| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315483 | A. BUILDING _____ B. WING _____ | C 01/25/2024 |

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| PLAZA HEALTHCARE & REHABILITATION CENTER | 456 RAHWAY AVENUE ELIZABETH, NJ 07202 |

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| F 000 | INITIAL COMMENTS<br><br>A Recertification and Complaint survey was conducted on behalf of the New Jersey Department of Health.<br><br>Complaint #: NJ154369, NJ160128, NJ160566, NJ164368, NJ169301<br><br>Survey Dates: 01/22/24 through 01/25/24<br>Survey Census: 89<br>Sample Size: 35<br>Supplemental Residents: 0<br><br>THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§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 | F 609 | | 2/5/24 |

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

Electronically Signed | 02/07/2024

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

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| F 609 | Continued From page 1<br>for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, interviews, and facility policy review, the facility failed to inform the New Jersey Department of Health (NJDOH) of one of NJ ex order 26.4b1 reviewed for Resident (R)73 and R41 on NJ ex order 26.4b1 within the mandated two-hour period of 35 sample residents.<br><br>Findings include:<br><br>Review of the "Investigation Summary" provided by the facility, dated NJ ex order 26.4b1, revealed the incident occurred on NJ ex order 26.4b1 The residents were questioned on NJ ex order 26.4b1 R41 had no recollection of the event and stated, NJ ex order 26.4b1 R73 stated he NJ ex order 26.4b1, and R41 NJ ex order R73 stated he [R73] opened the door and R41 [R73] in the The investigation concluded NJ ex order 26.4b1 and NJ ex NJ ex order 26.4b1 NJ ex order 26.4b1 The summary was signed by the then Director of Nursing (DON)2 NJ ex order 26.4b1 NJ ex order 26.4b1 and the US FOIA (B) (6) on NJ ex order 26.4b1 and | F 609 | 1. Reportable was called in and faxed to the New Jersey Department of Health on 5/22/2023<br><br>2. All residents have the potential to be affected by the facility not reporting alleged abuse within 2 hours.<br><br>3. The US FOIA (B) (6) reviewed and in serviced the US FOIA (B) (6) and Nurse Supervisors regarding the importance of reporting within the proper time frame.<br><br>4. The US FOIA (B) (6) or designee will monitor for two months that all reportable events are reported within the proper timeframe. All findings will be reported at the next quarterly quality assurance meeting | |

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| F 609 | Continued From page 2<br>faxed to the New Jersey Department of Health (NJDOH) on [redacted].<br><br>During an interview on 01/24/24 at 11:40 AM, the [redacted] stated she began the [redacted] on Monday, [redacted], after she heard about the [redacted]. The [redacted] stated she could not say if anyone else was called within two hours after the nurse heard the [redacted] on [redacted], but she [redacted] began the investigation on the following Monday.<br><br>During an interview on 01/24/24 at 12:15 PM, Licensed Practical Nurse (LPN)2 stated she called the Director of Nursing (DON)2 immediately after the [redacted] between R41 and R73 had occurred.<br><br>Review of the "Reportable Event Record/Report" provided by the facility, dated and faxed to the State on [redacted], indicated the [redacted] occurred at 4:20 PM on [redacted]. The report indicated the [redacted] and was not called in. The report indicated the [redacted] " box was checked under the "Type of Incident" section.<br><br>During an interview on 01/24/24 at 1:50 PM, the [redacted] stated he was not informed of the incident on the Saturday night of the incident. The [redacted] stated he did not answer phones or other communications on the Saturday Sabbath. He found out about the incident on the following Monday and began the process. He agreed the DON2 was called the night of the incident, as LPN2 stated in an earlier interview. The [redacted] agreed the NJDOH should have been informed within two hours of the [redacted] | F 609 | | |

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| F 609 | Continued From page 3<br><br>Review of the facility's policy titled, "Abuse and Neglect," with a revision date of December 2023, revealed "It is the policy of this Center that procedures are in place to prevent any incidence of abuse, neglect, mistreatment, or misappropriation of resident's property. If any actual or alleged incidents occur there is a process in place for the reporting and investigation; pursuant to the instruction in Federal and Long-Term Care statutes." The policy further indicated for identifying abuse: a. All personnel will be instructed/educated on the importance of identifying events. Identifying events: i.e., bruising of unknown origin (Please refer to "Types of Abuse" at the end of this policy.) b. Anyone witnessing abuse and/or hearing an allegation of abuse must report the incident immediately to their immediate supervisor and the nursing supervisor. c. The supervisor will then report to the Administrator, Nursing Director, and Social Service Director. The policy indicated for initial reporting that all cases involving residents over sixty, alleged abuse, neglect, or exploitation will be reported to the Ombudsman Office, and all appropriate authorities will be notified, "as directed in Federal and State statutes."<br><br>NJAC 8:39-9.4(f) | F 609 | | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination | F 644 | | 2/5/24 |

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| F 644 | Continued From page 4<br>includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and facility policy review, the facility failed to ensure one of five residents (Residents (R) 46) reviewed for NJ Exec Order 26.4b1 had a NJ ex order 26.4b1 updated upon receipt of NJ ex order 26.4b1 NJ ex order 26.4b1 of 35 sample residents. This failure placed residents at risk for unmet care needs and not receiving appropriate and necessary NJ Exec Order 26.4b1<br><br>Findings include:<br><br>Review of R46's undated "Admission Record" from the electronic medical record (EMR) "Profile" tab showed a facility admission date of NJ ex order 26.4b1 with medical diagnoses of NJ ex order 26.4b1<br><br>Review of R46's undated "Admission Record" from the EMR "Diagnosis" tab revealed a diagnosis of NJ ex order 26.4b1 was added on NJ ex order 26.4b1; NJ ex order 26.4b1, NJ ex order 26.4b1 the | F 644 | 1. Resident 46 NJ Ex Order 26 was updated immediately with the proper diagnosis.<br><br>2. All residents have the potential to be affected by the Passar not being updated upon reciept of a new serious mental health diagnosis.<br><br>3. The Administrator in serviced the US FOIA (b)(6) regarding the importance of updating the Passar upon receipt of a new mental health diagnosis.<br><br>4. The Administrator or designee will monitor weekly for two months that all Passars are properly updated. All findings will be reported at the next quarterly quality assurance meeting. | |

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| F 644 | Continued From page 5 | F 644 | | |

diagnosis NJ ex order 26.4b1 was added on NJ ex order 26.4b1; and the diagnosis of NJ ex order 26.4b1 NJ ex order 26.4b1 was added on NJ ex order 26.4b1.

Review of R46's EMR "Miscellaneous" tab showed a NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 that NJ ex order 26.4b1

During an interview on 01/23/24 at 4:01 PM, in response to a request for a NJ ex order 26.4b1 the US FOIA (b)(6) provided R46's NJ ex order 26.4b1, dated NJ ex order 26.4b1 When R46's EMR "Diagnosis" tab was reviewed, the US FOIA (B) (6) stated, "Oh, it should have been resubmitted."

During an interview on 01/24/24 at 10:59 AM, the US FOIA (B) (6) stated R46's NJ ex order 26.4b1 was received from the NJ ex order 26.4b1 on NJ ex order 26.4b1. When the NJ ex order 26.4b1 one was reviewed and NJ ex order 26.4b1 NJ ex order 26.4b1, the (US FOIA (b) stated, "That should have been corrected." When R46's EMR "Diagnosis" tab was reviewed and the US FOIA (b saw the NJ ex order 26.4b1 diagnoses, US FOIA (b stated, "Yes, it should have been updated with the correct diagnosis."

Review of the facility's policy titled, "PASARR," dated December 2023, showed: "The purpose of the Preadmission Assessment and Annual Resident Review Program (PASARR) policy and procedure is to develop guidelines for admission related to those individuals with mental illness and intellectual disabilities to ensure they receive the care and services needed in the most appropriate setting ..." The policy did not address an incorrect admission screening or the

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| F 644 | Continued From page 6<br>screening resubmission if a serious mental health diagnosis was received after admission.<br><br>NJAC 8:39-40.3(d) | F 644 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes. | F 656 | | 2/5/24 |

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| F 656 | Continued From page 7<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, the facility failed to develop a comprehensive person-centered care plan with goals and approaches for three of three residents (Residents (R) 32, R33, and R71) reviewed for NJ ex order 26.4b1 and one of three residents (R71) reviewed for NJ ex order 26.4b1 of 35 sample residents.<br><br>Findings include:<br><br>1. Review of R32's undated "Admission Record" from the electronic medical record (EMR) under the "Profile" tab, showed a facility admission date of NJ ex order 26.4b1, NJ ex order 26.4b1 on NJ ex order 26.4b1, with medical diagnoses that included NJ ex order 26.4b1 NJ ex order 26.4b1, and NJ ex order 26.4b1.<br><br>Review of R32's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, located in the "MDS" tab of | F 656 | 1. Care plan for NJ ex order 26.4b1 Use was developed for Residents 32, 33 and 71. Resident 71 also had a Care plan developed for NJ ex order 26.4b1.<br><br>2. All residents have the potential to be affected by a care plan not being developed for Side Rail Use and Limited Range of Motion.<br><br>3. The Nurses and US FOIA (B) (6) were In Serviced by the Director of Nursing regarding the importance of having a Care Plan developed for Side Rail Use and Limited Range of Motion.<br><br>4. The Director of Nursing or designee will monitor weekly for two months that all residents requiring Care Plans for Side Rail Use and Limited Range of Motion are properly developed. All findings will be reported at the next quarterly quality assurance meeting. | |

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| F 656 | Continued From page 8<br>the EMR, showed R32 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1<br><br>Review of R32's "Care Plan" from the EMR "Care Plan" tab, showed NJ ex order 26.4b1 were not addressed in any area of the plan of care.<br><br>During an observation on 01/22/24 at 12:17 PM, R32 was in bed, with an NJ ex order 26.4b1, being NJ ex order 26.4b1 during lunch with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 where an aide was seated.<br><br>During an observation on 01/25/24 at 8:08 AM and 9:15 AM, R32 was observed on an NJ ex NJ ex order 26.4b1 with NJ ex order 26.4b1 in the NJ Exec Order 26.4b1.<br><br>2. Review of R33's undated NJ ex order 26.4b1 from the EMR "Profile" tab showed an admission date of NJ ex order 26.4b1 with medical diagnoses that include NJ ex order 26.4b1 .<br><br>Review of R33's quarterly "MDS" with an ARD of NJ ex order 26.4b1, located in the "MDS" tab of the EMR, showed R33 had a "Brief Interview for Mental Status (BIMS)" score of NJ ex out of a possible 15, indicative of being NJ ex order 26.4b1, and NJ ex ord<br><br>Review of R33's "Care Plan" from the EMR "Care Plan" tab showed the NJ ex order 26.4b1 was not addressed in any area of the plan of care.<br><br>During an observation and interview on 01/22/24 at 12:21 PM, R33 stated had been in the | F 656 | | |

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facility for NJ Exec Order 26.4b1. It was observed that [redacted] had NJ ex order 26.4b1. When asked, R33 stated NJ ex order 26.4b1 when asked if anyone had advised [redacted] of the risks and benefits of NJ ex ord NJ ex ord (NJ Exec Order 26.4b1 [redacted]), R33 stated [redacted] had not been advised of any risks or benefits.

During an observation on 01/25/24 at 8:10 AM and 9:15 AM, R33 was asleep in bed with NJ ex order 26.4b1.

During an interview on 01/25/24 at 2:15 PM, the US FOIA (B) (6) stated, "The admission nurse starts the care plan and then all the departments do their own part. Then when I do the US FOIA (B [redacted] I check out the care plan to make sure everything is in there." When asked if NJ ex order 26.4b1 would/should be care planned, US FOIA (B) (6 responded, "They NJ ex order 26.4b1 ] would be in ADLs [activities of daily living] NJ ex order 26.4b1." US FOIA (B) (6 reviewed R32's care plan at 2:22 PM and commented that the NJ ex ord should be in one of those ADL areas, then confirmed NJ ex order 26.4b1 were not present in R32's care plan. At 2:25 PM, US FOIA (B) (6 reviewed R33's care plan and confirmed bed rails were not present. When queried why NJ ex order 26.4b1 should be care planned, US FOIA (B) (6 replied, NJ ex order 26.4b1 [redacted]

3. a. Review of R71's quarterly "MDS" with an ARD of NJ ex order 26.4b1, located in the "MDS" tab of the EMR, revealed R71 had an admission date of NJ ex order 26.4b1. R71 had no BIMS score, and cognition was NJ ex order 26.4b1. R71 NJ ex order 26.4b1 [redacted]

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| F 656 | Continued From page 10<br>NJ ex order 26.4b1 was NJ ex order 26.4b1 when NJ ex order 26.4b1<br><br>Review of R71's care plan located in the EMR under the "Care Plan" tab, dated NJ ex order 26.4b1, revealed "R71 has an ADL self-care performance deficit r/t [related to] NJ ex order 26.4b1 NJ ex order 26.4b1 and an intervention which included NJ ex order 26.4b1 NJ ex order 26.4b1<br><br>Review of R71's NJ ex order 26.4b1 provided by the facility, dated NJ ex order 26.4b1 revealed "3. NJ ex order 26.4b1 "5. NJ ex order 26.4b1 "10. NJ ex order 26.4b1 ." Alternatives included "2 NJ ex order 26.4b1 " and "3. NJ ex order 26.4b1 ." Recommendations included "1. NJ ex order 26.4b1 a. NJ ex order 26.4b1 b. NJ ex order 26.4b1." "NJ ex order 26.4b1 "5a. NJ ex order 26.4b1, a. NJ ex order 26.4b1, b. NJ ex order 26.4b1, 5b. NJ ex order 26.4b1 b. NJ ex order 26.4b1." The assessment did not include the risk of NJ Exec Order 26.4b1 or what condition the NJ Exec Order 26.4b1 were needed for.<br><br>Review of R71's order located in the EMR under the "Orders" tab, dated NJ ex order 26.4b1, revealed "NJ ex order 26.4b1 ."<br><br>During an observation on 01/23/24 at 9:46 AM, | F 656 | | |

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| F 656 | Continued From page 11 | F 656 | | |

R71 was observed in bed with the [NJ ex order 26.4b1] in the [NJ Exec Order 26.4b1] on both sides of the bed.

During an observation on 01/24/24 at 9:08 AM, R71 was observed in bed with [NJ ex order 26.4b1] in the [NJ Exec] on both sides of the bed.

During an observation on 01/25/24 at 8:01 AM, R71 was observed in bed with [NJ ex order 26.4b1] in the [NJ Exec] on both sides of the bed.

During an interview on 01/25/24 at 2:15 PM, the [US FOIA (B) (6] was asked about care plan development. [US FOIA (B] stated the admitting nurse started the care plans and the department heads developed their own care plans specific to their area. The [US FOIA (b)(6)] stated when she reviewed the care plans, she would add interventions if she noticed they were missing. [US FOIA (B) (6] was asked about the [NJ ex order 26.4b] care plans. The [US FOIA (B) (6] stated the [NJ ex order 26.4b1] were included only as an intervention and not a full care plan with goals and objectives saying, "the [NJ Exec Order 26.4b] are just under ADLs and not as a problem." The [US FOIA (B) (6] was then asked should the [NJ Exec Order 26.4b] be fully care-planned if an assessment was conducted. The [US FOIA (B) (6] stated "yes, for safety from danger of [NJ Exec Ord] and [NJ Exec Order 26.4b1] The [US FOIA (B) (6] was asked if [NJ ex order 26.4b1] could present a danger should R71's care plan only address the [NJ ex order 26.4b1] as only an intervention and not a full care plan with a focus area, goals, and interventions. The [US FOIA (B) (6] stated, "yes it should be fully care planned."

3. b. Review of R71's quarterly "MDS," with an ARD date of [NJ ex order 26.4b1], located in the "MDS" tab of the EMR, revealed R71 had an admission date of [NJ ex order 26.4b1]; had no "BIMS score, [NJ ex order 26.4b1] [NJ ex order 26.4b1]

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| F 656 | Continued From page 12<br>the NJ ex order 26.4b1 [redacted]<br><br>Review of R71's care plan located in the EMR under the "Care Plan" tab, dated NJ ex order 26.4b1 revealed "R71 NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted]"<br>and an intervention included NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted]<br><br>Review of R71's order located in the EMR under the "Orders" tab, dated NJ ex order 26.4b1, revealed " NJ ex order 2 [redacted] NJ ex order 26<br><br>Review of R71's Medication Administration Review (MAR), dated NJ ex order 2, located in the EMR under the "Orders" tab, revealed NJ ex order 26.4b1 to NJ ex order 26.4b1 for day and evening shifts the right-hand NJ ex order 26.4b1. The only day the NJ ex order was not marked as applied was on NJ ex order 26.4b1 when the MAR was coded as NJ ex [Other / See Progress Notes].<br><br>Review of R71's progress notes located in the EMR under the "Progress Notes" tab revealed notes dated NJ ex order 26.4b1 did not include a note related to R71's NJ ex order 26.4b1. No note dated NJ ex order 26.4b1 was found for the MAR related to the NJ ex code.<br><br>During an observation on 01/23/24 at 10:32 AM, R71 was observed in her NJ ex order 26.4b1 in room. R71 did not have a NJ ex order in place on NJ ex ord<br>NJ ex order 2 | F 656 | | |

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| F 656 | Continued From page 13<br><br>During an observation on 01/23/24 at 1:11 PM and at 1:36 PM, R71 was observed in [redacted] NJ ex order 26.4b1 in [redacted] room. R71 did not have a [redacted] NJ ex order in place on [redacted] NJ ex order 26.4b1. A [redacted] NJ ex order was observed on the bed next to R71.<br><br>During an observation on 01/24/24 at 10:32 AM, R71 was observed in [redacted] NJ ex order 26.4b1 in [redacted] room. R71 did not have a [redacted] NJ ex order in place on [redacted] NJ ex order [redacted] NJ ex order [redacted].<br><br>During an interview on 01/24/24 at 10:47AM, the US FOIA (B) (6) was asked about R71's NJ ex order 26.4b1. The US FOIA (B) stated R71 was NJ ex order 26.4b1 to encourage R71 to NJ ex order 26.4b1. The US FOIA (B) went on to say R71 was noncompliant with it. The US FOIA (B) stated R71 NJ ex order 26.4b1. The US FOIA (B) was asked if R71 refused to wear the NJ ex order, should staff document [redacted] refusals. The US FOIA (B) stated, NJ ex order 26.4b1 NJ ex order 26.4b1." The US FOIA (B) stated the NJ ex order 26.4b1<br><br>During an observation and interview on 01/25/24 at 10:30 AM, R71 was observed awake in [redacted] NJ ex order 26.4b1 in [redacted] room not wearing a NJ ex order 26.4b1 on the right hand. Nurse Aide (NA)2 was observed in R71's room. At 10:32 AM, NA2 was asked if she cared for R71 and if she got R71 out of bed this morning. NA2 stated, [redacted] NJ ex order" NA2 was then asked why R71 NJ ex order 26.4b1. NA2 stated because R71 NJ ex order 26.4b1. NA2 went on to say R71 NJ ex order 26.4b1. NA2 stated "when this happens, I report it to the nurse." NA2 stated she was R71's nurse aide on NJ ex order 26.4b and [redacted] NJ ex order 26.4b and R71 NJ ex order 26.4b1 | F 656 | | |

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| F 656 | Continued From page 14 | F 656 | | |

During an interview on 01/25/24 at 10:38 AM, the Director of Nursing (DON)1 was asked about R71's NJ ex order who confirmed NJ Exec Order 26.4 The DON1 was asked if R71's NJ ex order 26.4b1 the NJ ex order was care planned. The DON1 stated she would have to check.

During an interview on 01/25/24 at 10:40 AM, Licensed Practical Nurse (LPN)1 was asked why the NJ ex order 26.4b1 MAR reflected R71's NJ ex order 26.4b1 NJ ex when observations of R71 NJ ex order 26.4b1 and NA2 stated R71 NJ ex order 26.4b1. LPN1 stated because "NJ ex order 26.4b1 ." LPN1 stated there was no other way to document it on the MAR.

During an interview on 01/25/24 at 2:25 PM, the US FOIA (B) (6 was asked about R71's NJ ex order 26.4b1 the NJ ex order and if R71's NJ Exec Order should be care planned. The US FOIA (B) (6 stated, " NJ ex o ."

Review of the facility's policy titled, "Comprehensive Care Plans," revised 12/23, revealed "Purpose: 1. To provide nursing care to the resident on a 24-hour basis to ensure that resident care and treatment is planned appropriately for the resident's needs. 2. A comprehensive care plan should be defined as person-centered and comprehensive, developed and implemented to meet individual preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. 3. To document the response to the prescribed plan of care to communicate the resident's condition to the health care team." "5. The Comprehensive Care Plan (CCP) will be reviewed and revised on a quarterly basis, with a significant change in condition, on re-admission from inpatient hospital stay, for any interim problems prior to CCP."

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| F 656 | Continued From page 15<br><br>Review of the facility's policy titled, "Use of Side Rails," dated 12/23, revealed "11.) Care Planning: a.) Interdisciplinary team, once assessment determines appropriateness of side rails will implement interventions supportive of their assessment. b.) Interventions may reflect measures to enhance self-sufficiency or to minimize decline ... d.) care Plan goal and interventions will be reflective of any changes in the resident's medical condition."<br><br>NJAC 8:39-11.2(e) thru (i)<br>NJAC 8:39- 27.1(a),(d) | F 656 | | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing | F 700 | | 2/5/24 |

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| F 700 | Continued From page 16<br>and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, interview, and facility policy review, the facility failed to ensure that three of three residents (Resident (R) 32, R33, and R71) reviewed for NJ ex order 26.4b1 of 35 sample residents had attempted alternatives documented, quarterly and NJ ex order 26.4b1 NJ ex order 26.4b1 completed according to facility policy, and the Resident or Resident Representative (RR) were advised of the risks and/or benefits of NJ ex order 26.4 with an informed consent signed prior to the installation of the NJ Exec [redacted] This failure had the potential for the resident, or the RR be uninformed of the risks associated with NJ Exec Order 26.4b1 and could put the residents at NJ Exec Order 26.4b1.<br><br>Findings include:<br><br>1. Review of R32's undated "Admission Record" from the electronic medical record (EMR) "Profile" tab showed a facility admission date of NJ ex order 26.4b1 and readmission on NJ ex order 26.4b1 with medical diagnoses that included NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted]<br><br>Review of R32's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 located in the "MDS" tab of the EMR, showed a "Brief Interview for Mental Status (BIMS)" score of NJ ex order out of 15, indicative of NJ ex order 26.4b1 .<br><br>During an observation on 01/22/24 at 12:17 PM, R32 was in bed, with an NJ ex order 26.4b1, being | F 700 | 1. NJ ex order 26.4b1, NJ ex order 26.4b1 NJ ex order 26.4b1 and consent was immediately completed for Resident 32,33 and 71.<br><br>2. All residents have the potential to be affected by not attempting to use appropriate bed rail alternative, side rail use assessment and obtaining consent<br><br>3. The Nurses were In Serviced by the Director of Nursing regarding the importance of attempting to use appropriate bed rail alternative, side rail use assessment and obtaining consent from resident or resident representative.<br><br>4. The Director of Nursing or designee will monitor weekly for two months that all residents have been evaluated for appropriate bed rail alternative, side rail use assessment was completed and obtaining consent from resident or resident representative. All findings will be reported at the next quarterly quality assurance meeting. | |

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| F 700 | Continued From page 17 | F 700 | | |

assisted during lunch with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 where an aide was seated.

During an observation on 01/25/24 at 8:08 AM and 9:15 AM, R32 was observed on an NJ ex NJ ex order 26.4b1 with NJ ex order 26.4b1 in the up position.

Review of the "NJ ex order 26.4b1" form for R32 provided by the facility, dated NJ ex order 26.4b1, revealed the following: "A. Factors 1. Is the resident ambulatory? NJ ex o. 2. Is the resident NJ Exec Order 26.4 or NJ Exec Order 26.4b1 NJ ex o. 3. Does the resident has [sic] NJ Exec Order 26.4b1 due to altered NJ Exec Order 26.4b1 NJ ex o. 4. Does the resident has [sic] history NJ Exec Order ? NJ ex o. 5. Does the resident have difficulty NJ Exec Order 26.4b1 ? NJ ex o. 6. Does the resident have NJ Exec Order 26.4b1 of the bed? NJ ex o. 7. Does the resident have the [sic] NJ Exec Order 26.4b1 ? NJ ex o. 8. Does resident have NJ Exec Order 26.4b1 NJ ex o. 9. Does resident take any medication that would require NJ Exec Order 26.4b1 ? NJ ex. 10. Does resident currently in use of [sic] NJ ex order 26.4b1 for NJ Exec Order 26.4b1 NJ ex o. 11. Has the resident or family asked / requested to have NJ Exec Order 26.4b1 [sic]? NJ ex o. B. Alternatives. 1. NJ Exec Order 26. Schedule. 2. Reminders to use call light for assistance [this was marked]. 3 NJ ex order 26.4b1 C. Recommendations. 1 NJ ex order . a. NJ ex order NJ ex o. a. [sic] NJ ex order 26.4b1. b. NJ ex order 26.4b1 NJ ex order 26.4b1 [this was marked]. c. Carry out request. 2. NJ ex order 26.4b1 not indicated at the present time. 3. Evaluation will continue to determine appropriateness. 4. Notes. NJ ex order 26.4b1.

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| F 700 | Continued From page 18<br>5a. NJ ex order 2 a. NJ ex ord b. NJ ex order c. NJ ex order 26.4b1 d. Neither. 5b. NJ ex order a. NJ ex ord b. NJ ex order 26.4b1 NJ ex ord NJ ex order 26.4b1 The last part of the form was a place for a signature (signed by a nurse) and a signature date. No other NJ ex order 26.4b1 were provided by the facility.<br><br>Review of R32's care plan tab, Medication Administration Record (MAR)/ Treatment Administration Record (TAR), miscellaneous tab, and evaluation/ assessments in the EMR revealed no documentation related to the use of alternative measures utilized prior to the use of NJ ex order 26.4b1.<br><br>2. Review of R33's undated "Admission Record" from the EMR "Profile" tab showed an admission date of NJ ex order 26.4b1 with medical diagnoses that included NJ ex order 26.4b1, NJ ex order 26.4b1 a NJ ex order 26.4b1<br><br>Review of R33's quarterly "MDS," with an ARD of NJ ex order 26.4b1, located in the "MDS" tab of the EMR, showed R33 had a "BIMS" score of NJ ex out of 15, indicative of NJ ex order 26.4b1, and NJ ex order 26.4b1 NJ ex order 26.4b1.<br><br>During an observation and interview on 01/22/24 at 12:21 PM, R33 stated NJ ex order 26.4b1 NJ ex order 26.4b1 and it was observed that NJ ex order 26.4b1. When asked, R33 stated NJ ex order 26.4b1; when asked if anyone had advised of the risks and benefits of NJ ex order 26.4b1 NJ Exec Order 26.4b1 R33 stated had not been advised of any risks or benefits. | F 700 | | |

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| F 700 | Continued From page 19 | F 700 | | |

During an observation on 01/25/24 at 8:10 AM and 9:15 AM, R33 was asleep in bed with NJ ex order 26.4b1 in the NJ Exec Order 26.4b1

Review of the "NJ ex order 26.4b1 form for R33 provided by the facility, dated NJ ex order 26.4b1, revealed the following: "A. Factors. 1. Is the resident ambulatory? NJ ex . 2. Is the resident NJ Exec Order 26 or NJ Exec Order 26.4b1 NJ ex . 3. Does the resident has [sic] NJ Exec Order 26.4b1 due to altered NJ Exec Order 26.4b1 NJ ex ord . 4. Does the resident has [sic] history of NJ Exec Or NJ ex . 5. Does the resident have NJ Exec Order 26.4b1 in bed? NJ ex ord . 6. Does the resident have NJ Exec Order 26.4b1 of the bed? NJ ex ord . 7. Does the resident have the [sic] NJ Exec Order 26.4b1 ? NJ ex ord . 8. Does resident have NJ Exec Order 26.4b1 NJ ex ord . 9. Does resident take any medication that would require NJ Exec Order 26.4b1 ? NJ ex . 10. Does resident currently in use of [sic] NJ Exec Order 26.4b for NJ Exec Order 26.4b1 ( NJ Exec Order 26. NJ ex ord . 11. Has the resident or family asked / requested to have NJ Exec Order 26.4b1 ]? NJ ex ord . B. Alternatives. 1. NJ Exec Order 26. Schedule. 2. Reminders to use call light for assistance [this was marked]. 3. NJ ex order 26.4b1 . C. Recommendations. 1. NJ ex ord . a. NJ ex order NJ ex . a. [sic] NJ ex order 26.4b1 . b NJ ex order 26.4b1 c. Carry out request. 2. NJ Exec Order 26.4b1 not indicated at the present time. 3. Evaluation will continue to determine appropriateness. 4. Notes. NJ ex order 26.4b1 . 5a. NJ ex order 2 a. NJ ex order 26.4b1 b. NJ ex order 26.4b1 NJ ex order 26.4b1 c. NJ ex orde d. NJ ex order 26.4 . 5b. NJ ex orde a. NJ ex ord b. NJ ex order 26.4b1 NJ ex order 26.4b1 "
The last part of the form was a place for a signature and a signature date. No other NJ ex order 26.4b

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| F 700 | Continued From page 20 | F 700 | | |

assessments were provided by the facility.

Review of R33's care plan tab, MAR/ TAR, miscellaneous tab, and evaluation/ assessments in the EMR NJ ex order 26.4b1 [redacted]

On 01/24/24 at 2:55 PM, the Administrator and Director of Nursing (DON)1 provided the "[redacted]" form for R32 and R33 and the [redacted] stated there was no risk/benefit statement or consent.

3. Review of R71's quarterly "MDS," with an ARD of [redacted], located in the "MDS" tab of the EMR, revealed R71 had an admission date of [redacted]. R71 had no BIMS score, and [redacted]. R71 [redacted] to the "[redacted] and on the [redacted], [redacted]

Review of R71's care plan located in the EMR under the "Care Plan" tab, dated [redacted] revealed "R71 has an [redacted] and an intervention included [redacted]: [redacted]."

Review of R71's [redacted] assessment provided by the facility, dated [redacted], revealed "3. Does the resident has [sic] NJ Exec Order 26.4b1 [redacted]

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due to NJ Exec Order 26.4b1? NJ ex or," "5. Does the resident have NJ Exec Order 26.4b1 in bed? NJ ex or," "10. Does resident currently use NJ ex order 26.4b1 for NJ Exec Order 26.4b1 or to assist with NJ Exec Order 26.4b1 NJ ex or." Alternatives included "2. Reminders to use call light for assistance" and "3. Restorative care to enhance NJ Exec Order 26.4b1 Recommendations included "1. NJ ex order 26.4b1 are indicated at the present time. a. They will b. NJ ex order 26.4b1." 'NJ ex order 26.4b1 included "5a. NJ ex order 2, a. NJ ex or, b. NJ ex order 5b. NJ ex order b. NJ ex order 2. The assessment did not include the risk of entrapment or what condition the NJ ex order 26.4b1 were being used for. No other NJ ex order 26.4b assessments were provided by the facility.

Review of R71's order located in the EMR under the "Orders" tab, dated NJ ex order 26.4b1, revealed 'NJ ex order 26.4b1 ."

Review of R71's EMR and hard chart revealed no informed consent.

Review of R71's care plan tab, MAR/TAR, miscellaneous tab, and evaluation/ assessments in the EMR revealed no documentation related to the use of alternative measures utilized prior to the use of NJ ex order 26.4b1

During an observation on 01/22/24 at 2:50 PM, R71 was in a NJ ex order 26.4b1 next to bed. R71's bed was noted to have one silver NJ ex order 26.4b up on the side closest to the door that was loose and slightly leaning away from the bed. A hand size gap was present between the mattress and NJ ex orc NJ ex or

During an observation on 01/23/24 at 9:38 AM, R71 was observed in bed with the NJ ex order 26.4b1 NJ Ex on

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both sides of the bed as Nurse Aide (NA)2 used bed remote to bring R71's head of bed up. At 9:46 AM, R71 was again observed in bed with the NJ ex order 26.4b1 in the up position. The NJ ex order 26.4b on the side of the bed closest to the door was noted to be loose and leaning away from the bed.

During an interview on 01/23/24 at 1:25 PM, Licensed Practical Nurse (LPN) 4 was asked why R71 had side rails on bed. LPN4 stated the NJ ex order 26.4b1 were "NJ Exec Order 26.4" for R71 during care." LPN4 was asked if the NJ ex order 26.4b1 were NJ Exec Order 2 during care and LPN4 stated, "NJ Exec O LPN4 was then asked if it was okay for R71 to have the NJ Exec O while in bed after R71 was provided care and LPN4 stated, "yes."

During an observation on 01/24/24 at 9:08 AM, R71 was in bed asleep with NJ ex order 26.4b1 on both sides of the bed in the NJ Exec Order 26.4b1.

During an interview on 01/24/24 at 10:51 AM, the US FOIA (B) (6) was asked if therapy got involved with NJ ex order 26.4b1. US FOIA (B) stated, "no." The US FOIA (B was asked if R71 had the capacity to use NJ ex order 26.4b1 and the US FOIA (B stated, NJ ex ord, NJ ex ord NJ ex order 26.4b1. The US FOIA (B stated R71's NJ ex order 26.4b1 NJ ex order 26.4b1 and NJ ex order 26.4b1 . The US FOIA (B went on to say R71 NJ ex order 26.4b1. The US FOIA (B was asked if R71 needed assistance when using the NJ ex order 26.4b and should the NJ ex order 26.4b remain up after R71 had been assisted. The US FOIA (B) stated, NJ ex order because R71 could and could reposition using the NJ ex order 26.4b1 NJ ex order 26.4b1

During an interview on 01/24/24 at 2:10 PM, DON1 was asked why R71 had NJ ex order 26.4b1 and was

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informed consent obtained. The DON1 stated R71 had NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1. The US FOIA (B) was asked if the NJ ex order 26.4b1 use was for only one hand, why did R71 have NJ ex order 26.4b1 and NJ Exec Order 26.4b1 on the other side. The US FOIA (B) stated she "would have to look at the report." The US FOIA (B) was asked if there were any more recent NJ ex order 26.4b1 assessments for R71 than the NJ ex order 26.4b1 she had provided. The US FOIA (B) stated not that she was aware of. The US FOIA (B) was asked why the assessment didn't include NJ Exec Order 26.4b1 The US FOIA (B) stated she started in NJ ex order 26.4b1 of NJ ex order 26.4b1, and she had recently recreated a new form for the NJ ex order 26.4b1 assessment that included more details including informed consent.

During an observation on 01/25/24 at 8:01 AM, R71 was asleep in bed with NJ ex order 26.4b1 up on both sides of the bed.

During an interview on 01/25/24 at 2:15 PM, the US FOIA (B) (6) ) was asked about R71's NJ ex order 26.4b1. The US FOIA (B) (6) stated R71 could use the NJ ex order 26.4b1 with her good NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. The US FOIA (B) (6) was asked if there was a risk for NJ Exec Order 26.4b1 if R71 could only move one side and the US FOIA (B) (6) stated, NJ ex order 26.4b1 The US FOIA (B) (6) stated R71 used the NJ ex order 26.4b1 when the NAs reposition during care. The US FOIA (B) (6) was asked should both NJ ex order 26.4b1 remain up after care and the US FOIA (B) (6) stated, NJ ex order 26.4b1

Review of the facility's policy titled, "Use of Side Rails," effective December 2023, showed: "Policy: It is the policy of this facility to ensure the safety and psychosocial well-being of its Residents while avoiding the use of side rails as a physical restraint. However, in review of resident's medical symptoms, the Physician and the Interdisciplinary

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team will review and determine through assessment the appropriateness of side rails. Procedure: 1.) Upon admission/readmission the resident will have a side rail screen assessment to evaluate the individual need for side rails. 2.) In addition, a side rail screen assessment will also be completed with each quarterly and annual assessment to determine the continued need for side rails. 3.) The side rail screen assessment will also be completed when deemed necessary and appropriate between regular assessments. 4.) Side rails will be used for safety when assessed as appropriate and documented as necessary: a. documented medical diagnosis, i.e., Seizure Disorder, Multiple Sclerosis, Parkinson disease, Hypotensive episodes. b. behavioral symptoms may include repetitive physical movements. c. Psychiatric diagnosis requiring psychoactive medications which may have the potential to cause disturbance in balance or vertigo. d. Severe cognitive loss as associated with the end stages of Dementia where safety awareness is absent. 5.) Staff may utilize side rails while care is provided to enable the resident to assist in their ADL's. 6.) Half side rails or one (1) side rail may be utilized for residents who require/request an assist device in promoting bed mobility or enhance a resident's ability to be more self-sufficient. An example, half rails may assist a resident to enter or to exit their bed independently. 7.) A resident may request a side rail to facilitate their capability of entering or exiting their bed, self-positioning in a safe and independent manner. 8). The Resident and/or Responsible representative will be informed: a. Their medical condition, the potential risks and benefits considered in utilizing a restraint, not using a restraint, and alternatives to restraint use. b. It will be explained to the resident and/or their

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| F 700 | Continued From page 25<br>responsible representative how the restraint would benefit the resident's medical symptoms and assist in attaining or maintaining their present physical well-being, c. Also, the negative outcomes of side rail use may contribute to a decline in muscle condition, incontinence, agitation. d. Once the resident and/or responsible representative has had a discussion with the Interdisciplinary team in regard to the resident's assessment, the determined appropriate use of side rails and their care planning decision the resident and/or the responsible representative will be asked to sign an informed consent ...10.) Assessment for use of side rails. a. bed mobility. b. ability to transfer between positions, does the raised side rail enable the resident to transfer. safely or does it pose a potential risk. c. restorative care to enhance and maintain abilities to stand, transfer and walk safely. d. trapeze to enhance resident's mobility while in bed. e. exercise, encouragement of active ROM, or restorative passive ROM."<br><br>NJAC 8:39-27.1(a)<br>NJAC 8:39-31.8(c)1 | F 700 | | |
| F 909 SS=E | Resident Bed<br>CFR(s): 483.90(d)(3)<br><br>§483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.<br>This REQUIREMENT is not met as evidenced by: | F 909 | | 2/5/24 |

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| F 909 | Continued From page 26<br>Based on observation, interview, record review, and facility policy review, the facility failed to have an ongoing monitoring of bed [redacted] as part of their routine maintenance program for one of one resident (Resident (R)71) of 35 sample residents and 86 of 87 occupied beds reviewed for [redacted]<br><br>Findings include:<br><br>1. Review of R71's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] located in the "MDS" tab of the electronic medical report (EMR), revealed R71 had an admission date of [redacted] There was no "Brief Interview for Mental Status (BIMS) score conducted and R71 had [redacted] R71 [redacted] were not used and R71 [redacted]<br><br>Review of R71's [redacted] provided by the facility, dated [redacted], revealed "3. Does the resident has [sic] [redacted]," "5. Does the resident have [redacted] in bed? [redacted]" "10. Does resident currently in use of [redacted] for [redacted] or to assist with [redacted]." Alternatives included "2. Reminders to use call light for assistance" and "3. Restorative care to enhance [redacted] Recommendations included "1. [redacted] a. They will b. [redacted]." [redacted] included "5a. [redacted], a. [redacted], b. [redacted], 5b. [redacted] b. | F 909 | 1.Maintenance Director immediately inspected all beds and implemented ongoing monitoring of side rails as part of his routine maintenance program.<br><br>2. All residents have the potential to be affected by not having bed inspections as part of the Maintenance directors routine regular maintenance program.<br><br>3. US FOIA (B) (6) was in serviced by the Administrator regarding the importance of having bed inspections as part of his routine maintenance program.<br><br>4. The Administrator or designee will monitor weekly for two months that bed inspections are being implemented as part of the maintenance directors routine maintenance program . All findings will be reported at the next quarterly quality assurance meeting. | |

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NJ Exec Or NJ Exec Order 26.4b1 The assessment did not include the risk of NJ Exec Order 26.4b1 or what condition the NJ ex order 26.4b1 were needed for.

Review of R71's care plan located in the EMR under the "Care Plan" tab, dated NJ ex order 26.4b1, revealed "R71 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 and an intervention included 'NJ ex order 26.4b1 NJ ex order 26.4b1, to NJ ex order 26.4b1 NJ ex order 26.4b1

Review of R71's order located in the EMR under the "Orders" tab, dated NJ ex order 26.4b1, revealed 'NJ ex order 26.4b1 ."

Review of the 200-hall maintenance log for NJ ex order 26.4b1, did not include an entry for NJ Exec Order 26 maintenance.

During an observation on 01/22/24 at 2:50 PM, R71 was in a NJ ex order 26.4b1 next to bed. R71's bed was noted to have one silver NJ ex order 26.4b up that was loose and slightly leaning away from the bed. A hand size gap was present between the mattress and NJ ex order 26.4b.

During an observation on 01/23/24 at 9:38 AM, R71 was in bed with silver NJ ex order 26.4b1 in the up position as Nurse Aide (NA)2 used the bed remote to bring R71 up to a seated position. At 9:46 AM, R71 was again observed in bed with the NJ ex order 26.4b1 in the NJ Exec Order 26.4b1. The NJ ex order 26.4b on the right side of the bed was noted to be severely loose and leaning away from the bed.

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| F 909 | Continued From page 28<br>During an interview on 01/23/24 at 1:11 PM, the US FOIA (B) (6) was asked about bed inspections. The stated he didn't conduct bed checks. The stated the staff would log problems for him to address in a maintenance notebook located at the nurse's station. The was asked if he conducted inspections. The stated every morning he checked the but didn't document the inspections. The then demonstrated what he checked for on an empty bed. The stated the only gap he checked was the gap between the top of the and the headboard but didn't check for gaps between the and mattress. The was shown R71's on the right side of bed. The was observed, and the MS confirmed the NJ ex order 26.4b1, causing it to wobble back and forth. The was noted to have hand size (five inch) gap. The stated, "it's loose because the nurse aides put them up and down and the bolt gets loose." The then tightened the bolt. The then stated the silver side rails were the old ones and he would replace R71's with new ones that were black. The went on to say he had new that worked better on their beds.<br><br>2. Review of a resident roster with occupied beds highlighted with side rails, dated , provided by the facility revealed 86 NJ ex order 26.4b1<br>NJ ex order 26.4b1 | F 909 | | |

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| F 909 | Continued From page 29<br>NJ ex order 26.4b1 and NJ ex order 26 of 87 occupied beds had NJ Exec Order 26.4b in use.<br><br>During an interview on 01/24/24 at 1:46 PM, the US FOIA (B) (6) was asked for the bed maintenance/manufacture instructions, and he stated they only had the parts catalog.<br><br>Review of the 2009 on-line manual titled, "Owner's Operator and Maintenance Manual - Invacare Continuing Care, Inc. [incorporated] Carroll®DLX Series Long Term Care Beds IH820DLX, IH820-3MDLX, SC900DLX" https://www.1800wheelchair.com/media/manuals/invacare_dlx_bed_manual.pdf, included on page nine, "Entrapment Warning" that revealed "Proper patient assessment and monitoring, and proper maintenance and use of equipment is required to reduce the risk of entrapment. Variations in bed rail dimensions, and mattress thickness, size or density could increase the risk of entrapment. Visit the FDA website at http://www.fda.gov to learn about the risks of entrapment. Review "A Guide to Bed Safety," published by the Hospital Bed Safety Workgroup. Refer to the individual instruction sheet included with the bed rails and/or positioning device for additional product and safety information. After any adjustments, repair, or service and before use, make sure all attaching hardware is tightened securely. Assist rails with dimensions different from the original equipment supplied or specified by the bed manufacturer may not be interchangeable and may result in entrapment or other injury. Mattress must fit bed frame, assist rails and/or positioning device snugly to reduce the risk of entrapment." | F 909 | | |

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| F 909 | Continued From page 30<br><br>On 01/25/24 at 2:05 PM, the US FOIA (B) (6) was asked for a bed maintenance/inspection policy. None was provided.<br><br>Review of the facility's policy titled, "Use of Side Rails," dated 12/23, revealed "It is the policy of this facility to ensure the safety and psychosocial well-being of its Residents while avoiding the use of side rails as a physical restraint. However, in review of resident's medical symptoms, the Physician and the Interdisciplinary team will review and determine through assessment the appropriateness of side rails ... 10.) Assessment for use of side rails ... h.) frequent monitoring by staff." The policy did not address the risk of entrapment.<br><br>NJAC 8:39- 31.4(c)<br>NJAC 8:39-31.8(c)1 | F 909 | | |

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| S 000 | Initial Comments<br><br>The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations. | S 000 | | |
| S 560 | 8:39-5.1(a) Mandatory Access to Care<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on 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.<br><br>Findings include:<br><br>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were | S 560 | 1.The staffing coordinator continues to utilize all possible means to increase facility staff including offering bonuses to staff that refer CNAs. We reached out to staffing agencies and they assured us that they will make every effort to supply us with the necessary staff.<br><br>2. All residents have the potential to be affected by this deficient practice when staffing regulations are not met.<br><br>3. The Staffing Coordinator was in serviced by the Administrator in regards to the minimum staffing requirements and to utilize all possible avenues to increase staffing in the facility. | 2/5/24 |

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

Electronically Signed | 02/07/24

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 602030 | A. BUILDING: _____ B. WING _____ | C 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLAZA HEALTHCARE & REHABILITATION CENTER | 456 RAHWAY AVENUE ELIZABETH, NJ 07202 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 560 | Continued From page 1<br>effective on 02/01/2021:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift.<br><br>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and<br><br>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.<br><br>1. For the week of Complaint staffing from 04/24/2022 to 0430/2022, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows:<br><br>-04/24/22 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs.<br>-04/27/22 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs.<br><br>2. For the week of Complaint staffing from 12/11/2022 to 12/17/2022, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows:<br><br>-12/11/22 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-12/14/22 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-12/15/22 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs.<br>-12/17/22 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. | S 560 | 4. The Administrator or designee will monitor daily staffing levels with the Staffing Coordinator for two months. All findings will be reported at the next quarterly quality assurance meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 602030 | A. BUILDING: _____ B. WING _____ | C 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLAZA HEALTHCARE & REHABILITATION CENTER | 456 RAHWAY AVENUE ELIZABETH, NJ 07202 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 560 | Continued From page 2<br><br>3. For the week of Complaint staffing from 11/19/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:<br><br>-11/19/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-11/21/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-11/23/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-11/24/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-11/25/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br><br>4. For the 2 weeks of staffing prior to survey from 01/07/2024 to 01/20/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows:<br><br>-01/07/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs.<br>-01/08/24 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs.<br>-01/09/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-01/12/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.<br>-01/13/24 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.<br>-01/14/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.<br>-01/16/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-01/17/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.<br>-01/18/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. | S 560 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 602030 | A. BUILDING: _____ B. WING _____ | C 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLAZA HEALTHCARE & REHABILITATION CENTER | 456 RAHWAY AVENUE ELIZABETH, NJ 07202 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 560 | Continued From page 3<br>-01/20/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. | S 560 | | |

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 315483 Y1 | A. Building<br>B. Wing Y2 | 3/15/2024 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLAZA HEALTHCARE & REHABILITATION CENTER | 456 RAHWAY AVENUE<br>ELIZABETH, NJ 07202 |

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 | Correction | ID Prefix | Correction |
| Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 02/05/2024 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 1/25/2024 | ☐ YES ☐ NO |

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 315483 Y1 | A. Building<br>B. Wing Y2 | 3/15/2024 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLAZA HEALTHCARE & REHABILITATION CENTER | 456 RAHWAY AVENUE<br>ELIZABETH, NJ 07202 |

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 | F0644 | Correction | ID Prefix | F0656 | Correction |
| Reg. # | 483.12(b)(5)(i)(A)(B)(c)(1)(4) | Completed | Reg. # | 483.20(e)(1)(2) | Completed | Reg. # | 483.21(b)(1)(3) | Completed |
| LSC | | 02/05/2024 | LSC | | 02/05/2024 | LSC | | 02/05/2024 |
| ID Prefix | F0700 | Correction | ID Prefix | F0909 | Correction | ID Prefix | | Correction |
| Reg. # | 483.25(n)(1)-(4) | Completed | Reg. # | 483.90(d)(3) | Completed | Reg. # | | Completed |
| LSC | | 02/05/2024 | LSC | | 02/05/2024 | LSC | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | LSC | | | LSC | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | LSC | | | LSC | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | LSC | | | LSC | | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 1/25/2024 | ☐ YES ☐ NO |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 602030 Y1 | A. Building<br>B. Wing Y2 | 3/15/2024 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLAZA HEALTHCARE & REHABILITATION CENTER | 456 RAHWAY AVENUE<br>ELIZABETH, NJ 07202 |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix S0560 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 8:39-5.1(a) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 02/05/2024 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 1/25/2024 | ☐ 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 |
|---|---|---|---|
| | 315483 | A. BUILDING **01**<br>B. WING _____ | **01/25/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PLAZA HEALTHCARE & REHABILITATION CENTER** | **456 RAHWAY AVENUE**<br>**ELIZABETH, NJ 07202** |

| (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<br><br>An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 01/22/24. The facility was found to be in compliance with 42 CFR 483.73. | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/22/24 and was found not to be in compliance with 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.<br><br>Plaza Healthcare and Rehabilitation Center was constructed in 1965 and is three stories. The third floor has no occupants and is used for activities and dining. The facility has a service basement below ground that is used for food service and laundry. The steel joists lack protective coatings on each floor but are protected by one hour ceiling tile. Residents occupy the first and second floors only. The facility is a type II (III) non-combustible construction with concrete flooring, concrete roofing and bearing walls. The facility has a 151 KW (kilowatt) diesel generator. It is unknown what percent of load the facility tests currently. The facility has 89 occupied beds. The facility has ten smoke zones including the third and basement floors as one zone each. | K 000 | | |
| K 252<br>SS=E | Number of Exits - Corridors<br>CFR(s): NFPA 101 | K 252 | | 2/5/24 |

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

Electronically Signed | 02/07/2024

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315483 | A. BUILDING **01**<br>B. WING _____ | **01/25/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PLAZA HEALTHCARE & REHABILITATION CENTER** | **456 RAHWAY AVENUE**<br>**ELIZABETH, NJ 07202** |

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|---|---|---|---|---|
| K 252 | Continued From page 1<br><br>Number of Exits - Corridors<br>Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies.<br>18.2.5.4, 19.2.5.4<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview, the facility failed to ensure it provided two acceptable exits, remote from each other on each floor; or fire section of the building in accordance with NFPA 101 (2012 edition) sections 7.4 and 7.5.1.2. This deficient practice had the potential to affect seven residents and one staff member observed in the area during activities.<br><br>Findings include:<br><br>An observation on 01/22/24 at 9:50 AM revealed a secondary exit on the 3rd floor near the Physical Therapy area that led to a roof egress leading to a stairwell and eventually to the ground floor. The egress involved approximately 50 feet from the exit door to the exit stairwell on the other side of the roof. The stairwell emptied into another part of the building. The area was used for Physical Therapy, recreation services, and dining services.<br><br>An observation on 01/22/24 at 2:30 PM revealed seven residents and one staff were using the area for activities. | K 252 | Construction to have two acceptable exits was completed with DCA approved plans. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315483 | A. BUILDING **01**<br>B. WING _____ | **01/25/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PLAZA HEALTHCARE & REHABILITATION CENTER** | **456 RAHWAY AVENUE**<br>**ELIZABETH, NJ 07202** |

| (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 252 | Continued From page 2<br><br>During an interview on 01/22/24 at 9:50 AM, the US FOIA (b)(6) stated that the roof was used for exit access.<br><br>NJAC 8:39-31.2(e) | K 252 | | |
| K 352 SS=F | Sprinkler System - Supervisory Signals<br>CFR(s): NFPA 101<br><br>Sprinkler System - Supervisory Signals<br>Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired.<br>9.7.2.1, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure that one sprinkler control valve was installed with a supervisory electronic device or tamper switch in accordance with NFPA 101 (2012 edition) section 9.7.2.1. This deficient practice had the potential to affect all 89 residents who resided at the facility.<br><br>Findings include:<br><br>An observation on 01/22/24 at 11:15 AM in the electrical room in the basement of the facility revealed a control valve in the ceiling of the room that connected to a three-inch sprinkler pipe that supplied sprinkler system water to the building. The valve lacked electronic supervision or a tamper switch. The valve was painted gray. | K 352 | 1. Sprinkler control valve was installed with a supervisory electronic device or tamper switch<br><br>2. All residents have the potential to be affected by this deficient practice to ensure that sprinkler control valves are installed with a supervisory electronic device or tamper switch.<br><br>3. The US FOIA (B) (6) was in serviced by the Administrator regarding the importance of ensuring appropriate installation of the tamper switch on the sprinkler control valve.<br><br>4. The administrator or designee will | 4/18/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315483 | A. BUILDING **01**<br>B. WING _____ | **01/25/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PLAZA HEALTHCARE & REHABILITATION CENTER** | **456 RAHWAY AVENUE**<br>**ELIZABETH, NJ 07202** |

| (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 352 | Continued From page 3<br><br>A review of the quarterly and annual sprinkler inspection reports titled "Form for Inspection Testing and Maintenance of Four-inch Wet Pipe Sprinkler Systems" located in an untitled red binder, provided by the US FOIA (B) (6) revealed for the quarterly statements dated 11/03/23, 08/18/23, 02/18/23; and an annual statement dated 05/12/23, the statements were checked "yes" for "Control valves including back flow preventer with seals passed inspection."<br><br>During an interview at the time of the observation, the US FOIA (B) (6) and US FOIA (B) (6) verified the sprinkler valve in question did not have electronic supervision or a tamper switch.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 13, 25 | K 352 | monitor all sprinkler control valves weekly for 2 months ensuring that all sprinkler control valves have a supervisory electronic device or tamper switch. All findings will be reported at the next quarterly quality assurance meeting. | |
| K 362<br>SS=E | Corridors - Construction of Walls<br>CFR(s): NFPA 101<br><br>Corridors - Construction of Walls<br>2012 EXISTING<br>Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code.<br>Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames.<br>If the walls have a fire resistance rating, give the | K 362 | | 2/5/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315483 | A. BUILDING **01**<br>B. WING _____ | **01/25/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PLAZA HEALTHCARE & REHABILITATION CENTER** | **456 RAHWAY AVENUE**<br>**ELIZABETH, NJ 07202** |

| (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 362 | Continued From page 4<br>rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.<br>19.3.6.2, 19.3.6.2.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure corridor walls were provided in accordance with NFPA 101 (2012 edition) section 19.3.6.2.1. The deficient practice had the potential to affect five residents and staff in the area.<br><br>Findings include:<br><br>An observation on 01/22/24 at 11:05 AM revealed a large sliding glass window opening measuring 27 and one-half inches high and 39 inches wide. The windows had a half inch gap between each allowing for the passage of smoke. Therefore, the wall was not continuous from the floor to the ceiling. The sliding glass window is in a wall, in the corridor near the front exit of the building. The business office and open use area both lacked smoke detection.<br><br>During an interview at the time of the observation, the US FOIA (B) (6) verified the sliding glass window and opening. The US FOIA (B) (6) stated the window was scheduled to be changed in the near future to ensure it was completely sealed.<br><br>NJAC 8:39-31.2(e) | K 362 | 1.The sliding glass window with a half inch gap was replaced with a window that had no gap and completely sealed.<br><br>2. All residents have the potential to be affected by this deficient practice to ensure that corridor walls are continuous from floor to ceiling.<br><br>3. The US FOIA (B) (6) was in serviced by the Administrator regarding the importance of ensuring appropriate walls that are continuous from floor to ceiling.<br><br>4. The administrator or designee will monitor all corridor walls weekly for 2 months ensuring that all walls are floor to ceiling with no gap and completely sealed. All findings will be reported at the next quarterly quality assurance meeting. | |
| K 372 SS=F | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101 | K 372 | | 2/5/24 |

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|---|---|---|---|
| | 315483 | A. BUILDING **01**<br>B. WING _____ | **01/25/2024** |

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| **PLAZA HEALTHCARE & REHABILITATION CENTER** | **456 RAHWAY AVENUE**<br>**ELIZABETH, NJ 07202** |

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| K 372 | Continued From page 5<br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview, the facility failed to ensure four of six smoke barrier walls were maintained in accordance with NFPA 101 (2012 edition) section 19.3.7.3 to 8.5 to 8.5.2.1. This deficient practice has the potential to affect all 89 residents who resided at the facility.<br><br>Findings include:<br><br>An observation on 01/22/24 at 1:30 PM, above the ceiling tile and cross corridor doors near bedroom 224, revealed a large hole in the concrete wall extending eight inches wide and four inches high in the smoke barrier wall. The hole had blue electrical wiring going through to the other side.<br><br>An observation on 01/22/24 at 1:40 PM, above the ceiling tile and cross corridor doors near bedroom 229, revealed a hole measuring six inches wide by four inches high in the smoke barrier wall. The hole had blue wires going through to the other side. | K 372 | 1.All holes in the smoke barriers above the ceiling near rooms 224,229, 128,121 were sealed completely.<br><br>2. All residents have the potential to be affected by this deficient practice to ensure that smoke barriers are maintained with no holes.<br><br>3. The US FOIA (B) (6) was in serviced by the Administrator regarding the importance of ensuring appropriate smoke barriers.<br><br>4. The administrator or designee will monitor all smoke barriers weekly for 2 months ensuring that there are no holes. All findings will be reported at the next quarterly quality assurance meeting. | |

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| K 372 | Continued From page 6<br><br>An observation on 01/22/24 at 1:45 PM, above the ceiling tile and cross corridor doors near bedroom 128, it was revealed two holes the size of tennis balls, one above the other in the smoke barrier wall. The holes had blue wires going through to the other side.<br><br>An observation on 01/22/24 at 1:55 PM, above the ceiling tile and cross corridor doors near bedroom 121, revealed one hole the size of a tennis ball in the smoke barrier wall. The hole had blue wires going through to the other side.<br><br>During an interview on 01/22/24 at 2:00 PM, the US FOIA (B) (6) indicated the electrical work for the blue wires was done three years ago. He stated he did not routinely check the smoke walls for holes.<br><br>NJAC 8:39-31.2(c), 31.2(e) | K 372 | | |
| K 541 SS=F | Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101<br><br>Rubbish Chutes, Incinerators, and Laundry Chutes<br>2012 EXISTING<br>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.<br>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. | K 541 | | 2/5/24 |

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| K 541 | Continued From page 7<br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)<br>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.<br>19.5.4, 9.5, 8.4, NFPA 82<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview with staff, the facility failed to ensure a second-floor laundry chute door latched and an incinerator was sealed with fire resistive construction to prevent further use in accordance with NFPA 101 (2012 edition) sections 19.5.4. to 19.5.4.6. and 9.5. to 9.5.1.1 to 8.3.3.3. This deficient practice had the potential to affect all 89 residents who resided at the facility.<br><br>Findings include:<br><br>An observation on 01/22/24 at 10:20 AM of a laundry chute in the second-floor trash collection room, revealed the latching device on the outside of the laundry chute was broken. Due to the broken latch, the laundry chute door would not latch. When the door was closed three times, it remained ajar each time.<br><br>During an interview at the time of the observation, the US FOIA (B) (6) verified the door latch was broken and would not close and latch.<br><br>An observation on 01/22/24 at 11:20 AM of an incinerator located in the kitchen trash collection room, in the basement revealed an incinerator with plastic five-gallon buckets inside with the | K 541 | 1. Second floor laundry chute latching device was immediately fixed and the incinerator was sealed with fire resistive construction to prevent further use.<br><br>2. All residents have the potential to be affected by the facility not ensuring laundry chute door latched and an incinerator was sealed with fire resistive construction.<br><br>3. The US FOIA (B) (6) was in serviced by the Administrator regarding the importance of laundry chute door latching and the incinerator being sealed with fire resistive construction.<br><br>4. The Administrator or designee will monitor daily for two months that the laundry chute is latching and the incinerator is sealed with fire resistive construction. All findings will be reported at the next quarterly quality assurance meeting. | |

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| K 541 | Continued From page 8<br>door to the incinerator hanging open about one foot wide at one section. The device was not sealed to prevent further use.<br><br>During an interview at the time of the observation, the US FOIA (B) (6) and US FOIA (B) (6) verified device was an incinerator, and that the incinerator door was open and not sealed to prevent further use.<br><br>NJAC 8:39-31.2(e) | K 541 | | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to | K 918 | | 2/5/24 |

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| K 918 | Continued From page 9<br>manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the essential electrical system had been maintained in accordance with NFPA 110 (2010 edition) section 7.3.1. This deficient practice had the potential to affect all 89 residents who resided at the facility.<br><br>Findings include:<br><br>An observation on 01/22/24 at 11:30 AM revealed the facility generator transfer switch located on the lower level or basement electrical room was lacking emergency battery powered lighting. The generator was a diesel 151-KW (kilowatt) located outside near the parking area.<br><br>During an interview at the time of the observation, the US FOIA (B) (6) indicated the facility did not have battery backup lighting for the generator transfer switch.<br><br>NJAC 8:39-31.2(e), 31.2(g)<br>NFPA 99, 110 | K 918 | 1. Emergency battery powered lighting above the emergency generator□s transfer switch was installed.<br><br>2. All residents have the potential to be affected by the facility not providing an operational battery backup emergency light above the emergency generator□s transfer switch.<br><br>3. The US FOIA (B) (6) was in serviced by the Administrator regarding the necessity of monitoring the functioning status of the emergency lighting fixture.<br><br>4. The Administrator or designee will monitor daily for two months that the emergency lighting fixture is in good working order. All findings will be reported at the next quarterly quality assurance meeting. | |

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| | 315483 | A. BUILDING **01**<br>B. WING _____ | R<br>**05/02/2024** |

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| {E 000} | Initial Comments<br><br>No deficiencies related to Emergency Preparedness | {E 000} | | |
| {K 000} | INITIAL COMMENTS<br><br>An onsite revisit was conducted to verify the facility Life Safety Code Plan of Correction for the 1/25/2024 Recertication survey. The facility was found to be not in complaince 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, specifically K252.<br><br>Plaza Healthcare and Rehabilitation Center was constructed in 1965 and is three stories. The third floor has no occupants and is used for activities and dining. The facility has a service basement below ground that is used for food service and laundry. The steel joists lack protective coatings on each floor but are protected by one hour ceiling tile. Residents occupy the first and second floors only. The facility is a type II (111) non-combustible construction with concrete flooring, concrete roofing and bearing walls. The facility has a 151 KW (kilowatt) diesel generator. It is unknown what percent of load the facility tests currently. The facility has 89 occupied beds. The facility has ten smoke zones including the third and basement floors as one zone each. | {K 000} | | |
| K 211 SS=F | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance | K 211 | | 5/2/24 |

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

Electronically Signed | 05/14/2024

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

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| K 211 | Continued From page 1<br>with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>New Citation:<br><br>Based on observation and interview on 05/02/2024 in the presence of facility management, the facility failed to ensure exits were free from obstructions in accordance with NFPA 101:2012 edition Section 9.2.1. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following:<br><br>An observation at 10:00 AM revealed that the exit discharge stairs from the exit stairway near the lobby to the parking lot was obstructed by empty crates preventing exit access.<br><br>In an interview at the time, the US FOIA (B) (6) US FOIA (B) (6) confirmed the obstructions.<br><br>The US FOIA (B) (6) was informed of the deficient practices at the survey exit at 10:30 AM.<br><br>NJAC 8:39-31.1(c), 31.2(e) | K 211 | 1. Empty crates were immediately removed to ensure the exit was free from obstruction and all other exits were reviewed to ensure they were free from obstruction.<br>2. All residents have the potential to be affected by this deficient practice to ensure exits are free of obstruction.<br>3. All employees were in serviced by the administrator regarding the importance of keeping all exits free from obstruction.<br>4. The Administrator or Designee will monitor all exits weekly ensuring that all exits are free from obstruction. All findings will be reported at the next quarterly quality assurance meeting. | |
| {K 252} SS=E | Number of Exits - Corridors<br>CFR(s): NFPA 101<br><br>Number of Exits - Corridors<br>Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors | {K 252} | | 5/1/27 |

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| {K 252} | Continued From page 2<br>or lobbies.<br>18.2.5.4, 19.2.5.4<br><br>This REQUIREMENT is not met as evidenced by:<br>Repeat Citation:<br><br>Based on observation and interview on 05/02/2024 in the presence of facility management, it was determined that the facility failed to provide 2 acceptable exits from the 3rd floor in accordance wit NFPA 101:2012 edition Section 19.2.5.4. This deficient practice had the potential to affect residents using the 3rd floor as evidenced by the following:<br><br>An observation at 09:30 AM revealed that the 3rd floor which provided activity/dining services, Physical Therapy, and Salon services was provided with a exit stairway to the ground floor exit discharge and a second designated exit onto a open roof. The roof had been recently altered to include a raised chain-linked fence around the perimeter of the roof, a small ramp to traverse a change in floor level, and the door to an exit stairway was reversed to swing with egress located 55-feet away. This exit pathway was not enclosed or protected as an exit passageway to the exit stairway for evacuation.<br><br>In an interview at the time, the facility's US FOIA (B) (6) confirmed the exit pathway was not enclosed or protected.<br><br>The US FOIA (B) (6) was notified at the survey exit at 10:30 AM. | {K 252} | " We have been notified by the DOH to provide an enclosed means of egress per NFPA guidelines from the existing 3rd floor. This will take time as we need to retain an architect, draw up plans, submit to DCA, DOH, and local building/ zoning departments for approval and then do the actual construction. Therefore we are requesting a time limited waiver.<br>" Facility provides limited patient access to the 3rd floor with no sleeping rooms. ¿ All staff and patients that have access will be trained to know where the exit is. ¿ The Facility will provide monthly in-services to all staff regarding the limited egress from the 3rd floor and way to exit in case of an emergency. ¿ During our monthly fire drills we will provide extra focus on the 3rd floor and the quickest and safest emergency exit. Battery operated smoke detection will be installed for all spaces in the zone, including closets, bathrooms etc. This is in addition to the wired-in smoke detection already installed in that zone. Administrator will monitor weekly safety measures and milestones throughout the project.<br><br>TASK Start Date/End Date:<br>" Architectural and Engineering Design | |

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| {K 252} | Continued From page 3<br><br>NJAC 8:39-31.2(e) | {K 252} | 5/02/2024 -10/02/2024<br>" DOH Review/ Approval 10/02/2024-3/02/2025<br>" DCA Review/ Approval 3/02/2025 -9/02/2025<br>" Local Building and Zoning Review/ Approval 9/02/2025 -6/02/2026<br>" Construction 6/02/2026 -1/2/2027<br>" Local Building and Zoning Inspection and CO 1/2/2027- 4/2/2027<br>" DOH Inspection 4/2/2027- 5/1/2027 | |
| K 293 SS=F | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>New Citation:<br><br>Based on observations and interview on 05/02/2024 in the presence of facility management, it was determined that the facility failed to ensure exit directional signs were provided in 2 of 2 exit stairways in accordance with NFPA 101:2012 edition Section 7.10. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following:<br><br>At 09:30 AM, the surveyor observed the following: | K 293 | 1. Illuminated exit directional signs with continuous illumination also served by the emergency lighting system were installed on the 3rd floor open roof pathway identifying the enclosed stairwell as the path of exit and on the 2 exit stairwells from the 3rd floor to the exit discharge doors.<br><br>2. All residents have the potential to be affected by this deficient practice to ensure exit directional signs have continuous illumination also served by the | 5/3/24 |

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|---|---|---|---|---|
| K 293 | Continued From page 4<br><br>1. There was no illuminated exit directional sign located across the 3rd floor open roof pathway (see K252) identifying the enclosed stairway as the path of exit.<br><br>In an interview at the time, the facility's US FOIA (B) (6) stated that this was the designated path of egress and confirmed the absence of exit directional signs.<br><br>2. There were no exit directional signs located within either of the 2 exit stairways from the 3rd floor to the exit discharge doors. There were multiple doors in the stairway but there were no signs to identifying the designated exit.<br><br>In an interview at the time, the facility's US FOIA stated the doors at the ground level to the exterior of the building were the designated exits and confirmed the absence of exit directional signs.<br><br>The US FOIA (B) (6) was informed of the deficient practice at the survey exit at 10:30 AM.<br><br>NJAC 8:39-31.1(c), 31.2(e) | K 293 | emergency lighting system.<br><br>3. The US FOIA (B) (6) was in serviced by the administrator regarding the importance of appropriate exit signage.<br><br>4. The Administrator or Designee will monitor all exits weekly for 2 months ensuring that all exit directional signs have continuous illumination also served by the emergency lighting system. All findings will be reported at the next quarterly quality assurance meeting. | |

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 |
|---|---|---|
| 315483 Y1 | A. Building 01 - MAIN BUILDING 01<br>B. Wing Y2 | 5/2/2024 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLAZA HEALTHCARE & REHABILITATION CENTER | 456 RAHWAY AVENUE<br>ELIZABETH, NJ 07202 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0352 | 04/18/2024 | LSC K0362 | 02/05/2024 | LSC K0372 | 02/05/2024 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # | Completed |
| LSC K0541 | 02/05/2024 | LSC K0918 | 02/05/2024 | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 1/25/2024 | ☐ 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 |
|---|---|---|---|
| | 315483 | A. BUILDING **01**<br>B. WING _____ | R<br>**05/17/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PLAZA HEALTHCARE & REHABILITATION CENTER** | **456 RAHWAY AVENUE**<br>**ELIZABETH, NJ 07202** |

| (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 | {E 000} | | |
| {K 000} | INITIAL COMMENTS<br><br>Based on review of the facility's Plan of Correction, the facility was found to be not in complaince 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, specifically K252.<br><br>Plaza Healthcare and Rehabilitation Center was constructed in 1965 and is three stories. The third floor has no occupants and is used for activities and dining. The facility has a service basement below ground that is used for food service and laundry. The steel joists lack protective coatings on each floor but are protected by one hour ceiling tile. Residents occupy the first and second floors only. The facility is a type II (111) non-combustible construction with concrete flooring, concrete roofing and bearing walls. The facility has a 151 KW (kilowatt) diesel generator. It is unknown what percent of load the facility tests currently. The facility has 89 occupied beds. The facility has ten smoke zones including the third and basement floors as one zone each. | {K 000} | | |

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

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

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

# POST-CERTIFICATION REVISIT REPORT

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| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0211 | 05/02/2024 | LSC K0252 | 05/02/2024 | LSC K0293 | 05/02/2024 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
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| 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 | |
|---|---|
| 1/25/2024 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |