order 2 and receives a NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). On 6/14/24 at 9:04 AM, the surveyor reviewed Resident #27's hybrid (paper and electronic) medical record which revealed the following: Resident #27's Admission Record (an admission summary) documented that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) following NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . The Minimum Data Set (MDS), an assessment tool used for the management of care dated NJ Ex Order 26.4, documented the resident had a Brief Interview for Mental Status (BIMS) and scored a NJ Ex out of 15, indicating that Resident #27 had NJ Ex Order 26.4(b)(1) . The MDS also showed that Resident #24 was receiving NJ Ex Order of NJ Ex Order 26.4(b)(1) from a NJ Ex O A review of the NJ Ex Order 26.4(b)(1) Physician Orders (PO) included a PO dated NJ Ex Order 26.4, " NJ Ex Order 26.4(b)(1), five	F 692	The Registered Dietician corrected the order for resident # 27 on NJ Exec Order 2 Residents receiving tube feedings have the potential to be affected. The Registered Dietician audited residents receiving tube feeding on 6/14/24 and no discrepancies were found. 1. The Director of nursing educated licensed nurses and the U.S. FOIA (b) (6) regarding tube feeding order entry and confirming tube feeding orders. 2. The Director of Nursing or designee with review order listing report daily for new or updated tube feeding orders to ensure accuracy. Discrepancies will be corrected. The registered Dietitian or designee will audit residents receiving tube feeding weekly X 4 weeks and then monthly to ensure tube feeding orders are accurate. The Audit will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits. Completion Date: 7/5/24	

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F 692		F 692		

Continued From page 36

times a day [NJ Ex Order 26.4(b)(1)]) 6 times per day via [NJ Ex Order 26.4(b)(1)]."

The Medication Administration Record (MAR) revealed from [NJ Ex Order 26.4] through [NJ Ex Order 26.4], Resident was receiving [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] [redacted] of [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26] five times daily.

On 6/14/24 at 9:41 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1), who regularly oversees Resident #27's care. LPN #1 stated, Resident #27 receives a [NJ Ex Order 26.4(b)(1)] five times daily which was confirmed when LPN #1 checked the MAR.

On that same date and time, the Surveyor asked LPN #1 to review the PO for the [NJ Ex Order 26.4(b)(1)]. LPN #1 acknowledged that the order for [NJ Ex Order] [redacted] should had been clarified because the order states five and six times daily [NJ Ex Order 26.4(b)(1)]. LPN #1 further stated they have not previously observed the error and would contact the [U.S. FOIA (b) (6)]) for correction.

On 6/14/24 at 11:59 AM, the surveyor interviewed the [U.S. FOI] who stated the [NJ Ex Order 26.4(b)(1)] order should have been for six times daily but could not state why the error occurred and was not caught by themselves or facility staff. No further comments provided.

On 6/17/24 at 9:04 AM, the [U.S. FOIA (b) (6)] [redacted] provided the surveyor with a facility policy titled, Enteral Feeding with a revised date of November 2018.

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F 692	Continued From page 37 Under the policy interpretation and implementation, it states, "4. Enteral nutrition is ordered by the provider based on recommendations of the dietitian. 8. The dietitian monitors residents who are receiving enteral nutrition and make appropriate recommendations to enhance tolerance and nutritional adequacy of enteral feeding. 11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include: a. the enteral nutrition product; d. administration method (continuous, bolus); e. volume and rate of administration." On 6/17/24 at 12:46 PM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6)). The Surveyor notified the facility management of the above findings and concerns. The facility management did not provide any comments at that time. On 6/18/24 at 9:46 AM, the U.S. FOIA (b) and U.S. FOIA met with the survey team with responses to the survey teams concerns. The U.S. FOIA stated, "we were not compliant, the resident had been receiving five NJ Ex Order 26.4(b)(1) a day when they should have been receiving six. The resident's doctor and family were notified, the resident did not have any NJ Ex Order 26.4(b)(1) . The U.S. FO completed an audit on all residents who were NJ Ex Order 26.4(b)(1)), and the completed an assessment on the resident and the NJ Ex order was corrected. An audit was completed on all NJ Ex Order 26.4(b)(1) residents. NJAC 8:39-11.2(e), 17.1(c), 27.1(a)	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		7/5/24

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F 756	Continued From page 38	F 756		

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

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F 756	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the U.S. FOIA (b) (6) failed to clarify medication route for a resident during the monthly medication (med) reviews for one (1) of six (6) Residents, Resident #27. The deficient practice was evidenced by the following: On 6/13/24 at 10:24 AM, the surveyor interviewed Resident #27 in the resident's room. The resident stated he/she does not take any medications (meds) NJ Ex Order 26.4(b)(1 On 6/14/24 at 9:04 AM, the surveyor reviewed Resident #27's hybrid (paper and electronic) medical record which revealed the following: Resident #27's Admission Record (an admission summary) documented that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) following NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The Minimum Data Set (MDS), an assessment tool used for the management of care dated NJ Ex Order 26.4, documented the resident had a Brief Interview for Mental Status (BIMS) and scored a NJ Ex out of 15, indicating that Resident #27 had NJ Ex Order 26.4(b)(1). A review of the NJ Ex Ord NJ Ex Orde Physician Orders (PO) included a PO dated NJ Ex Order 26.4 that read, 'NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1), NJ Ex Ord	F 756	The Order for NJ Exec Order 26.4b1 for resident # 27 was corrected to reflect it is administered via NJ Ex Order 26.4(b) on NJ Exec Order 26 Residents with orders for nothing by mouth have the potential to be affected. The Director of Nursing audited residents with orders for nothing by mouth to ensure no medications were being administered by mouth. No discrepancies were found The U.S. FOIA (b) (6) was educated by a Senior Pharmacy consultant on ensuring residents with tube feedings or NPO orders have medication ordered written to be administered via Peg Tube. The Pharmacy Consultant will review every resident with NPO orders Monthly to include route of administration for each medication. The Senior Pharmacy Consultant or designee will audit the recommendations of the Pharmacy consult for residents with NPO orders Monthly for 3 months. The audit will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality assurance committee will determine the continuation of the audits.	

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F 756	Continued From page 40 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)." And an addition PO dated NJ Ex Order 2 4, "NJ Ex Order 26.4(b)(1) , Give 1 tablet NJ Exec Order 26.4b two times a day for NJ Ex Order 26.4(b)(1) Give with NJ Ex Order 26.4(b)(1)." A review of the U.S. Fo medication review for NJ Ex Ord and NJ Ex Order 26.4(b)(1 read, "the following is a list of residents which were reviewed during the U.S. FOIA visits but did not require any recommendations." The list included Resident #27 for both NJ Ex Ord and NJ Ex Ord On 6/17/24 at 10:36 AM, the surveyor conducted a phone interview with the U.S. FO who stated, they missed the NJ Ex Order 26.4(b)(1) med written as NJ E not via NJ Ex Order 26.4(b)(1) is a NJ Exec Order 26.4b1 a NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1), or NJ Ex Ord , allow you to NJ Ex Order 26.4(b)(1)). No further explanation provided. On 6/17/24 at 11:00 AM, the U.S. FOIA (b) (6)) provided the surveyor with a facility policy title, CP with a revised date of August 2021. Under the policy interpretation and implementation section of the policy it states, "1. The facility will arrange for the provision of a CP who shall direct pharmaceutical services and provide consultation as needed. 3. The pharmacist shall assist the facility with: d. Reviewing med administration records (MAR) on a quarterly basis .... documenting any concerns, proposing solutions to identified concerns." On 6/17/24 at 12:46 PM, the survey team met with the U.S. FOIA (b) 1 U.S. FOIA (b) (6)), U.S. FOIA (b) (6)),	F 756	Completion Date: 7/5/24	

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F 756	Continued From page 41 U.S. FOIA (b) (6)). The Surveyor notified the facility management of the above findings and concerns. The facility management did not provide any comments at that time. On 6/18/24 at 9:46 AM, the U.S. FOIA (b) and U.S. FOIA met with the survey team with responses to the survey teams concerns. The U.S. FOIA stated, "we were not compliant with the meds, an audit was completed on all residents who were NJ Exec Ord and the U.S. FO will be developing a Quality Assurance and Performance Improvement (QAPI) to assure this does not happen again." No further comments made.	F 756		
F 812 SS=F	NJAC 8:39- 29.3 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		7/5/24

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F 812	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 6/13/24 at 9:15 AM, the surveyor in the presence of the U.S. FOIA (b) (6)) observed the following during the kitchen tour: Upon entering the kitchen the surveyor observed the U.S. FOIA and Dietary Aide #1 (DA#1) both wearing earrings that hung more than one inch (in) from their earlobes. The U.S. FOIA acknowledged both she/he and DA#1 were wearing jewelry that was prohibited in the kitchen area. On 6/17/24 at 9:04 AM, the U.S. FOIA (b) (6) provided the surveyor with a kitchen policy titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, with a revised date of November 2022. Under the policy interpretation and implementation section it states, "Fingernails/Jewelry, 17. Jewelry will be kept to a minimum. Hand jewelry and wrist jeweler are covered with gloves during food handling. On 6/17/24 at 12:46 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) to discuss the above findings and concerns. There were no comments from facility staff.	F 812	No Residents were Identified. The U.S. FOIA (b) (6) and dietary aide (DA#1) were immediately educated on the sanitation policy. All residents have the potential to be affected. All food service employees were educated on appropriate dress code policy. Dietary Staff were educated by the Administrator on Employee hygiene and restrictions in regard to Jewelry. The Dietary Manager or designee will conduct rounds three times weekly to ensure dietary staff are following the Hygiene policy. The administrator/ designee will perform an audit on the employees in the kitchen to ensure the dress code policy is being enforced weekly x4 weeks and then monthly x3 months. Any concerns identified during the audit will be addressed immediately to ensure compliance with professional standards. The results of the audits will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits.	

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F 812	Continued From page 43 On 6/18/24 at 9:46 AM, the U.S. FOIA (b) and U.S. FOIA met with survey team to provide explanations for previous concerns. The U.S. FOIA (b) provided a copy of an in-service for the dietary staff for jewelry and hygiene. No further comments provided. NJAC 8:39-17.2(g)	F 812	Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits	
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility provided documentation, it was determined that the facility failed to ensure that the employed designated U.S. FOIA (b) (6) had completed specialized training in infection prevention and control per Centers for Medicare & Medicaid Services (CMS) guidance	F 882	No Residents were Identified All residents have the potential to be affected. The Infection Preventionist completed the required certification on NJ Exec Order 2.	7/5/24

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F 882	Continued From page 44 prior to assuming the U.S. role for one (1) of one (1) employee reviewed for U.S. F... This deficient practice was evidenced by the following: On 6/14/24 at 12:10 PM, the surveyor reviewed the facility provided signed job description for the U.S. which listed the date of hire as NJ Ex Order 26.4. The U.S. FO job description included the following Educational and Certification Requirements: The U.S. FO job description included the following acknowledgement that was signed by the U.S. and dated NJ Ex Order 26.4: I have read this job description and fully understand that the requirements set forth therein have been determined to be essential to this position (unless otherwise noted in Column 2). I hereby accept the position of U.S. FOIA (b) (6) and agree to perform the tasks outlined in this job description in a safe manner and in accordance with the Center's established procedures. At that same time, the surveyor reviewed the facility provided U.S. FO specialized training certificates for which were dated from. The surveyor then reviewed the facility provided specialized training certificates for 15 modules that had different completion dates from NJ Exec Order 2... . The U.S. did not have the specialized training prior to assumption of the U.S. role. On 6/17/24 at 10:49 AM, in the presence of the U.S. FOIA (b) (6)), the surveyor interviewed the U.S. F... The U.S. confirmed that her date of hire as the facility's U.S. was NJ Ex Order 26.4. The U.S. confirmed that the specialized training certificates were done in NJ Exec Order 26.4b1. She added that she had done some [name redacted] training but had	F 882	The U.S. FOIA (b) (6) was educated to ensure infection preventionists have required certifications prior to extending job offer. The US FOIA (b) (6) in the facility will obtain required infection control certification (Nursing Home Infection Preventionist Training Course) to serve as back up in the event the Infection Preventionist resigns. Administrator will designate one of the nursing leadership as Interim Infection Preventionist until Certified Infection Preventionist is Hired. Regional Director of Infection Prevention will audit facility Monthly for 3 months to Ensure infection Preventionist has required certification. The Audit will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Completion Date: 7/5/24	

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 882	Continued From page 45 not finished the certification. The [U.S.] did not provide documentation of any additional training. On 6/17/24 at 12:47 PM, in the presence of the survey team, the surveyor notified the [U.S. FOIA (b) (6)]), [U.S. FOIA (b)] U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), the concern that the [U.S.] did not have specialized training prior to assuming the role of [U.S. F] On 6/18/24 at 9:55 AM, in the presence of the survey team and [U.S. FOIA (b)] the [U.S. FOIA (b)] stated that the [U.S.] started as the [U.S.] after the date of hire that was on the job description. She added that when the facility was acquired by a new company the staff had new job descriptions done. The surveyor asked the [U.S. FOIA (b)] that if the [NJ Ex Order 26.4] [U.S.] job description dated [NJ Ex Order 26.4] was not for function of [U.S.] then should the job description signed indicate a different job description. The [U.S. FOIA (b)] added that she was not the [U.S. FOIA (b)] at that time. On 6/18/24 at 12:32 PM, the surveyor reviewed a timeline for [U.S.] that the facility provided. The timeline did not reflect the same information that the signed [U.S.] job description dated [NJ Ex Order 26.4] by the current [U.S.] that the facility provided prior to the timeline. A review of the facility provided policy titled "Infection Preventionist" with a revised date of September 2022, included the following: Specialized Training 1. The infection preventionist has obtained specialized IPC training beyond initial professional training or education prior to assuming the role.... 2. Evidence of training is provided through a	F 882		

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F 882	Continued From page 46 certificate(s) of completion or equivalent documentation. N.J.A.C. 8:39-19.1(b)	F 882		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ172611 REPEAT DEFICIENCY Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	No Residents were identified All Residents have the Potential to be Affected The Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for the next day, and staffing for upcoming week. The facility has developed a Culture Committee focused on recruitment. and retention of staff along with customer service and the employee experience. The facility has implemented the Care	7/5/24

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

Electronically Signed | 07/05/24

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in	S 560	Champion Program to mentor new employees which has been proven to raise retention rates. The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. The facility conducts an exit interview with any employee who resigns to better improve the employee experience and help with retention. The facility has implemented processes to increase communication with employees through monthly town hall meetings. The facility has contracts in place with multiple staffing agencies as an effort to provide staff when needed Trends identified from the daily staffing meeting between Director of Nursing, Administrator and Staffing coordinator will be presented during monthly Quality Assurance Meeting. Starting July 2024 the Administrator/designee will review the minutes from monthly resident council meetings for 3 months to determine whether there are any concerns regarding care and services. The Administrator/designee will interview five residents weekly for 4 weeks and then monthly for an additional 3 months to determine if needs are being met.	

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S 560	Continued From page 2 subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period beginning 3/31/2024 and ending 4/06/2024 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 7 of 7-day shifts, 1 of 7-evening shifts, and 3 of 7-night shifts as follows: 03/31/24 had 5 CNAs for 100 residents on the day shift, required at least 12 CNAs. 04/01/24 had 5 CNAs for 99 residents on the day shift, required at least 12 CNAs. 04/02/24 had 5 CNAs for 99 residents on the day shift, required at least 12 CNAs. 04/02/24 had 6 total staff for 99 residents on the overnight shift, required at least 7 total staff. 04/03/24 had 4 CNAs for 99 residents on the day shift, required at least 12 CNAs.	S 560	The results of the audits will be reviewed by the Quality Assurance Committee. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits. Completion Date: 7/5/24	

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S 560	Continued From page 3 04/04/24 had 7 CNAs for 99 residents on the day shift, required at least 12 CNAs. 04/05/24 had 4 CNAs for 99 residents on the day shift, required at least 12 CNAs. 04/05/24 had 9 total staff for 99 residents on the evening shift, required at least 10 total staff. 04/05/24 had 6 total staff for 99 residents on the overnight shift, required at least 7 total staff. 04/06/24 had 6 CNAs for 99 residents on the day shift, required at least 12 CNAs. 04/06/24 had 6 total staff for 99 residents on the overnight shift, required at least 7 total staff. 2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period beginning 4/28/2024 and ending 5/04/2024 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 7 of 7-day shifts, 2 of 7 evening shifts, and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: 04/28/24 had 2 CNAs for 99 residents on the day shift, required at least 12 CNAs. 04/28/24 had 6 total staff for 99 residents on the evening shift, required at least 10 total staff. 04/28/24 had 1 CNA to 6 total staff on the evening shift, required at least 3 CNAs. 04/29/24 had 6 CNAs for 99 residents on the day shift, required at least 12 CNAs. 04/29/24 had 8 total staff for 99 residents on the evening shift, required at least 10 total staff. 04/30/24 had 7 CNAs for 99 residents on the day shift, required at least 12 CNAs. 05/01/24 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs.	S 560		

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S 560	Continued From page 4 05/02/24 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. 05/03/24 had 5 CNAs for 99 residents on the day shift, required at least 12 CNAs. 05/04/24 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. 3. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 5/26/2024 and ending 6/08/2024 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for CNA staffing for residents on 14 of 14 day shifts and in the total staff for residents on 5 of 14 overnight shifts as follows: 05/26/24 had 5 CNAs for 111 residents on the day shift, required at least 14 CNAs. 05/27/24 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. 05/28/24 had 8 CNAs for 109 residents on the day shift, required at least 14 CNAs. 05/28/24 had 7 total staff for 109 residents on the overnight shift, required at least 8 total staff. 05/29/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. 05/30/24 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. 05/31/24 had 6 CNAs for 108 residents on the day shift, required at least 13 CNAs. 05/31/24 had 7 total staff for 108 residents on the overnight shift, required at least 8 total staff. 05/01/24 had 8 CNAs for 108 residents on the day shift, required at least 13 CNAs. 05/01/24 had 7 total staff for 108 residents on the overnight shift, required at least 8 total staff. 06/02/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs.	S 560		

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S 560	Continued From page 5 06/02/24 had 5 total staff for 108 residents on the overnight shift, required at least 8 total staff. 06/03/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. 06/04/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. 06/05/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. 06/06/24 had 6 CNAs for 105 residents on the day shift, required at least 13 CNAs. 06/07/24 had 6 CNAs for 107 residents on the day shift, required at least 13 CNAs. 06/07/24 had 7 total staff for 107 residents on the overnight shift, required at least 8 total staff. 06/08/24 had 6 CNAs for 107 residents on the day shift, required at least 13 CNAs. On 6/18/24 at 11:58 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding staffing. The LNHA stated that she was aware of the mandated CNA ratios. The LNHA stated the facility was working to improve staffing including retaining hired staff and reducing employee turnover. The LNHA further stated the facility had a recruiter and recruitment calls are followed up weekly. The LNHA explained she was working closely with the staff coordinator to monitor call outs and staffing levels to further address staffing concerns. A review of the facility provided policy titled, "Staffing- New Jersey" dated April 5, 2022, read under Policy Interpretation and Implementation: " ... 3. NJ 30:13-18 requires the following minimum direct care staff to resident ratios: a. Day shift: one (1) CNA to every eight (8) residents. b. Evening shift: one (1) direct care staff member	S 560		

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S 560	Continued From page 6 to every 10 residents, provided that no fewer than half of all staff members are CNAs, and each staff member shall be signed in to work as a CNA and perform CNA duties. c. Night shift: one (1) direct care staff member to every fourteen (14) residents, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties ..." On 6/18/24 at 01:15 PM, the surveyor informed the LNHA of the above concerns for staffing. There was no additional information provided by the facility.	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. 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 residents two evening activity programs per week. This deficient practice was identified for two (2) of three (3) months reviewed, May 2024, and June 2024 as evidenced by the following: On 6/14/24 10:43 AM, the surveyor observed the facility's activity calendar on a bulletin board on the south unit. The calendar did not have two evening activities for each week of June 2024. The week of June 2, 2024 did not have any evening activity listed on the calendar.	S 720	No Residents were identified. All residents have the potential to be affected. Two evening activities a week were added to the activity calendar and all future calendars. The life enrichment director must make the administrator aware if there is an issue with coverage to plan for alternate coverage. The Life Enrichment Director was educated on the requirement to have	7/5/24

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S 720	Continued From page 7 On 6/14/24 at 10:44 AM, the surveyor interviewed the Director of Life Enrichment (DoLE) regarding the facility's activities and requested a copy of April, May and June 2024 facility's activity calendars. On 6/14/24 at 10:53 AM, in the presence of the DoLE, the surveyor reviewed the provided calendars which included the following: April 2024 had two evening activities each week. May 2024 had one evening activity for the weeks of May 5, May 12 and May 26, 2024. The week of May 19, 2024 had no evening activity. June 2024 had no evening activity the week of June 2, 2024. On that same date and time, the DoLE stated that she had an employee leave and that she had to hire someone and that was the reason there was not two evening activities each week. The DoLE stated that she did not have the coverage but that she tried. On 6/17/24 at 12:47 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations/Registered Nurse (RDoO/RN) and Administrator in Training (AIT), the concern that the facility did not have two evening activities each week. On 6/18/24 at 9:45 AM, in the presence of the survey team and the DON, the LNHA stated that she educated the DoLE that she must provide coverage for activities at night. She added that the DoLE must notify her if there was no coverage. The LNHA stated that they had a resignation without enough notice and the staff	S 720	at least two evening Activities per week. In the event of a gap in coverage for evening activities the Life Enrichment Director will conduct the Evening Programs. The life enrichment Direct will provide a Calendar with evening activities and the staff member responsible to the Administrator weekly. The administrator will audit each calendar monthly to ensure that the calendar is in compliance. The administrator will audit each calendar monthly to ensure that the evening activities are scheduled. The Administrator will audit 2 evening activities monthly to ensure they are occurring. The results of the audits will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.	

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S 720	Continued From page 8 tried to cover. The facility did not provide any additional information. A review of the undated facility provided policy titled, "Activity Programs" included the following: 12. Individualized and group activities are provided that: ... b. are offered at hours convenient to the residents, including evenings, holidays and weekends; ...	S 720		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.	S1410		7/5/24

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S1410	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on the review of employee files and interview with the Licensed Nursing Home Administrator (LNHA), it was determined that the facility failed to provide evidence of timely NJ Ex Order 26.4(b)(1)) screening for six (6) of 10 employees who had not had screenings before their hire dates. The deficient practice was evidenced by the following: 1. Licensed Practical Nurse was hired on NJ Ex Order 26.4 and did not have a NJ Ex screening. 2. Certified Nursing Assistant #1 (CNA#1) was hired on NJ Ex Order 26.4 and did not have a NJ Ex screening. 3. Dietary Aide was hired on NJ Ex Order 26.4 and did not have a NJ Ex screening. 4. Housekeeper was hired on NJ Ex Order 26.4(b and did not have NJ Ex screening. 5. CNA #2 was hired on NJ Ex Order 26.4 and did not have a NJ Ex screening. 6. CNA #3 was hired on NJ Ex Order 26.4 and did not have a NJ Ex screening. On 6/18/24 at 01:15 PM, the surveyor interviewed the LNHA regarding pre-employment NJ Ex screening. The LNHA acknowledged that the above employees have a copy of the NJ Ex screening with them, and the facility contacted the employees to obtain their copies. The LNHA agreed that a copy of the NJ Ex test should have been included in the employee files.	S1410	No Residents were identified. All residents have the potential to be affected. All new hires from NJ Exec Order 26.4b1 were audited for appropriate NJ Exec Order 26.4b1 screening. Variances were addressed. The Human Resources Director performed an audit on all current employees that were hired in the last NJ Exec Or for appropriate NJ Exec Order 26.4b1 screening. The Assistant Director of Nursing and the Human Resources Director were educated by the Administrator regarding the requirement that all newly hired employees must have tuberculosis screening started prior to start date. The assistant Director of nursing/ designee will screen new hires prior to employment to ensure appropriate Tuberculosis testing and screening is being completed. The Director of Nursing will review New Hire paperwork prior to start date to ensure tuberculosis screening is completed. The Administrator will audit all new hires every week for all departments weekly x4 and monthly to ensure compliance with tuberculosis screening.	

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ALLENDALE REHABILITATION AND HEALTHCARE CI	85 HARRETON ROAD ALLENDALE, NJ 07401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1410	Continued From page 10 At that same time, the LNHA provided the undated facility policy for Tuberculosis, Employee screening. As stated under the policy, "All employees are screened for latent tuberculosis infection (LTBI) and active tuberculosis infection (LTBI), using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment." On 6/18/24 at 01:50 PM, the survey team met with the facility's LNHA, Director of Nursing, Regional Director of Operations/ Registered Nurse, and Administrator in Training and discussed the above concern. No additional information was provided.	S1410	The results of the audits will be submitted monthly to the quality Assurance committee for review and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.	

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
315497 Y1	A. Building B. Wing Y2	8/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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	F0609	Correction	ID Prefix	F0610	Correction	ID Prefix	F0625	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.12(c)(2)-(4)	Completed	Reg. #	483.15(d)(1)(2)	Completed
LSC		07/05/2024	LSC		07/05/2024	LSC		07/05/2024
ID Prefix	F0641	Correction	ID Prefix	F0645	Correction	ID Prefix	F0658	Correction
Reg. #	483.20(g)	Completed	Reg. #	483.20(k)(1)-(3)	Completed	Reg. #	483.21(b)(3)(i)	Completed
LSC		07/05/2024	LSC		07/05/2024	LSC		07/05/2024
ID Prefix	F0692	Correction	ID Prefix	F0756	Correction	ID Prefix	F0812	Correction
Reg. #	483.25(g)(1)-(3)	Completed	Reg. #	483.45(c)(1)(2)(4)(5)	Completed	Reg. #	483.60(i)(1)(2)	Completed
LSC		07/05/2024	LSC		07/05/2024	LSC		07/05/2024
ID Prefix	F0882	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.80(b)(1)-(4)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		07/05/2024	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?
6/21/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060201	A. Building B. Wing	8/20/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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 07/05/2024	ID Prefix S0720 Reg. # 8:39-7.3(d) LSC	Correction Completed 07/05/2024	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 07/05/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/21/2024	☐ 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
	315497	A. BUILDING **01** B. WING _____	**06/21/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD** **ALLENDALE, NJ 07401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 06/21/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 06/21/24 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Allendale Rehabilitation and Healthcare Center is a one-story building that was built in 1967 and is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does approximately 100 % of the building per the U.S. FOIA (b) (6). The current occupied beds are 101 of 114.	K 000		
K 324 SS=F	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 appliances such as microwaves, hot plates, toasters) are used for food warming or limited	K 324		7/5/24

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

Electronically Signed | 07/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING **01** B. WING _____	**06/21/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD** **ALLENDALE, NJ 07401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 1 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 document review, observation, and interview, the facility failed to ensure the kitchen's automatic fire-extinguishing system was inspected at least semi-annually in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 edition) section 11.2.1. This deficient practice had the potential to affect all 101 residents who resided at the facility. Findings include: A review of the facility's "Kitchen Automatic Fire System Reports," provided by the facility, revealed the fire-extinguishing system was inspected on 01/03/24 and 01/04/23 no inspection report for September 2023. An observation on 06/21/24 at 12:30 PM of the	K 324	No Residents were Identified. All residents have the potential to be affected. An audit was done to ensure all life safety inspections were completed. No discrepancies were identified. The Administrator educated the U.S. FOIA (b) (6) [redacted] on ensuring required inspections are completed in a timely manner. The Maintenance Director will keep a log of required inspections and the date the inspections were completed. The administrator or designee will audit the Maintenance preventative checklist weekly x4 weeks and then monthly X2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING **01** B. WING _____	**06/21/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD** **ALLENDALE, NJ 07401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 2 automatic extinguishing system revealed the inspection tag was for January 2024 and no indication of an inspection in September 2023. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the kitchen's automatic fire-extinguishing system was not inspected semi-annually. The U.S. FOIA (b) (6) stated that the automatic extinguishing company was going through bankruptcy and that is why they did not do the inspection in September 2023. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	The results of the audits will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure nonmetallic sheathed cable (brand name NJ Ex Order 26.4 was concealed within walls, floors, or ceilings that provided a thermal barrier of material that had at least a 15-minute finish rating as identified in listings of fire-rated	K 511	No residents were identified. All residents have the potential to be affected.	7/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING **01** B. WING _____	**06/21/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD** **ALLENDALE, NJ 07401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 3 assemblies in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 334.10 (3) (5). This deficient practice had the potential to affect all 101 residents who resided at the facility. Findings include: An observation on 06/21/24 at 1:24 PM revealed nonmetallic sheathed cable was exposed in the sprinkler room coming out of the flow and tamper switches and not protected by a 15-minute fire rating finish. During an interview at the time of the observation, the U.S. FOIA (b) (6) verified the nonmetallic sheathed cable was not protected by a 15-minute fire rating. NJAC 8:39-31.2(e) NFPA 70	K 511	A comprehensive building inspection was completed by the maintenance director to identify if any other metallic sheath cable was in use. The maintenance director replaced the non-metallic sheathed cable with a BX wire. The Maintenance Director will add to the maintenance preventive checklist to check for nonmetallic sheathed cable. The administrator or designee will audit the Maintenance preventative checklist weekly x4 weeks and then monthly X2 months. The results of the audits will be submitted monthly to the Administrator for review at the monthly Quality Assurance meeting and quarterly to the Quality Assurance Committee for review and action, as appropriate. The Quality Assurance Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the Quality Assurance committee will determine the continuation of the audits.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315497	A. Building 01 - ALLENDALE NURSING HOME B. Wing	8/20/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 07/05/2024	ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 07/05/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/21/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO