STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING _____ B. WING _____	C 12/19/2024

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F 000	INITIAL COMMENTS Complaint#s: NJ#168820 and NJ#169518 Survey Date: 12/19/2024 Census: 86 Sample: 21 sample + 3 closed records = 24 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		2/5/25

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

Electronically Signed | 01/09/2025

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility-provided documents, it was determined that the facility failed to ensure that a) meals were consistently provided in a dignified and homelike manner and b) resident meal assistance was provided in a dignified manner. The deficient practice was observed in the recreation dining room for 2 of 6 residents (Residents #15 & #44). The deficient practice was evidenced by the following: On 12/15/24 at 11:46 AM, the surveyor observed the U.S. FOIA (b)(6) deliver the food truck to the recreation room, there were 6 residents, 4 residents at one table, 1 resident at one table, and another resident at one table, there were 2 U.S. FOIA (b)(6)) inside the dining area and later U.S. FOIA (b)(6)) came and assisted in distributing lunch trays. The	F 550	How the corrective action will be accomplished for any resident affected by deficient practice? The facility staff immediately offered Resident #44 hand hygiene where she refused - resident education given for importance of hand hygiene before and after meals. Recreation Staff was in serviced on Dining room Services 12/16/24. All residents will be offered and assisted with hand hygiene before and after meals. All staff were in serviced on tray delivery and accuracy. This includes the resident name, room number and diet as ordered on 12/16/24.	

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F 550	Continued From page 2 surveyor observed RA #1, RA#2, and U.S. FOIA (b) assisted 5 of 6 residents with hand hygiene using individually wrapped hand wipes on each resident's lunch trays. The facility staff did not offer Resident #44 hand hygiene and the staff then proceeded to set up the resident's meal. At that same time, the surveyor observed 5 out of 6 residents eating lunch except for Resident #15, who was seated at the same table with the other 3 residents. The surveyor then asked RA#2 why Resident #15 had no tray, and RA#2 responded that she would get back to the surveyor. Later, the surveyor asked the U.S. FOIA (b) why Resident #15 had no tray while the rest of the residents at the same table were eating, and the U.S. FOIA (b) responded that she would ask someone to get the resident's tray. On 12/15/24 at 11:56 AM, the surveyor observed the U.S. FOIA delivered a tray to Resident #15, the U.S. FOIA (b) provided the tray, set up the tray, and the U.S. FOIA (b) left the recreation room. The surveyor observed there was no diet slip in the tray and the piece of paper with black marker written NJ Exec Ord. On 12/15/24 at 12:01 PM, the surveyor interviewed RA#2 regarding Resident#44's hand wipes not use, and RA#2 responded that the resident should have been provided an opportunity to perform hand hygiene and the hand wipes should have been used. RA#2 further stated that she was not the one who provided Resident #44's tray. The surveyor also asked RA#2 why Resident #15 had no diet slip and what NJ Exec Ord in the paper meant. RA#2 stated that NJ Exec Ord was the room number and resident should receive a meal ticket (diet slip; that included the resident's name and diet). She further stated that	F 550	Resident #44 and resident # 15 were assessed with NJ Ex Order 26.4(b)(1). No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Resident #44 is Long Term Resident who will be monitored daily for 7 days then weekly for 4 weeks then monthly for 3 months to ensure they are offered hand hygiene before and after meals. Resident #15 will be monitored daily for 7 days then weekly for 4 weeks then monthly for 3 months to ensure tray is served to the resident and it is served timely. All staff was in serviced on offering hand hygiene before and after meals on 12/16/24. Hand Hygiene Policy and Procedure including resident's use if hand wipes before and after meals were reviewed to all staff on 12/17/24.	

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F 550	Continued From page 3 the resident was in room [NJ Exec Ord] and not [NJ Exec Ord]. The surveyor then asked RA#2 what the diet of [NJ Exec Ord] was and [NJ Exec Order] and why Resident #15 received the wrong tray. RA#2 then went to the next table and took the paper, and RA#2 stated that according to the paper, Resident #15 who was in room [NJ Exec Ord] diet was regular and room [NJ Exec Ord] was also regular diet. RA#2 stated that Resident#15 should have a diet slip and should receive the right diet. The surveyor asked RA#2 why Resident #15 had to wait for 10 minutes while the 3 other residents were eating lunch at the same table, and RA#2 did not respond. A review of the medical records revealed: Resident#15's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [NJ Exec Order 26.] , section [NJ E] included the brief interview for mental status (BIMS) score of [NJ Exec Order 26.4b1] which reflected that the resident's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . Resident#44's most recent significant change in status MDS with an ARD of [NJ Exec Order 26.4b1] section [NJ E] included the BIMS score of [NJ] which reflected that the resident's NJ Exec Order 26.4b1 . On 12/17/24 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding dining services. The surveyor asked the [U.S. FOIA (b)] what the facility's process for dining services was. The [U.S. FOIA (b)] stated that the food truck comes in from the kitchen, the dietary staff brings the food truck trays, and then the recreation staff distributes the trays, always one	F 550	All residents will be assisted on hand hygiene before and after meals. Kitchen staff were in serviced on 12/16/24 Dining room Services, Accuracy of meals using a tray card. Plates will be verified for accuracy before leaving the kitchen. Registered Dietician or designee will check tray lines during meals for accuracy weekly. All staff assisting with residents' meals ensure tray card information, right diet, right room number and right patient are accurate. Director of Nursing, Unit Managers, Registered Dietician and dietary staff will develop appropriate table seating, positioning, among residents and to ensure resident receives his or her tray together with other residents on the same time. On 12/18/24, facility updated table seating. A copy was provided to the kitchen to ensure meal trays are delivered at the same time so they are served at the same time. Director of Nursing or designee will audit meal tray delivery to ensure the delivery is consistent with the table seating 5 days a week x 4 weeks then monthly times 3 months, then quarterly. Regional food service Director or	

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F 550	Continued From page 4 assigned nurse for lunch and dinner, and breakfast residents eat in their room. The surveyor asked the U.S. FOIA (b) who verified the meal ticket, and the U.S. FOIA (b) responded that it was the "recreation people" who must check the meal ticket versus what was in the tray. The surveyor asked when and who offered assistance with hand hygiene during mealtime, the U.S. FOIA (b) stated that the recreation staff or whoever bringing the tray to the resident should offer and assist residents in performing hand hygiene by using individual packets of hand wipes in the resident's tray be done before and after eating. On that same date and time, the surveyor notified the U.S. FOIA (b) of the concerns with Resident # 15. The U.S. FOIA (b) stated that the staff should have brought the resident inside their room or asked for the tray because residents should be eating all at the same time. The surveyor also notified the U.S. FOIA (b) of the concerns with Resident # 44 with hand hygiene during lunch observation, and the U.S. FOIA (b) stated that the staff should have checked and if not opened should been offered for hand hygiene. On 12/18/24 at 11:14 AM, the survey team met with the U.S. FOIA (b) (6) . The surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns. A review of the facility's Food, Dining Service and HS (bedtime) Snacks Policy with a reviewed date of 6/2024 that was provided by the U.S. FOIA (b) revealed: Policy Explanation and Procedures: -Nursing staff will remind all residents/patients of the meal. Nursing is responsible for assisting those needed help. Individuals are assisted to	F 550	designee will observed meal tray pass weekly for 30 days and monthly X 6 months and thereafter. How the concern will be monitored and title of person responsible for monitoring? Director of Nursing or designee will observe meal pass in the dining area 5 x per week times 4 weeks for meal accuracy then monthly for 3 months then quarterly for one year. Director of Nursing or designee will observe meal pass for residence being offered hand hygiene 5 x per week x 4 weeks then monthly for 3 months then quarterly for one year.. Results of these observations will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance	

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F 550	Continued From page 5 prepare for the meal (glasses on, hearing aids in, hands washed, etc)... -Food service staff members will serve the food choices made with consideration given to dietary restrictions/texture modifications. Plates will be verified for accuracy of service... -Individuals are offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room... Eating Environment: -Staff will develop appropriate measures to try to maximize appropriate seating, positioning, and interactions among residents and to assure that each resident receives his or her prescribed diet.... A review of the Handwashing/Hand Hygiene Policy with a revised date of April 2010 that was provided by the U.S. FOIA (b)(revealed: Policy Interpretation and Implementation: 5. Employees must wash their hands for at least 20 seconds using antimicrobial soap and water under the following conditions: g. Before and after assisting a resident with meals... On 12/19/24 at 01:48 PM, the survey team met with the U.S. FOIA (b)(6), Regional DON #1 (RDON#1), RDON#2, U.S. FOIA (b) (6) , and U.S. FOIA (b) (6) for an exit conference, and there was no additional information provided by the facility.	F 550		
F 578 SS=D	NJAC 8:39-4.1(a),12,28;27.1(a);27.3(a) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or	F 578		2/5/25

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F 578	Continued From page 6 discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	F 578		

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F 578	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to ensure accurate documentation of a resident's NJ Ex Order 26.4(b)(1) for 1 of 7 residents (Resident #10) reviewed. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (electronic and paper) medical records of Resident #10 which revealed: The Admission Record (a summary of important information about the resident) revealed that the resident was admitted with diagnoses that included but were not limited to, NJ Exec Order 26.4b1 [redacted] A Significant Change Minimum Data Set (MDS) assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #10 scored a U.S. FOIA (b)(6), which indicated the resident had no U.S. FOIA (b)(6) [redacted]. The New Jersey NJ Ex Order 26.4(b)(1) [redacted]) form, which was undated and not filled out indicating what NJ Ex Order 26.4(b)(1)) NJ Ex Order 26.4(b)(1) [redacted]) nor was it signed by the resident, attending or facility	F 578	How the corrective action will be accomplished for any resident affected by deficient practice? Resident #10 NJ Ex Order 26.4(b)(1) [redacted] FORM was immediately completed and reviewed with the resident. The NJ Ex Order 26.4(form was completed signed by the resident and primary physician. NJ Ex Order 26.4(b)(1) [redacted] orders were entered to Electronic Medical Record This deficient practice was corrected during survey with a correction date of NJ Exec Order 26.4b1 [redacted]. Completed NJ Ex Order 26.4(b)(1) [redacted] FORM was uploaded to the miscellaneous tab in electronic medical record. All active residents NJ Ex Order 26.4(b)(1) were reviewed with no other residents being affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents were audited for completion of POLSTs in the Electronic Medical Record. Missing POLSTs were completed with the resident or their representative if applicable. All residents have the potential to be affected by this deficient practice.	

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F 578	Continued From page 8 staff. There was no documentation that indicated what [NJ Ex O] status the resident desired to have. A review of the physician's orders did not reveal any orders reflecting any [NJ Ex O] status. A review of the resident's electronic medical record (eMR) did not reveal any information that reflected any [NJ Ex O] status in the resident information area. On 12/16/24 at 11:51 AM the surveyor interviewed the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)). The surveyor confirmed with the [NJ Exec Or] that the [U.S. FOIA (b)(6] were part of the process for obtaining and documenting the [U.S. FO] and [NJ Ex Order 26.4(] status for residents. The surveyor asked how the [U.S. FOIA (b)] and [U.S. FOIA (b)] obtain and document [U.S. FO] and [NJ Ex Order 26.4(] status for residents. The [U.S. FOIA (b)] stated that the [NJ Ex Order 26.4(] was addressed in the resident assessment, and, depending on the resident's [NJ Ex Order 26.4(b)(1] status, the forms are brought to the resident, everything was explained to the resident and forms were signed. The form was then signed by the physician, the form uploaded to the resident's eMR and the form was filed. The [U.S. FOIA (b)] further stated that the family can be contacted to confirm the resident's [NJ Ex Order 26.4(b)(1)] status if needed. The status should also be included in the resident's Care Plan (CP). The [U.S. FOIA (b)] also stated that as of NJ Exec Order 26.4b1, the U.S. FOIA (b)(6) department had an ongoing project to ensure all resident's have completed [NJ Ex Order 26.4(b)(1)] and the results were reported to the facility's Quality Assurance Performance Improvement (QAPI) committee.	F 578	Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Advanced Directives Policy and Procedure was updated to include FULL CODE and POLST FORM completion on admission. A POLST folder is kept at the nurse's station for easy access for all staff and physicians to be signed and reviewed. Unit Clerk or Designee will upload completed POLST forms into the Electronic Medical Record. U.S. FOIA (b)(6) were in serviced on completion of resident advanced directives on 12/16/24. Licensed Nurses were in-service on getting orders from the primary physician on 12/16/24 Social Services or Designee will monitor all new admissions for Advanced Directives, completion status, and monitor for any changes. How the concern will be monitored and title of person responsible for monitoring. Administrator or designee will review 5 admission charts for completion of	

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F 578	Continued From page 9 The surveyor reviewed Resident #10's eMR and paper chart with the [redacted]. At this time the surveyor showed the [redacted] the blank [redacted] form and asked the [redacted] if there was any information in the medical record that indicates the [redacted] or [redacted] status. The [redacted] stated they did not know why the blank form was in the chart and why there was no form uploaded, no note or order for an NJ Ex Order 26.4(b)(1). The [redacted] removed the blank form from the paper chart. The [redacted] stated they would get back to the surveyor with any additional information. On 12/16/24 at 1:29 PM the surveyor interviewed the [redacted]. The [redacted] stated that all residents that were full code prior to September did not have a [redacted] in the chart. In September, when the need was seen verify that there were [redacted] in the medical records, the QAPI project was started. The [redacted] stated there was some difficulty getting the physicians sign [redacted] for residents who were full code. The [redacted] stated that Resident #10 had an admission date in August. The surveyor asked the [redacted] what would happen if a resident with no [redacted] listed in the medical record needed to be checked for code status during an emergency, especially if the nurse on duty was unfamiliar with the resident. The [redacted] stated that the family would be called. The surveyor asked what if the family could not be reached. The [redacted] stated that the hospital records would be checked. The surveyor asked if these options could take extra time and possibly delay care. The [redacted] stated yes, they could. The surveyor asked the [redacted] if the missing documentation for Resident #10 could have been inadvertently missed or "fell through the cracks". The [redacted] stated yes, it could have.	F 578	POLSTs weekly X 30 days, then monthly for 90 days and thereafter. Director of Social Services or Designee will monitor all new admissions for POLST completion. Any missing POLSTs will be completed immediately. The director of social services or designee will monitor POLSTS and ensure they are completed and uploaded. These findings will be brought to Monthly QAPI and will be part of the Quarterly Quality Assurance. Results of this audit will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance.	

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F 578	Continued From page 10 At that time, the [U.S. FOIA (b)] stated that a progress note (PN) was placed in chart addressing the missing code status. A review of the resident's eMR revealed a new note by nursing recorded after surveyor inquiry. A review of the PN revealed: [NJ Ex Order 26.4(b)(1)] 13:30 Note Text: PMD (primary medical doctor) notified of (redacted name) [NJ Ex Order] [redacted] as [NJ Ex Order 26.4(b)(], [NJ Ex Order 26.4(b)(1)] updated. On [NJ Ex Order 26.4(b)(] at 10:56 AM, the survey team met with the[U.S. FOIA (b)(6)] [redacted] and made them aware of the concern with the missing documentation for Resident #10's [NJ Ex Order 26.4(b)(1)]. A review of the facility's Advance Directive Policy, revised 11/2021, provided by the [U.S. FOIA (] revealed: 4. ...executed advance directive be displayed prominently in med record. The policy does not reflect anything specific about [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)]. The facility did not provide any further pertinent information.	F 578		
F 580 SS=D	N.J.A.C. 8:39-9.6(b) Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		2/5/25

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	315129	A. BUILDING _____ B. WING _____	C 12/19/2024

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F 580	Continued From page 11	F 580		

results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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F 580	Continued From page 12 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: COMPLAINT NJ#169518 Based on interviews, review of medical records, and pertinent facility documentation, it was determined that the facility failed to notify the Resident's Representative (RR) of a change in condition for 1 of 24 sampled residents (Resident # 239). This deficient practice was evidenced by the following: The surveyor reviewed Resident #239's closed hybrid (paper and electronic) medical record. Resident #239's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]. A review of Resident #239's Universal Transfer Form (UTF) from the return to the facility after the NJ Ex Order 26.4(b)(1), indicated that the resident did not have any NJ Exec Order 26.4b1 A review of Resident #239's progress notes (PN) included a NJ Exec Order 26 note written by a U.S. FOIA (b) (6)	F 580	How the corrective action will be accomplished for any resident affected by deficient practice? The facility was not able to assess resident # 239 as they were discharged in the year NJ Ex Order 26 [redacted] No other residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice especially those that have wounds. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. The facility must promptly notify the resident and the resident representative, if any, when there is a changed in condition. This should include the Primary Physician. Licensed nurses were reeducated regarding accurate documentation and notification of resident's responsible party on 12/18/24. Wound Nurse was re in serviced on documentation and notification of	

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F 580	Continued From page 13 U.S. FOIA (b) (6)) dated NJ Ex Order 26 which included the following: being seen today for a follow up NJ Ex Order 26.4 evaluation ...patient with NJ Exec Order 26.4b1. I was asked to evaluate and manage NJ Exec Order 26 care for this patient .... Further review of the NJ Exec Order 26 notes written by the U.S. FO indicated that the next visit was NJ Exec Order 26. There were three weeks of NJ Ex Order 26.4 notes that were not in the resident's medical record. The next NJ Exec Order 2 note written by the U.S. FO was dated NJ Exec Order 26.4b1. There was no documented evidence of NJ Ex Order 26.4 measurements or appearance during those 3 weeks in Resident #239's medical record. There was no documentation in the U.S. FOIA note that the RR was notified. Further review of Resident #239's PN did not include a documented notification of the RR regarding the NJ Exec Order 26.4b1 [redacted]) identified on NJ Exec Order 2. On 12/18/24 at 9:37 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding Resident #239's NJ Exec Order 26. The U.S. FOIA (b)(6) stated that the resident did not have any NJ Exec Order 26.4b on readmission from the hospitalization but that on NJ Exec Order 26 there was a NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1. The surveyor asked the U.S. FOIA (b)(6) if there was documented notification of the family of the NJ Exec Order. The U.S. FOIA (b)(6) stated that she would have to check the medical record. On 12/18/24 at 3:00 PM, the surveyor notified the U.S. FOIA (b)(6)	F 580	Resident's Representative for developed and NJ Exec Order 26.4b1 [redacted] Unit Manager or primary nurse will review 5 charts weekly x 90 days for documentation and notification of Resident's representative for changed in condition. How the concern will be monitored and title of person responsible for monitoring. Assistant Director of Nursing or designee will review wound reports for documentation and notification of changed in condition weekly x 4 weeks for 90 days and thereafter Results of this audit/ review will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance.	

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F 580	Continued From page 14 and U.S. FOIA (b)(6)) the concern that there was no documented evidence that the RR was notified of the change in condition, specifically the NJ Exec Orde that were investigated on NJ Exec Order2 in the resident's medical record. On 12/19/24 at 9:59 AM, in the presence of the survey team, the U.S. FOIA (b)(6) stated that the notification of the NJ Exec Orde to the RR was documented in the "NJ Ex Order 26.4(b)(1) Investigation Form." The surveyor asked if the investigation form was part of the medical record. The U.S. FOIA (b)(6) stated that she would have to ask because she was not sure. The U.S. FOIA (b)(6) then confirmed that there was no documentation in the electronic medical record that the RR was notified of the NJ Exec Order 26.4b1. On 12/19/24 at 10:18 AM, in the presence of the survey team, the U.S. FOIA (b)(6) confirmed that the investigation form was not part of the medical record. On 12/19/24 at 12:31 PM, in the presence of the survey team, U.S. FOIA (b)(6) DON #1, Regional DON #2 and the U.S. FOIA (b)(6), the surveyor asked if the notification of the RR should be documented in the resident's medical record and the U.S. FOIA (b)(6) stated yes. A review of the facility provided policy titled, "Acute Condition Changes-Clinical Protocol" with a revised date of 6/2024, included the following under Cause Identification: ...2. As needed, the Physician will discuss with the staff and resident and/or family the benefits and risks of diagnosing and managing the situation in the facility or via hospitalization ...	F 580		

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F 580	Continued From page 15 The facility did not provide any additional information. N.J.A.C. 8:39-13.1(a)(d)	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		2/5/25

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F 584	Continued From page 16 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding. This deficient practice was identified for 3 of 21 residents reviewed, Resident #48, #71 and #47. The deficient practice was evidenced by the following: 1. During the initial tour of the facility on 12/15/24 at 11:35 AM, the surveyor observed Room [redacted] and Resident #48 was not in the room. The surveyor observed dressers on both sides of the bed. Some areas of the wood on the left dresser and the edges of the right dresser were peeled, exposing the underlying particle board which created a rough surface and edges on the dressers. The heater unit in Room [redacted] was observed without the front grill cover. The front grill cover was observed laying against the wall. The surveyor also observed Resident #48's bed frame visibly soiled with a dry, brown substance on the right, foot side of the bed frame. On 12/15/24 at 11:51 AM, the surveyor observed the Resident #48 in the activity room, sitting on a wheelchair. The surveyor attempted to interview the resident but did not answer any questions.	F 584	How the corrective action will be accomplished for any resident affected by deficient practice? For Resident # 48, the dresser was immediately replaced with a new one. For Resident # 48, The Air conditioning unit grill was immediately replaced with a new one. For Resident # 48, The soiled bed frame was immediately cleaned. For resident # 71, the closet door was immediately replaced. For resident # 47, the spider webs on top of the mirror, ceiling, right side of window, heating unit grill, windowsill, and at the top of the dresser were immediately cleaned. All rooms were inspected by the maintenance. All dressers with peeled wood or damaged were removed and replaced during the survey. All Closet doors, heating grill, and furniture/beds were checked and any	

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F 584	Continued From page 17 The surveyor reviewed the medical records of Resident #48 and revealed: The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with a diagnoses which included but not limited to NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 [redacted] According to the Quarterly Minimum Data Set (QMDS), an assessment tool which drives the plan of care, dated NJ Exec Order 26 revealed a Brief Interview of Mental Status (BIMS) score of NJ Exec Order [redacted] On 12/16/24 at 12:18 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) and stated, "I have reported about the drawers being jammed, and the grill cover since last week. I wrote on the maintenance book about the drawers. I told the U.S. FOIA (b)(6)), that the grill was falling off. I did not notice the stain on the bed board. The resident NJ Exec Order 26.4b1, the resident is NJ Exec Order 26.4b ." At that same time, the surveyor and the U.S. FOIA (reviewed the Maintenance Logbook together and found a log for NJ Exec Order 26.4b1 for dresser drawer being jammed but not for the wood edges peeling or heating unit grill cover missing. On 12/16/24 at 12:49 PM, the U.S. FOIA of the NJ E Unit confirmed in Room NJ Exec Order the two side drawers with peeled wood, and the bed stain on right side of the bed frame. The U.S. FOIA stated, "I was not aware that the wood for the dressers were like that, and I do not know what that brown	F 584	issues were fixed immediately. Housekeeping Team inspected all Rooms for environmental cleanliness to include]spider webs, dirt and dust on top of mirrors, ceilings, windows, heating unit grills, windowsills, and dressers. Any issues found were immediately resolved. No residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Housekeeping, maintenance and nursing staff were in serviced on how to maintain sanitary, orderly, and comfortable interior on 12/17/24. All staff were educated to report issues to Maintenance Director, Designee, or entered into the Maintenance Log on 12/17/24 The Interdisciplinary Team will check rooms during biweekly clinical rounds for sanitation. Findings will be reported to housekeeping Department for cleaning or repairs.	

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F 584	Continued From page 18 substance on the bed frame is. I will call maintenance and housekeeping." On 12/16/24 at 1:51 PM, the surveyor observed maintenance staff in Room [NJ Exec Orde] putting new drawers in the room after surveyor's inquiry. The surveyor interviewed the [U.S. FOIA (b)(6)]) who was also in the room at that time. The [U.S. FOIA (b)], who has been with the company for four years stated, "Usually the turnaround time for work orders is 24 hours." The surveyor requested for the policy for work orders. On 12/17/24 at 9:00 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] regarding the facility Policy and Procedure for maintenance work orders and he stated, "We do not have a formal work order policy but usually if the equipment needs to be ordered, it can take time, it depends but we usually get it done as soon as we can." The [U.S. FOIA (b)(6)] stated that the facility did not have a maintenance policy. On 12/17/24 at 9:15 AM, the surveyor notified the [U.S. FOIA (b)(6)], regarding the drawers with the rough edges near the Resident #48's head of the bed, the heating system grill cover off and laying against the wall and the brown substance on the foot of the bed frame found during initial tour on 12/15/24. 2. During the initial tour of the facility on 12/15/24 at 11:12 AM, the surveyor observed the Resident #71 lying in bed in Room [NJ Exec Orde], and the resident was [NJ Ex Order 26.4(b)(1)] answer questions at that time but waved at the surveyor. The surveyor observed the closet with no door. The surveyor reviewed the medical records of	F 584	How the concern will be monitored and title of person responsible for monitoring. Maintenance Director will report results of inspection to the administrator for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement x 12 months and this will be a part of quarterly Quality Assurance.	

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F 584	Continued From page 19 Resident #48 and revealed: The AR reflected that the resident had diagnoses which included but not limited to NJ Exec Order 26.4b1 [redacted]. According to the Annual MDS (AMDS) dated NJ Exec Order 26.4b1 revealed a BIMS score of NJ Exec Order 26.4b1 indicating NJ Exec Order 26.4b1. On 12/16/24 at 9:47 AM, the surveyor observed Room NJ Exec Or still missing the closet door. The surveyor interviewed the U.S. FOIA of the NJ E Unit, who confirmed the closet had no door. The U.S. FOIA stated, "I will find out why there is no door to the closet. I did not notice that before." On 12/16/24 at 11:56 AM, the surveyor reviewed the Maintenance Request Book in the nursing unit from NJ Exec Order 26.4b1 and found no work order submitted for Room NJ Exec Order 2 missing closet door. On 12/16/24 at 12:07 PM, the U.S. FOIA stated, "[Name Redacted] from maintenance took the door out on Friday to replace it with a lighter door. I do not know why it was not on the maintenance book log." On 12/16/24 at 12:12 PM, the surveyor interviewed the U.S. FOIA (b)(6) who has been working in the facility for NJ Exec Order 26.4b1 The U.S. FOIA (b) stated, "That door was heavy, off the track, one of the aides told me, a lot of things are not listed on the logbook, and we do it when it happens. I had to order the door, already picked	F 584		

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F 584	Continued From page 20 up the door, will put it in today or tomorrow." On 12/16/24 at 1:57 PM, the surveyor requested for the requisition order form from the [redacted] for the new closet door. On 12/17/24 at 9:15 AM, the surveyor notified the [redacted] regarding the above findings and concerns with the closet door missing in Room [redacted] observed during the initial tour. On 12/17/24 at 10:40 AM, the surveyor interviewed the [redacted] who stated, "I ended up picking up the door at the other facility in [Name Redacted], we share things. I do not work on weekends that was why I put the door in on Monday." On 12/17/24 at 11:45 AM, the surveyor requested for the facility's Maintenance Policy and the [redacted] stated, "We do not have a Maintenance Policy." On 12/19/24 at 9:00 AM, the surveyor requested from the [redacted] any Policy and Procedure for Environment, specifically, residents' rooms. On 12/19/24 at 10:50 AM, the surveyor requested from the [redacted] the policy for Environment. There was no policy for Environment was provided. On 12/19/24 at 11:38 AM, the survey team met with the U.S. FOIA (b)(6) Regional DON#1 (RDON#1), RDON#2, U.S. FOIA (b)(6) [redacted]. The [redacted] stated, "Hinge was broken in the closet door, we removed it, it was fixed after the surveyors saw it." The surveyor notified the [redacted]	F 584		

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F 584	Continued From page 21	F 584		

and his staff that the [U.S. FOIA (b)] confirmed that maintenance issues had a 24 hour turn around. The closet door was reported and taken out on Friday and not replaced until 3 days later.

On 12/19/24 at 1:05 PM, the [U.S. FOIA (b)(6)] stated, "Some projects take more time, we were going to order the door, but we found one off site."

3. On 12/17/24 at 1:28 PM, the surveyor conducted the Resident council meeting. During the Resident Council meeting, Resident #47 stated, "There are still cobwebs on top of my mirror, ceiling, and on top of my dresser, they have not cleaned it. I told them last month. I think it's dust bunnies I do not think it was cobwebs because I do not see anything crawling."

A review of the Resident Council minutes completed on [NJ Exec Order 26.4b], revealed that Resident #47 complained of spider webs in the resident's room. The previous U.S. FOIA (b)(6), who was no longer working in the facility, filled out the grievance form titled "Resident Council Concern Form" on [NJ Exec Order 26.4b]. The U.S. FOIA (b)(6) signed the form ten days later [NJ Exec Order 26.4] and under action taken, "Had [Name Redacted] clean the cobwebs."

On 12/17/24 at 2:32 PM, the surveyor and Resident #47 observed Room [NJ Exec Orde], with dust above the top of the dresser, cobwebs on the ceiling on the right side of the windows, heating unit grill covered with dust and dirt, and the windowsill with dirt and dust.

On 12/17/24 at 2:41 PM, the U.S. FOIA (b)(6) [redacted] confirmed dust on top of dresser, spiderwebs on the right side of the room by the

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F 584	Continued From page 22 ceiling, the windowsill dirty and heating unit grill with dirt and dust. The [redacted] stated, "I have not seen that before." On 12/17/24 at 3:00 PM, the surveyor requested from the [redacted] the facility Policy and Procedure for housekeeping. The surveyor reviewed the medical records of Resident #47 and revealed: The AR reflected that the resident was admitted to the facility with diagnoses which included but not limited to NJ Exec Order 26.4b1 [redacted] According to the AMDS, dated [redacted], which revealed a BIMS score of [redacted] indicating [redacted]. On 12/18/24 at 11:13 AM, the surveyor discussed above concerns with the U.S. FOIA (b)(6) and both were notified of the Resident Council minutes for November which mentioned cobwebs. A review of the facility's Cleaning and Disinfecting Residents' Rooms Policy and Procedure revealed that Housekeeping surfaces will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.	F 584		
F 641 SS=C	NJAC 8:39-31.4(a)(c)(f) Accuracy of Assessments	F 641		1/30/25

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F 641	Continued From page 23 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on interview and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 1 of 24 residents, (Residents #88), reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: The surveyor reviewed the medical records of Resident #88 and revealed: The Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to, NJ Exec Order 26.4b1 [redacted]. The most recent Discharge Return Not Anticipated (DRNA) MDS, Section A-Identification Information revealed that the resident had an unplanned discharge (d/c) to NJ Ex Order 26.4(b)(1) [redacted]).	F 641	How the corrective action will be accomplished for any resident affected by deficient practice. Resident #88 MDS was modified to accurately reflect the status of the patient. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. MDS coordinators were in serviced on accuracy on MDS coding on 12/20/24 for 30 minutes. MDS Director or designee will review and audit MDS completed to ensure accuracy of coded before it is transmitted. Regional MDS Directors or designee will audit 5 MDS Assessments weekly x 30 days, then monthly and thereafter for	

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F 641	Continued From page 24 A Review of the Progress Notes, documented as a Late Entry, with an effective date of [NJ Exec Order 26.4b] was electronically signed by the [U.S. FOIA (b)(6)]) revealed that Resident #88 was d/c to home and was picked up by Resident's Representatives. On 12/16/24 at 01:41 PM, the surveyor interviewed the [U.S. FOIA (b) (6)]) who informed the surveyor that the facility followed the Resident Assessment Instrument (RAI) manual as their policy and protocol for doing MDS. The [U.S. FOIA (b)(6)] stated that information in the MDS was gathered from the resident's medical records, interviews of staff and resident, and assessment of the resident. The surveyor then notified the [U.S. FOIA (b)(6)] of the above findings and concerns that the resident's MDS for DRNA was coded as d/c to [NJ Ex Order 26.4(b)(1)] when the PN of the [U.S. FOIA (b)] revealed that the resident was d/c to [NJ Ex Order 26] The [U.S. FOIA (b)(6)] stated that she had to check the records and would get back to the surveyor. She further stated that the MDS and the medical records should match. On 12/16/24 at 01:56 PM, the [U.S. FOIA (b)(6)]) informed the surveyor that after review of the concern regarding MDS coding accuracy for Resident # 88, the Section should have been coded d/c to [NJ Ex Order 26.4(b)(1)] and not to [NJ Ex O] and it was a "mistake." On 12/19/24 at 01:48 PM, the survey team met with the [U.S. FOIA (b)(6)] Regional DON #1 (RDON#1), RDON#2, [U.S. FOIA (b)(6)] for an exit conference and there was no additional	F 641	accuracy of assessment. How the concern will be monitored and title of person responsible for monitoring. Results of this audit and observation will be discuss in morning clinical meeting for immediate resolution and this will be discussed in monthly QAPI and this will be a part of quarterly QA for 4 Quarters or, based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 1/30/25.	

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F 641	Continued From page 25 information provided. NJAC 8:39-33.2 (d)	F 641		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to adhere to professional standards of clinical practice by failing to: a.) follow the residents' meal tickets for 2 of 2 meal observations for Residents #41, #43, and #44; b.) clarify the physician's order with regard to supplement for 1 of 24 residents, Resident #41; and c.) ensure medication was administered in accordance with the manufacturer's specifications, and d.) ensure proper disposal of excess medication in a safe and approved manner for 2 of 6 residents, Residents #45 and #339, reviewed during the medication pass observation. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential	F 658	How the corrective action will be accomplished for any resident affected by deficient practice? Resident #41 was immediately given a [redacted] from the kitchen. A [redacted]. All residents on [redacted] were reviewed and any refusals were documented or percentage eaten were immediately added to the electronic medical record. Resident # 44 likes and dislike were reviewed and the meal ticket was corrected immediately after asking the resident if [redacted] wants another cup but refused the second cup. Resident # 43 the tray card was immediately updated after speaking with the family member and the patient. Patient and family prefer both either [redacted]	2/5/25

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F 658	Continued From page 26 physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 12/15/2024 at 11:46 AM, the surveyor observed in the recreation room during lunch 6 residents and 3 staff. The surveyor observed Resident #41 received their tray and the meal ticket revealed that the resident should receive a NJ Exec Order 26.4b1 Resident #41 did not receive a NJ Exec Order . The surveyor asked Recreation Aide #1 (RA#1) about the NJ Exec Order 26.4b1 in the resident's meal ticket, and RA#1 could not state where the NJ Exec Order 26.4b1 was. The surveyor asked the U.S. FOIA (b)(6) about Resident #41's NJ Exec Order 26.4b1 and the U.S. FOIA (b asked RA#1 to get it from the kitchen. The U.S. FOIA (b acknowledged that the resident should receive what was on the meal ticket, including the NJ Exec Order 2 On 12/15/24 at 12:01 PM, the surveyor observed	F 658	NJ Exec Order 26.4b1 and that either is fine. The NJ Exec Order 26.4b1 that was disposed of incorrectly was immediately disposed of correctly in a drug buster and signed off by two nurses. The resident refused the medication so there were no adverse affects. The NJ Exec Order 26.4b1 medication was immediately called into the physician and timing was discussed. The administration times were adjusted to ensure the resident had an empty stomach when the medication was administered. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). No resident was affected of this deficient practice. Measures to ensure were/will be put into place to assist this area of concern. Licensed nurses certified Nursing Assistant and Activity staff were in-serviced on checking meal tray tickets for accuracy of meal served on 12/16/24. All dietary staff were in serviced on meal accuracy on 12/16/24. Policy and procedure for medication	

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F 658	Continued From page 27 RA#1 offered the with NJ Exec Order 26.4b1 that was taken from the kitchen and Resident #41 refused the NJ Exec Order 26.4b1. A review of the provided Minimum Data Set (MDS) by the U.S. FOIA (b)(6)) revealed: -Resident # 41's most recent quarterly MDS (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Exec Order 26., Section NJ E revealed a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1 reflected that the resident's NJ Exec Order 26.4b1 . A review of the Order Listing Report revealed an active physician's order (PO) dated NJ Exec Order 26 for 'NJ Exec Order 26.4b1 provide with lunch and dinner" for Resident #41. The above order for the NJ Exec Order 26.4b1 was transcribed to the NJ Exec Order 26.4b1 electronic Medication Administration Record (eMAR) and signed by nurses as administered (provided). On NJ Exec Order 26.4b1 at noon eMAR, the U.S. FOIA (b)(6) electronically signed the eMAR as administered. The eMAR did not include information of resident's amount of intake and refusal. On 12/19/24 at 8:42 AM, the surveyor interviewed the U.S. FO who signed the eMAR on NJ Ex Order 26.4(b)(1 at noon for Resident #41's NJ Exec Order 26.4b1. The U.S. FO confirmed that she was the nurse who signed the NJ Exec Order 26.4b1 at noon eMAR of Resident #41 for the NJ Exec Order 26.4b1 The U.S. FO acknowledged that she was not in the recreation dining room on NJ Exec Order 26.4b1 to observe the resident's intake of the NJ Exec Order 26.4b1 and did not receive a report about the resident's	F 658	disposal was revised to include correct disposal of excess medications. Excess medication will be disposed accordingly using a drug buster and witness by another licensed nurse. All Licensed nurses were in service on medication administration following medication cautionaries and proper disposal of excess medication on 12/16/24. All staff in serviced on resident preferences and rights on 12/16/24. Pharmacy Consultant or designee will observed 2 nurses monthly for Medication Pass. Licensed Practicing Nurse #1 was educated on proper disposal of excessed medication using a drug buster on 12/16/24. Any disposal of non-controlled meds must be witnessed by 2 nurses. Licensed Practicing Nurse #2 was in serviced on medication administration to follow medication cautionaries. Medications, given with meals or with food on 12/16/24. All dietary staff were re in-service on the accuracy of meal service following the dietary tray tickets to match with the food tray on 12/16/24. Recreation Aide #1 Recreation Aide #2	

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F 658	Continued From page 28 refusal to take the NJ Exec Order 26.4b1. The surveyor asked the U.S. FO why she signed the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 if the resident did not take the NJ Exec Order at lunchtime, and the U.S. FO did not respond. On that same date and time, the U.S. FO informed the surveyor that the PO for the NJ Exec Order 26.4b1 for Resident #41 should have been clarified with the physician to include the amount or percentage of intake of the NJ Exec Order 26.4b1 as what was ordered in the NJ Exec Order 26.4b1 as best practice. 2. On 12/17/24 at 8:31 AM, the surveyor observed the recreation room for breakfast and there was a total of 4 residents and 2 staff. The surveyor observed Resident#43's meal ticket and revealed that the resident should receive a NJ Exec Order 26.4b1 The surveyor observed there was NJ Exec Order 26.4b1 in the resident's tray. The surveyor asked RA#2 and RA#3 why the resident did not have NJ Exec Order 26.4b1, and RA#2 responded that there was no NJ Exec Order 26.4b1 in the kitchen that was why the NJ Exec Order 26.4b1 was provided instead. On that same date and time, the surveyor observed Resident #44's meal ticket for 2 cups of NJ Ex Order 26 and the resident did not receive two cups of NJ Ex Order 26.4 The surveyor asked RA#2 and RA#3 why the resident did not receive 2 cups of NJ Ex Order 26 according to what was in the meal ticket and RA#3 responded that it was the U.S. FOIA (b)(6)) who brought the breakfast tray and there was only one cup of NJ Ex Order 26 in the tray. On 12/17/24 at 8:44 AM, the surveyor went to the kitchen and interviewed the U.S. FOIA (b)(6)). The U.S. FOIA showed what the facility fluids	F 658	and Recreation Aide #3 were counselled and educated on checking the meal tray ticket for accuracy on 12/16/24. All resident's meal tickets were checked for accuracy of meals served on 12/16/24 by dietary and dietician. How the concern will be monitored and title of person responsible for monitoring. Registered Dietician or designee will check tray line distribution for accuracy of meals served daily for 2 weeks then monthly X 90 days and thereafter. Dietician or Designee will audit 4 residents' meal tray receiving magic cup to ensure that the ordered magic cup was served. This audit will be weekly for 1 month then 90 days and thereafter. Director of Nursing or designee will observe 3 or medication pass weekly X 1 month then 90 days and thereafter Results of this observation will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance.	

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could offer to the residents during mealtime. The surveyor observed the kitchen stocks for the pre-thickened honey and nectar water, pre-thickened honey and nectar cranberry juice, cranberry juice, apple juice, oj, and strawberry juice. The surveyor did not see a supply of pre-thickened nectar oj and the [U.S. FOIA] confirmed.

Later, the U.S. FOIA (b)(6) joined the [U.S. FOIA] during the interview. The [U.S. FOIA] stated that the facility had thickened powder that could be mixed with water and juice. The [U.S. FOIA (b)] further stated that she was responsible for mixing the thickened powder and ensuring that the meal ticket corresponded with what should be on the tray. The surveyor notified the [U.S. FOIA (b)(6)] and the [U.S. FOIA] of the above findings and concerns regarding meal tickets of Residents #41, #43, and #44. The surveyor also asked both [U.S. FOIA (b)], if the facility had a supply of NJ Exec Order 26.4b1, and why Resident #43 did not receive [NJ Exec Order 26.4b], and both [U.S. FOIA (b)] did not respond.

On 12/17/24 at 11:09 AM, the surveyor interviewed the [U.S. FOIA (b)] regarding dining services. The surveyor asked the [U.S. FOIA (b)] what the facility's process for dining services was and who verified the meal tickets. The [U.S. FOIA (b)(6)] responded that it was the "recreation people" responsibility to check the meal ticket and what was in the tray. She further stated that it was an expectation if there was a discrepancy with the meal ticket, it should be checked with the nurse or dietary. The surveyor notified the [U.S. FOIA (b)] of the above findings and concerns. The surveyor asked the [U.S. FOIA (b)] why Resident #43 did not receive [NJ Exec Order 26.4b] when there was a NJ Exec Order 26.4b1 and [NJ E], and the [U.S. FOIA (b)] did not respond.

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At that same time, the surveyor also notified the [U.S. FOIA (b)] of the concern with Resident # 44 that the resident did not have two cups of [NJ Ex Order 26] in their tray and the meal ticket revealed that the resident should have two cups of [NJ Ex Order 26.4] the [U.S. FOIA (b)] had no response when asked by the surveyor what should be the expectation when verifying the meal ticket and the tray, and the [U.S. FOIA (b)] had no response.

On 12/18/24 at 10:20 AM, the surveyor interviewed the U.S. FOIA (b)(6)). The [U.S. FOIA] informed the surveyor that everybody should have meal tickets in their trays. The surveyor asked what the importance of the preferences was in the meal ticket, and the [U.S. FO] responded that everybody was unique and for safety. The surveyor asked who should be checking the meal ticket and what was in the tray, and the [U.S. FO] responded that the aide serving should check. The surveyor notified the [U.S. FOIA] of the concern regarding Resident#43, and the [U.S. FO] responded that the RAs should follow the meal ticket for [NJ Ex]

At that same time, the surveyor notified the [ ] of the concern regarding Resident#44's coffee, the [U.S. FO] stated the meal ticket should have been followed for 2 cups of [NJ Ex Order 26.4]

Furthermore, the surveyor notified the [U.S. FO] of the concerns regarding Resident #41. The [U.S. FOIA] stated that Resident #41 was on the [NJ Exec Order 26.4b(1)] and multiple NJ Ex Order 26.4(b)(1) She further stated that her notes on [NJ Exec Order 26.4] reflected that the resident had a NJ Ex Order 26.4(b)(1) for the past [NJ] months and a one-month history of NJ Ex Order 26.4(b)(1) due to [NJ Ex Order 26.4(b)(1)] [NJ Exec Order 26.4b(1)]. The [U.S. FO] also stated that the [U.S. FOIA] was responsible for the tray line and following the diet according to the meal ticket.

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F 658	Continued From page 31	F 658		

On 12/18/24 at 11:14 AM, the survey team met with the U.S. FOIA (b)(6) The surveyor notified the U.S. FOIA (b)(6) and the U.S. FOIA (b) of the above findings and concerns.

On 12/18/24 at 3:01 PM, the U.S. FOIA (b)(6) acknowledged that the meal ticket should be followed. The U.S. FOIA (b)(6) stated that Resident#43's preference was NJ Exec Order 26.4b1 which was why the resident received the NJ Exec Order 26.4b1 The surveyor then asked the U.S. FOIA (b)(6) and the U.S. FOI, if the resident's preference was NJ Exec Order 26.4b1 and why the meal ticket did not specify that. The surveyor asked the U.S. FOIA (b)(6) and the U.S. FOI if was there documented evidence of the resident's preference for NJ Exec Order 26.4b1 and not nectar oj, and the U.S. FO responded that she would get back to the surveyor.

A review of the provided documents by the U.S. FOIA (b) revealed:
-Resident # 43's most recent qMDS with an ARD of NJ Exec Order 26.4b1 Section NJ Ex Order 26.4(b)(1) revealed a BIMS of NJ Exec Order 26.4b1 reflected that the resident's NJ Exec Order 26.4b1 .

-Resident # 44's most recent significant change in status MDS with an ARD of NJ Exec Order 26.4b1 revealed a BIMS score of NJ Exec Order 26.4b1 which reflected that the resident's NJ Exec Order 26.4b1 .

On 12/19/24 at 11:38 AM, the survey team met with the U.S. FOIA (b)(6) Regional DON #1 (RDON#1), RDON#2, U.S. FOIA (b)(6) . The surveyor notified the facility management of the above concerns and findings regarding Resident #41.

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F 658	Continued From page 32 A review of the facility's Food, Dining Service and HS (bedtime) Snacks Policy with a reviewed date of 6/2024 that was provided by the U.S. FOIA (b)(revealed: Policy Explanation and Procedures: -Food service staff members will serve the food choices made with consideration given to dietary restrictions/texture modifications. Plates will be verified for accuracy of service... Eating Environment: -Staff will develop appropriate measures to try to maximize appropriate seating, positioning, and interactions among residents and to assure that each resident receives his or her prescribed diet.... On 12/19/24 at 01:48 PM, the survey team met with the U.S. FOIA (b)(6), RDON#1, RDON#2, U.S. FOIA (b)(6), and the U.S. FOIA (b)(6) for an exit conference. The facility did not provide additional information. 3. On 12/17/24 at 8:23 AM, the surveyor began the Medication (med) Pass Observation task. At 9:02 AM, the surveyor observed Licensed Practical Nurse #1 (LPN#1) prepare and administer medications (meds) to Resident #45. The resident had a total of 4 meds to be administered. The meds included NJ Exec Order 26.4b1 belongs to a group of medications called NJ Exec Order 26.4b1 . The surveyor observed LPN#1 poured the NJ Exec Order 26.4b1 more than the order indicated. Then LPN#1 poured the excess liquid into a second dose cup to get the proper amount. The surveyor observed LPN#1 dispose of the second dose cup with the	F 658		

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excess liquid in the trash receptacle located on the side of the med cart (medcart). The surveyor observed the cup remain upright and not spill into the trash. Resident #45 refused the [NJ Exec Order 26.4b1] [redacted]. The surveyor observed LPN#1 dispose of the refused med into an approved med disposal system located in the bottom of the medcart. The surveyor asked LPN#1 what the policy or procedure on disposal of unused, refused, or extra meds was, and LPN#1 responded that they should be put in the med disposal system.

At 9:15 AM, the surveyor observed LPN#2 prepare and administer meds to Resident #339. The resident had a total of 2 meds to be administered. The meds included [NJ Exec Order 26.4b1] [redacted], ordered for 10:00 AM. During the administration of the meds to Resident #339, the surveyor observed the resident's breakfast tray present on a bedside table next to the resident. The surveyor observed that at least 50% of the meal was consumed. The surveyor asked Resident #339 when and if they had finished with the breakfast meal. The resident stated that they eat quickly and was finished eating approximately 8:15 AM to 8:20 AM.

The surveyor reviewed the electronic medical records (eMR) for Resident #45 and Resident #339.

Resident #45's eMR revealed a PO and eMAR for [NJ Exec Order 26.4b1] [redacted].

Resident #339's eMR revealed a PO and eMAR

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F 658	Continued From page 34 for NJ Exec Order 26.4b1 [redacted] Resident #339's eMR also reflected a nurse's progress note that revealed an assessment that the resident was NJ Exec Order 26.4b1. A review of the manufacturer's informational package insert (PI) for NJ Exec Order 26.4b1 which reflected, the recommended adult oral dosage for NJ Exec Order 26.4b1 [redacted] On 12/18/24 at 11:15 AM, the survey team met with the U.S. FOIA (b)(6), and the surveyor notified the above findings and concerns. The surveyor asked the U.S. FOIA (b) when meds were administered, what would be considered an NJ Exec Order 26.4b1." The U.S. FOIA (b) stated that it was usually 1 hour before a meal or 2 hours after a meal. The surveyor asked the U.S. FOIA (b) what the policy or procedure was for properly disposing of excess meds. The U.S. FOIA (b) stated that meds should be disposed of in the drug disposal system in the medcart. On 12/18/24 at 12:19 PM, the surveyor interviewed the facility U.S. FOIA (b)(6) [redacted] by telephone. The surveyor discussed the concerns with the med pass observation. The surveyor asked the U.S. FO when meds were administered, what would be considered an 'NJ Exec Order 26.4b1." The U.S. FOIA stated the standard would be 1 hour before meals or 2 hours after meals. The surveyor asked the U.S. FO if excess meds should be disposed of in the trash receptacle on the side of the medcart. The U.S. FO stated, no, meds should be disposed of in the	F 658		

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F 658	Continued From page 35 approved med disposal system in the cart. On 12/19/24 at 11:39 AM, the survey team met with the U.S. FOIA (b)(6), and the facility had no further pertinent information to provide. A review of the facility's Administering Medications Using Electronic System Policy dated 6/2024. The policy reflected under 3. Meds must be administered in accordance with doctor's orders, including any required time frame and following med cautionary. The policy did not reflect any information regarding disposal of unused or excess meds during the med pass. NJAC 8:39-11.2(b); 29.2 (d); 29.4(g)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary service to maintain good personal grooming for a resident who was NJ Ex Order 26.4 to carry out NJ Ex Order 26.4(b)(1)). This deficient practice was identified for 1 of 21 residents reviewed for care, Resident #71. The deficient practice was evidenced by the following: On 12/15/24 at 11:12 AM, the surveyor observed	F 677	How the corrective action will be accomplished for any resident affected by deficient practice? Resident #71 was NJ Exec Order 26.4b1. All residents were checked for good personal grooming and hygiene, no resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected.	2/5/25

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F 677	Continued From page 36 Resident #71 lying on an air mattress inside their room. The resident waved to the surveyor but was unable to answer questions at that time. The surveyor observed Resident #71 NJ Exec Order 26.4b1 [redacted] On 12/16/24 at 11:28 AM, the surveyor observed the Resident #71 sitting on the wheelchair (w/c) inside their room, NJ Exec Order 26.4b1 and Certified Nursing Assistant #1 (CNA#1) was combing the resident's NJ Exec Or. The resident communicated to the surveyor and whispered their name when the surveyor asked for the name of the resident. On 12/16/24 at 11:39 AM, the surveyor interviewed CNA #1, who stated, "I NJ Ex Order them, answer call bells, the resident is NJ Ex Order 26.4(b)(1). I have not been the regular aide, I was not here this weekend, sometimes the resident does not like to NJ Ex Order 26.4(b)(1) because he/she NJ Ex Order 26.4(b)(1), says NJ Ex Order 26.4(b)(1) but today the resident is NJ Ex Or and will try later to shave." The surveyor reviewed the medical records of Resident #71 and revealed: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with a diagnosis which included but not limited to NJ Exec Order 26.4b1 [redacted] According to the Annual Minimum Data Set (MDS), an assessment tool to drive the plan of care dated NJ Exec Order 26.4 revealed a Brief Interview of	F 677	All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. All CNA's was re in serviced regarding resident ADL's and how to maintain good personal hygiene and grooming on 12/16/24 License Nurses were in serviced on updating resident's plan of care when care was refused on 12/16/24 Residents refused care or treatment will be reported to his/her attending physician and family members. License Nurse will document any refusals of care. IDT will check residents personal grooming weekly during clinical rounds. How the concern will be monitored and title of person responsible for monitoring. Assistant Director of Nursing or designee will check 5 residents daily x 30 days then every month x 90 days and thereafter for being groomed and good personal hygiene.	

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F 677	Continued From page 37 Mental Status (BIMS) score of NJ Exec Order 26.4b1 indicating NJ Exec Order 26.4b1 . The section GG in the MDS revealed ADLs for NJ Exec Order 26.4b1 [redacted] On 12/17/24 at 11:15 AM, the surveyor observed the resident sitting on the w/c in the resident's room, with NJ Exec Order 26.4b1 . On 12/18/24 at 9:30 AM, the surveyor interviewed License Practical Nurse #1 (LPN#1). The [redacted] stated, "The resident is NJ Ex Order 26.4(b)(1) will nod to questions, does not usually NJ Ex Order 26 care for me." On 12/18/24 at 10:46 AM, the surveyor interviewed CNA #2. CNA#2 stated, "I do NJ Ex Order 26.4(b [redacted] care every morning. The resident likes care later in the morning, sometimes they will refuse NJ Ex Order 26.4(b [redacted] but once you tell the resident and explain, they will allow you to do it." On 12/18/24 at 11:13 AM, the surveyor notified the above concerns to the U.S. FOIA (b)(6) [redacted]. A review of the facility's Activities of Daily Living Policy, last reviewed on 10/2024 revealed that A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. On 12/19/24 at 11:38 AM, the survey team met with the U.S. FOIA (b)(6) [redacted], Regional DON #1 (RDON#1), RDON#2, and the U.S. FOIA (b)(6) The [redacted] stated, "[Name Redacted] was observed NJ Exec Order 26.4b1 . The	F 677	Results of this audit will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance.	

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F 677	Continued From page 38 care plan was updated to include refusal to be [redacted] and to reflect in the documentation the refusal and to ask the resident to be [redacted] in a later time." NJAC 8:39-27.2(g)	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice and facility policies and procedures for 1 of 24 residents, Resident #86, reviewed for quality of care. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered	F 684	How the corrective action will be accomplished for any resident affected by deficient practice Staff immediately in serviced on what to do if a lab or a radiology order cannot be carried out. Resident #86 was discharged and unable to assessed resident. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected.	2/5/25

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F 684	Continued From page 39 professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 12/18/24 at 9:31 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #86. The Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, [redacted]. A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] NJ Exec Order 26.4b1 indicated the facility assessed the resident's NJ Exec Order 26.4b1	F 684	All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Licensed nurses were re in serviced on notification of the physician for any changed in condition on 12/17/24. Licensed nurses were re in serviced on documentation regarding X-ray or any laboratory results on 12/17/24 Unit Managers or designee will review laboratory results for documentation and notifications to Physician and Responsible Party if any delays arise. How the concern will be monitored and title of person responsible for monitoring. Unit manager or designee will review 5 charts weekly for 30 days then every month x 90 days and thereafter for Radiology / Laboratory results documentation, and notification in changed in condition Results of this audit will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and	

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F 684	Continued From page 40 a Brief Interview Mental Status (BIMS) test. Resident #86 scored a [redacted], which indicated the resident had [redacted] A physician's order dated [redacted] documented [redacted]. A skilled progress note (PN) dated [redacted] at 12:31 PM revealed Licensed Practical Nurse #1 (LPN#1) documented the physician visited the resident and orders for [redacted]. There was no further documentation about the [redacted] status in the PN. There was no documentation of the [redacted] results in the paper chart or the EMR. A review of the resident's [redacted]) results revealed: - [redacted] at 5:32 AM, the resident's documented [redacted] There were no other vital signs (VS; includes BP, pulse, respiratory rate, temperature, oxygen saturation) documented for the resident at this time. - [redacted] at 6:05 AM, the resident's documented [redacted] There was no other VS documented for the resident at this time. A review of the resident's [redacted] revealed the resident's [redacted] was	F 684	Performance Improvement and this will be a part of Center quarterly Quality Assurance.	

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NJ Exec Order 26.4b1 documented for the resident.

A review of the PN, indicated there was no documentation of the physician being notified of the resident's NJ Exec Order 26.

On 12/18/24 at 10:25 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that if there was a change of condition with the resident an SBAR [Situation, Background, Assessment, and Recommendation; a tool that can be used to help healthcare teams share information about a patient's condition or concerns] and the physician should be notified for any orders to be carried out. The surveyor asked the NJ Exec Order 26.4b1 if a resident's NJ Exec was outside of the baseline for the resident, what would be expected of the nurses. The U.S. FOIA (b)(6) stated that the physician should be made aware of the resident's U.S. FO for any orders.

The surveyor asked the U.S. FOIA (b)(6) about what would be expected for a NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) stated that the NJ Ex Order would be called in or entered in their electronic system and the technician would be expected within 3-4 hours. The U.S. FOIA (b)(6) further explained that she had never experienced any issues with stat orders and if they did not arrive that it would be expected to call the vendor, notify the physician, and the U.S. FOIA (b)(6) The surveyor discussed the concern that the results for Resident #86's NJ Ex Order 26.4(b)(1) was not found in the paper chart and the EMR. The U.S. FOIA (b)(6) stated she would follow up to provide additional information.

On 12/18/24 at 10:54 AM, the surveyor interviewed LPN #2 over the phone. The LPN

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F 684	Continued From page 42 stated that if there was a change with a resident, the resident needed to be assessed, an SBAR completed, the physician notified for orders and the RN supervisor notified to assess the resident. LPN #2 stated if a change in [NJ Ex O] from baseline occurred, the physician and supervisor should be notified for interventions. The surveyor asked if it would be documented in the EMR. The LPN replied that it would be documented in the PN of the EMR. The surveyor asked about Resident #86. LPN #2 replied that she could not recall everything as some time had passed and that anything pertinent would be documented in her PN in the EMR. On 12/18/24 at 11:14 AM, the surveyor notified the[U.S. FOIA (b)(6)] of the above concerns of the [NJ Ex Order 26.4(b)(1)] that was not completed, and no documentation of the physician being made aware of the resident's low[U.S. FOI] results. On 12/18/24 at 11:44 AM, the [U.S. FOIA (b)(6)] provided a [NJ Ex Orde] requisition form for Resident #86 and attached email. A review of the email document indicated that the vendor called the facility a notified a named facility staff member that they were overwhelmed and would be able to send a technician in the morning of [NJ Ex Order 26.4(]. On 12/19/24 at 11:38 AM, the [U.S. FOIA (b)(6)] Regional DON #1, Regional DON #2, and the [U.S. FOIA (b)(6)] met with the survey team. The surveyor asked who was the staff that was notified by the vendor that would not be able to do the [NJ Ex Order 26.4(b)(1)] and what would be expected of the	F 684		

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staff once notified. The [redacted] stated it was a nurse supervisor who was notified, and it was protocol to call the physician to notify that there would be a delay. The [redacted] and the [redacted] stated the nurse supervisor spoke with the physician. The surveyor asked if there was any documentation that the physician was notified. The facility stated they would review to provide any additional information. The surveyor asked if there was any response for the resident's [redacted] and the physician not being notified. The facility stated they would also review to provide additional information.

On 12/19/24 at 1:05 PM, the [redacted] stated that the resident's [redacted] went [redacted] upon the resident's re-check and that was why the nurse did not notify the physician. There was no additional information provided by the facility.

A review of the facility's Acute Condition Changes-Clinical Protocol Policy, with a last revised dated of June 2024. Under Assessment and Recognition, it specified, " ...5. Before contacting a physician about someone with an acute change of condition, the nursing staff will make pertinent observations and collect appropriate information to report to the Physician; for example, history of present illness and previous and recent test results for comparison."

Under Treatment/Management it documented, "The physician will help identify and authorize appropriate treatments". Under Monitoring and Follow-Up, it documented, "1. The staff will monitor and document the resident's progress and responses to treatment and the Physician will adjust treatment accordingly."

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DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE PARAMUS, NJ 07652**

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F 684	Continued From page 44 A review of the facility's Lab (laboratory) and Diagnostic Test Results- Clinical Protocol Policy, with a last revised dated of June 2024. The policy did not address the protocol for when a diagnostic test could not be performed by the diagnostic radiology provider. N.J.A.C. 8:39-3.2 (a), (b); 27.1 (a)	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary NJ Ex Order 26.4(b)(1) care and services of residents that were receiving NJ Ex Order 26.4(b) according to the standard of clinical practice and the facility's policy and procedure, specifically, administer NJ Ex Order 26.4(b)(1) according to the physician's order by documenting the date and time the NJ Ex Order 26.4(b)(1) was changed for 1 of 1 resident, Resident #10. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title	F 695	How the corrective action will be accomplished for any resident affected by deficient practice? Resident #10 NJ Exec Order 26.4b1 was immediately corrected, changed, labeled appropriately, and documented in the electronic Medical Record. All residents receiving NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) were checked. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected.	2/5/25

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F 695	Continued From page 45 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 12/15/24 at 11:55 AM, during initial tour the surveyor observed Resident #10 in a wheelchair (w/c), [redacted] with [redacted] being administered by [redacted] attached to and [redacted]. The surveyor did not observe a label or other marking on the [redacted] denoting when it was changed for a new set. On that same date and time, the surveyor	F 695	All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Licensed nurses were in serviced to document the date the oxygen tubing's was changed following facility Policy and Procedure to change weekly. Unit Manger or designee will review Physician's order and documentation to match with the date of Oxygen tubing's. Weekly oxygen tubing change and as needed which includes the date will be added to the care plan for individuals on oxygen. The Interdisciplinary Team will check O2 tubing's for the date during clinical rounds 2 x a week and ensure that the date is secured to the tubing to prevent it from falling off. How the concern will be monitored and title of person responsible for monitoring. Assistant Director of nursing and designee will audit 5 residents on Oxygen daily X4 weeks for dates on tubing, then every month X 90 days and thereafter. Any oxygen tubing that is found to be undated will be changed immediately.	

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F 695	Continued From page 46 interviewed Resident #10. The surveyor asked the resident how they use the [redacted] and if the staff prepares it or replaces the [redacted]. The resident stated that the staff does change the [redacted] but was unsure when that happens. The resident also stated they were in the process of weaning off the [redacted] and sometimes does not use it. On 12/16/24 at 10:11 AM, the surveyor observed Resident #10 in a w/c with [redacted] being used. The surveyor observed that the [redacted] had date written on a piece of surgical tape and applied near the connection to the [redacted]. The date reflected [redacted]). The surveyor reviewed the hybrid (electronic and paper) medical record for Resident #10. The Resident Admission Record (a summary of important information about the resident) revealed that the resident was admitted with diagnoses that included but were not limited to, [redacted]. A Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #10 scored a [redacted], which indicated the resident had no [redacted] Further review of the MDS, Section [redacted], revealed the resident was [redacted]. A review of the resident's Care Plan (CP) initiated [redacted], (a list of interventions and goals related	F 695	Results of this audit will be discussed in morning clinical meeting to identify trends and solutions which will be discussed in monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance.	

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F 695	Continued From page 47 to the resident's care), revealed that Resident #10 received [redacted] for NJ Ex Order 26.4(b)(1) and symptoms of NJ Ex Order 26.4(b)(1). A review of the resident's Physician Order Sheet (POS) revealed an order dated [redacted]: Change NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) weekly. Label with date, time, and nurse's initials every night shift every Wed (Wednesday) for preventative care and as needed for [redacted]. The above orders for U.S. FOIA (b)(6) was transcribed to the U.S. FOIA (b)(6) electronic Medication Administration Record (eMAR). There was no documented evidence that the PRN order for [redacted] change was signed on [redacted] according to the POS. On 12/18/24, the survey team met with the U.S. FOIA (b)(6) [redacted] The surveyor notified the U.S. FOIA (b)(6) of the above findings and concerns. On 12/19/24 at 11:39 AM, the survey team met with the U.S. FOIA (b)(6) [redacted] Regional DON #1 (RDON#1), RDON#2, and U.S. FOIA (b)(6)t for facility's responses from the above concerns and findings. The facility management response included documentation that reflected that the facility considered it an isolated event and was immediately corrected, and there was a possibility the date label fell off at some time. On 12/19/24 at 11:45 AM, the surveyor interviewed the U.S. FOIA (b)(6) after the response. The surveyor asked how the date was applied to the [redacted] The U.S. FOIA (b)(6) stated that it	F 695		

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F 695	Continued From page 48 was written on a piece of surgical tape, then applied to the [redacted]. The surveyor further inquired if there was any additional documentation that the label was replaced, would the nurse document the current day, would the nurse document under the PRN order and if the tape fell off, would it be considered not secure. The [redacted] responded that the reasoning that the tape fell off or was knocked off by the resident was a possible answer being provided, and there was no absolute way to know. After the facility response, the facility did not provide any further pertinent information. A review of the facility's Oxygen Administration Policy dated 10/2024 revealed: Preparation: 1. Verify that there is a physician's order (PO) for this procedure. Review the PO or facility protocol for O2 administration. Documentation: 1. The date and time that the procedure was performed. The policy did not reflect any mention of applying a date to the O2 tubing specifically. NJAC 8:39-11.2(b); 27.1(a)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 698	How the corrective action will be	2/5/25

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F 698	Continued From page 49 and review of other pertinent documents, it was determined that the facility failed to ensure that residents who require [U.S. FOIA (b)(6)] receive such services, consistent with professional standards of practice for 1 of 1 resident (Resident #25), reviewed for [U.S. FOIA (b)(6)] services. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 12/15/24 at 10:36 AM, the surveyor observed Resident #25 sitting in a wheelchair at their	F 698	accomplished for any resident affected by deficient practice? The [NJ Exec Order#] order was clarified with attending physician and was immediately corrected, administration time was altered to reflect correct administration timing and all of this was included in the Electronic Medical Record. Symptom monitoring was put into effect for this resident to ensure no adverse effects occurred – there were no adverse effects found. The Licensed Practicing Nurse was educated and disciplined on 12/16/24 for not carrying medication orders properly and sending medication to Dialysis Center without orders. All residents that go to dialysis centers had their orders checked for documentation of medication administered at Dialysis Center. Dialysis communication forms were reviewed and verified. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents, especially dialysis residents, have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future).	

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F 698	Continued From page 50 bedside. Resident #25 was NJ Exec Order 26.4b1 [redacted]. The resident stated they went to NJ Exec Order 26.4b1 and had no concerns with their care. On 12/16/24 at 11:48 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] assigned to care for Resident #25. The U.S. FOIA (b) stated the nurses documented on the NJ Exec Order 26 communication form (NJ Ex Order 2 when sending the resident to the NJ Exec Order 26 center, including vital signs (VS; blood pressure (BP), pulse, respiratory rate, and temperature) and any changes or concerns. The NJ Exec Order 26.4b center would document on the second portion of the form, which included pre and post treatment NJ Ex Order 26.4(b)(1) and NJ Ex Or any medications (meds) given to the resident during NJ Exec Order 26 and any concerns during the NJ Exec Order 26 session. The LPN provided the NJ Exec Order 26 communication binder for Resident #25. The binder included 2 NJ Ex Order The surveyor requested the additional NJ Ex Orde for Resident #25. On 12/16/24 at 12:02 PM, the U.S. FOIA (b)(6) [redacted] stated the NJ Ex Orde were uploaded to the resident's EMR and the original copies were kept in a binder for the year. The U.S. FOIA (b)(6) , in the presence of the surveyor reviewed the resident's EMR which revealed the scanned copies of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) [redacted]. On 12/18/24 at 9:28 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #25. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were	F 698	Measures to ensure were/will be put into place to assist this area of concern. All License Nurses were in serviced on Medication Administration on 12/16/24. Immediately upon return to the facility Nursing Supervisor or Designee will review dialysis communication book for medications administered. Coordination of care with Dialysis company Nurse supervisor or designee will review/verifies dialysis communication book for medications administered and appropriate documentation at Dialysis Center. License Nurses will coordinate care with Dialysis Center throughout the resident's stay that is on dialysis. Unit manager or designee will audit residents on dialysis daily X 30 days then monthly and thereafter for medication administration to ensure medication administered at Dialysis Center has proper order and with documentation to at test what was administered. How the concern will be monitored and title of person responsible for monitoring. Results of this audit will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement and this will be	

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F 698	Continued From page 51 not limited to, NJ Exec Order 26.4b1 [redacted] A comprehensive Minimum Data Set (MDS), an assessment tool to facilitate the management of care, dated [redacted], indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #25 scored a [redacted], which indicated the resident was [redacted]. A review of the scanned [redacted] for [redacted], revealed the following: On [redacted], under the facility section it was written "I left a [redacted] ([redacted]) in book ...Please give before leaving." There was no further documentation on the form about the [redacted] med. On [redacted] under the facility section of the form it was written [redacted] in Book." Under the [redacted] section of the form it was written "pt [patient] [redacted] post tx [treatment]." On the bottom of the form it was written, '[redacted], not given still in binder." On [redacted], under the [redacted] section of the form it was written '[redacted] given." There was no further documentation on the form about the [redacted] med. On [redacted], a [redacted] center communication log form, under the post [redacted] section it was written for meds given '[redacted] given." There was no further documentation on the form about the [redacted] med.	F 698	a part of quarterly Quality Assurance.	

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F 698	Continued From page 52 On [redacted], under the [redacted] section of the form it was written '[redacted]] given post [redacted]." There was no further documentation on the form about the [redacted] med. A physician's order (PO) dated [redacted] documented the resident had [redacted] on Tuesday (Tue), Thursday (Thu), and Saturday (Sat) with a pickup time of 8:15 AM. A PO dated [redacted] documented the resident was to receive NJ Exec Order 26.4b1 [redacted] for [redacted] at [redacted]. A PO dated [redacted] documented the resident was to receive NJ Exec Order 26.4b1 [redacted] There were no additional orders for [redacted] A review of progress notes (PN) for [redacted] revealed: On 12/10/24 at 5:47 PM a PN written by the [redacted] indicated per the [redacted] the resident [redacted] NJ Exec Order 26.4b1 tx and the [redacted] sent to [redacted] with the resident was not administered, still in the binder. The [redacted] nurse was called, reviewed that the resident had a [redacted] order, the med was in the binder to be given to the resident. There were no other PN related to the resident receiving NJ Exec Order 26.4b1. On 12/18/24 at 9:52 AM, the surveyor interviewed	F 698		

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F 698	Continued From page 53	F 698		

the [U.S. FOIA] who stated that the resident had episodes of having nausea when returning from [NJ Exec Order 26] and the physician ordered [NJ Exec Order 2] for the resident. The [U.S. FOIA] stated the [NJ Exec Order 26] was an individual dose sealed in its original packaging. The [NJ Exec Order 2] packaged dose would be placed in a clear plastic bag and attached inside of the binder. The [U.S. FOIA (b)] stated it would be documented on the [NJ Exec Order 26] communication book if the resident received the med in [NJ Exec Order 26].

On 12/18/24 10:07 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] about Resident #25 receiving [NJ Exec Order 2] in [NJ Exec Order 26]. The [U.S. FOIA (b)(6)] stated the PO for the resident to receive med [NJ Exec Order 26.4b1] due to NJ Exec Order 26.4b1. The [U.S. FOIA (b)(6)] further explained the [NJ Exec Order 26] center did not have the med and that was why the med was being sent with the resident. The [U.S. FOIA (b)(6)] confirmed there should be a PO for sending the med with the resident to [NJ Exec Order 26] and stated that the resident did have one. The [U.S. FOIA (b)(6)] showed the surveyor the resident binder which had a print out of a PO to send [NJ Exec Order 26.4b1] with the resident to [NJ Exec Order 26], dated [NJ Exec Order 26]. The surveyor asked the [U.S. FOIA (b)(6)] to review the PO in the EMR. The [U.S. FOIA (b)(6)] could not find an active order for [NJ Exec Order 26.4b1] to be sent to [NJ Exec Order 26] with the resident. The [U.S. FOIA (b)(6)] found an order that was discontinued (d/c) on [NJ Exec Order 26.4b1]. The [U.S. FOIA (b)(6)] could not speak to what happened and would have to follow up.

The surveyor asked the [U.S. FOIA (b)(6)] about accountability for the [NJ Exec Order 26] med. The [U.S. FOIA (b)(6)] stated that it would be written on the [NJ Exec Ord] if the resident received the med and if the med returned in the binder the med was not given. The [U.S. FOIA (b)(6)] added if the [NJ Exec Ord] did not document if the resident received or if there was a concern about

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NJ Exec Order 26 NJ Exec Order 26 administration, the staff would call the center to confirm it was given or not. The surveyor asked about the documentation of the time the NJ Exec Order 2 med was administered in NJ Exec Order 26 as the resident also had a NJ Exec Order 26.4b1 order. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) stated that it was given NJ Exec Order 26.4b1. The acknowledged the exact time the med was received was not known as it was not documented on the NJ Ex Orde and the facility nurse would have to call the NJ Exec Order 26 center to find out that information. The surveyor informed the U.S. FOIA (b) (6) of the concern that the administration time was unknown and NJ Exec Order 2 was sent with the resident without a PO.

On 12/18/24 at 11:14 AM, the surveyor notified the U.S. FOIA (b)(6)) of the above concerns related to the resident's NJ Exec Order 25 med.

On 12/19/24 at 11:38 AM, the U.S. FOIA (b)(6) Regional DON #1 (RDON#1), Regional DON #2 (RDON#2), and the U.S. FOIA (b)(6) met with the survey team. The facility stated the there was a PO for NJ Exec Order 25 and provided the Medication Administration Record (MAR). A review of the MAR revealed the NJ Exec Order 25 order was dated NJ Exec Order 26.4b1 and timed for administration 7:45 AM. It did not indicate NJ Exec Order 26.4b1 should be sent with the resident to NJ Exec Order 25. The surveyor rediscussed concern for Resident #25's NJ Exec Order 2. The facility stated they would review to provide any additional information.

On 12/19/24 at 12:59 PM, RDON#2 provided a physician PN, dated NJ Exec Order 26.4b1, which indicated the physician wanted to continue the NJ Exec Order 26 orders.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE PARAMUS, NJ 07652**

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F 698	Continued From page 55 The surveyor asked RDON#2 if it would be expected for there to be PO for the nurses to follow. RDON#2 acknowledged that there should have been a PO for it. There was no additional information provided by the facility. A review of the facility's End-Stage Renal Disease, Care of a Resident Policy with a last updated date of 10/2024 revealed: Under the Policy Statement it was written "Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care." Under Policy Interpretation and Implementation, it documented, " ...7. Facility will send dialysis communication form or communication book to dialysis Center. This communication form/book will be returned to the facility for review for orders, med administered at the Center, latest lab works, resident weights, or any significant changes ..." A review of the facility's Administering Medications Using Electronic System, with a last reviewed date of 6/2024 revealed: Under the Policy Statement it was written "Meds shall be administered in a safe and timely manner, and as prescribed." Under Policy Interpretation and Implementation, it documented, " ...3. Meds must be administered in accordance with doctor's orders, including any required time frame ..."	F 698		
F 732 SS=D	NJAC 8:39 - 27.1(a) Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility	F 732		2/5/25

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F 732	Continued From page 56 must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour	F 732	How the corrective action will be accomplished for any resident affected by deficient practice	

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F 732	Continued From page 57 staffing report posted was accurate and in a prominent place within the facility readily accessible to the residents and the visitors. This deficient practice was evidenced by the following: On 12/15/24 at 8:56 AM, the survey team entered the facility. The surveyor did not observe a 24-hour staffing report in the initial hallway leading to the nursing station or at the nursing station. The surveyor then turned right and proceeded down a different hallway, which contained the lower odd numbered resident rooms and observed a staffing report sheet that was posted on the right wall next to the menu. The surveyor observed that the posting would not be accessible or visible to residents and visitors that were located or visited the resident rooms that were in the hallway that contained the higher odd numbered rooms. The posting observed was dated 12/13/24 evening shift with a census of 85. The posting had not been updated for that day and did not include the accurate census which the Registered Nurse Supervisor informed the survey team was 86. On 12/16/24 at 9:15 AM, the surveyor observed the staffing report that was posted was dated 12/16/24 day shift with a census of 85. The posting was accurate. On 12/17/24 at 8:45 AM, the surveyor observed the staffing report that was posted was dated 12/16/24 evening shift. The posting had not been updated for that day. On 12/17/24 at 10:43 AM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding the posting of the staffing report. The	F 732	Immediately, the 24-hourly staffing report posting was corrected to show the right census and the correct date and shift. The 24-hourly staffing report is now posted in the receptionist area visible to residents, staff and visitors as soon as you walk in the building. An additional posting was put up at the front for more visibility to residents and visitors. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. U.S. FOIA (b) (6) U.S. FOIA (b) (6), Supervisors, and U.S. FOIA (b) (6) were in service regarding accurate posting of daily 24-hourly staffing report on 12/15/24. Additional copy of 24-hourly staffing report is posted in the entrance bulletin board accessible to residents, staff and visitors. Administrator or designee will check	

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F 732	Continued From page 58 U.S. FOIA (b) stated that the U.S. FOIA (b)(6)) posted the staffing report and that she believed it was posted for the whole day. On 12/17/24 at 11:31 AM, the U.S. FOIA (b) stated that the U.S. FO placed the 3 different sheets, 1 sheet for each shift, in the clear plastic sleeve that was located on the wall. She added that when the U.S. FO comes into the facility around 8 AM, she placed all 3 shifts and that when the U.S. FO left, she would remove the day shift report to reveal the evening shift report. The U.S. FOIA (b) then stated that the 3-11 Supervisor at the end of the evening shift would remove the evening shift report to reveal the night shift report. The surveyor asked the U.S. FOIA (b) who was responsible on the weekend to post the staffing reports. The U.S. FOIA (b) stated that the U.S. FO would print out all 3 days on Fridays and that the Supervisors on the weekend were supposed to post them each shift. The surveyor asked the U.S. FOIA (b) if the posting should be prominent for all residents and visitors. The U.S. FOIA (b) stated that it should be prominent. On 12/17/24 at 12:26 PM, the surveyor interviewed the U.S. FO regarding posting of the staffing report. The U.S. FO stated that she would print all 3 shifts which included the next day's day shift report and put them in the sleeve. She added that the Supervisor on the night shift would reveal the day shift report. The surveyor asked the U.S. FO who was responsible on the weekend. The U.S. FO stated that the Supervisors were responsible on the weekend. On 12/18/24 at 10:01 AM, the surveyor requested from the U.S. FOIA (b) (6) a facility policy for the posting of the staffing report. The U.S. FOIA (b)(6) stated that the facility	F 732	24-hourly staffing report daily x 30 days, then every 90 days and thereafter. How the concern will be monitored and title of person responsible for monitoring. Administrator or Designee will monitor the accurate postings of the 24 hour staffing report daily for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, then Quarterly after that. Results will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance. Depending on the findings of these audits, a determination will be made as to how long this project will take place.	

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F 732	Continued From page 59 did not have a policy for posting and that they followed the regulation. The [redacted] then stated that the staff brought it to his attention about the concerns with the posting and that he placed an additional posting in a different area. On 12/18/24 at 11:38 AM, in the presence of the survey team, the surveyor notified the [redacted] he concern that the staffing report was not posted in a prominent place within the facility readily accessible to the residents and the visitors and was not accurate and up to date on [redacted] On 12/19/24 at 11:47 AM, in the presence of the survey team, [redacted], Regional DON #1 (RDON#1), RDON#2 and [redacted] the [redacted] stated that he had a statement from the person that switched out the posting. The [redacted] then stated that he felt that the posting was visible since that was where the menus were located but that however he added a posting to another area. RDON# 1 stated that all 3 shifts were posted in the sleeve but that they were behind the one posted and that each shift was not visible. The [redacted] stated that she talked to the [redacted] and other staff to make sure it was visible at all times. The facility did not provide any additional information.	F 732		
F 812 SS=F	N.J.A.C. 8:39-41.2 (a)(b)(c) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		2/5/25

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F 812	Continued From page 60 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 12/15/24 at 9:28 AM, the surveyor, in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b)(6)), observed the following during the kitchen tour: 1. In the juice dispenser area, there were three 5-gallon beverage boxes that were past their best used by date. A thickened water (nectar consistency) 5-gallon box had a best if used by date of 9/11/24. A thickened water (honey consistency) 5-gallon box had a best if used by date of 7/31/24. A diet lemonade 5-gallon box had	F 812	How the corrective action will be accomplished for any resident affected by deficient practice? The box of expired diet lemonade was removed and disposed of. All food supplies were immediately checked for expiration date. All food in all refrigerators which included resident refrigerators were immediately checked for expired items and if any were found they were removed. The fiber was immediately removed and the entire food processor was cleaned. The U.S. FOIA (b) (6) was immediately given a beard restraint to wear. Extra beard restraints were ordered for supply.	

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F 812	Continued From page 61 a best if used by date of 10/3/23. The [U.S. FOIA (b)] stated that the beverage boxes were good for 6 months after their best if used by date. The [U.S. FOIA] acknowledged the diet lemonade was expired. The surveyor requested documentation from the U.S. FOIA (b)(6) which indicated the beverage boxes were still good to be used 6 months after the best if used by date. 2. On a food preparation (prep) table there was a food processor machine. The surveyor observed a single fiber- like strand, more than 3 inches long with the top compartment cover of the machine. The surveyor pointed out the observation to the [U.S. FOIA (b)(6)] who took off the top of the machine off and took the hair strand. On the food prep table next to the machine there were food items covered with clear plastic wrap. The surveyor asked the U.S. FOIA (b)(6) if there was any concern with the fiber strand being found on the food processor machine and the area being a food prep area. The [U.S. FOIA (b)(6)] stated the strand was part of a hairnet, it was outside of the machine, and there was no food in the machine. The U.S. FOIA (b)(6) confirmed the items on the table were being prepared for the next meal and the table was a food prep area. 3. In the drying rack storage area, 1 of 3 small veggie steam pans checked was observed to be soiled with a dry, hard food-like debris on the side wall of the pan. The [U.S. FOIA (b)] confirmed the pan was soiled that it was expected to have been clean and would put the pan to be re-washed. On 12/16/24 at 10:48 AM, the surveyor, in the presence of the U.S. FOIA (b)(6), observed the following during a kitchen tour:	F 812	All pans and bowls with food debris were immediately rewashed, dried and stored accordingly. The dish room was immediately cleaned thoroughly to remove any white solid debris or stains. The crumpled wash cloth was immediately removed and the dishwasher was immediately cleaned of all white solid food debris and removed from the area. All 5 gallon food bins were immediately removed and cleaned. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. All Dietary staff were in service on checking on expiration date of all food items on 12/16/24 All employee with mustache or beard guard will wear a beard hairnet when	

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F 812	Continued From page 62 4. The surveyor observed Dietary staff (DS) #1 exit the dishwashing area and walking through the food prep area to exit the kitchen. DS #1 had facial hair including a mustache and facial hair on their chin. DS #1 was not wearing a beard restraint (used to contain facial hair, such as, beards, mustaches, and goatees to prevent it from falling into food and contaminating it). The surveyor asked the [redacted] about the observation of DS #1 with facial hair and not wearing a beard restraint. The [redacted] stated DS #1 did not have facial hair. The surveyor interviewed DS #1 in the presence of the [redacted]. The DS #1 acknowledged he had a mustache, facial hair on his chin, and that it should have been covered with a beard restraint. The surveyor asked DS #1 if there were any available beard restraints for him. DS #1 was not able to provide a verbal response. The surveyor asked the [redacted] about beard restraints available for staff. The [redacted] went to look for the beard restraint supplies for the staff. 5. In the dishwashing area, the three-compartment sink had 1 of the 3-compartment filled with sanitizing solution water, and soaking dishes. No staff were in the dishwashing area. The [redacted] stated the dishes were still in progress of being washed by staff. On a metal table in which clean dishware would come out from the dishwasher there was white solid, food-like debris on the table. 6. In the dishwashing area on a shelf above the 3-compartment sink, there were three serving trays filled with dessert bowls which were faced down on it. The [redacted] stated it was to dry the	F 812	working in the kitchen. All kitchen staff were in service on Kitchen sanitation, Cleaning of food containers, Kitchen and table counter tops. Food Service Director or designee will check food items for expiration date. These in services were done on 12/16/24. Registered Dietician or designee will check kitchen staff for wearing hairnet and beard guard appropriately 3x a week. Administrator or designee will check dietary department for cleanliness and sanitation daily for 5 days, then weekly for 4 weeks, then monthly for 3 months, then quarterly thereafter. How the concern will be monitored and title of person responsible for monitoring. Regional Director Dietician or designee will review Dietary Department for Expired food items, for food debris in dessert bowl, bins, proper wearing of hair and beard guard for protection, weekly X 30 days, then 90 days or thereafter. Regional Director Dietician or designee will review Dietary Department Sanitation and Infection Control which includes Food processor, steam pans, and shelves. Facility will ensure beard guards are ordered Quarterly Results of this review will be discussed in	

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F 812	Continued From page 63 dish ware and the shelf area was considered a clean area. The surveyor asked about the soiled dishes still being washed in the 3-compartment sink below the shelf and if there was a risk of contamination of the dishes. The [redacted] replied that the clean dishes were not kept on that shelf when dirty dishes were being washed. The surveyor informed the [redacted] of the dishwashing area being in use prior to the surveyor entering area. There was no additional verbal response by the [redacted] about the clean bowls on the trays. Next to the trays on the shelf were four 5-gallon food bins on the shelf right side up and uncovered. The surveyor asked the [redacted] what the bins were used for. The [redacted] stated that the bins were considered clean and were used to store the dessert bowls when they dried. The [redacted] further stated the bins would be covered once the bowls were stored inside. The surveyor asked to check the inside of all 4 of the uncovered bins. The first bin had an accumulation of clear liquid on the bottom of the bin. The [redacted] stated that the bin was drying. The second bin had 1 dessert cup inside of it. The third bin had several loose dessert cups stored in it, and the last bin was empty. The outside of the bins had discolored stains/spots. The surveyor asked the [redacted] if it was considered clean. The [redacted] replied that the dishware was stored inside and covered for storage. 7. In the dishwashing area on the shelf above the 3-compartment sink there was a crumpled washcloth against the wall and next to one of the trays of the dessert bowls. The [redacted] took the washcloth, confirmed it was wet and acknowledged it should not have been up there.	F 812	morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance.	

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F 812	Continued From page 64	F 812		

The [U.S. FOIA (b)] stated she did not find any beard restraints and told DS #1 to wear a face mask to cover their facial hair. The [U.S. FOIA] acknowledged DS #1 had facial hair and stated that he should have been wearing a beard restraint.

The surveyor asked the [U.S. FOIA] about the clean and soiled areas of the dishwashing area. The [U.S. FOIA] stated the metal table in which the clean dishware comes out of dishwashing machine was considered a clean area. The surveyor asked about the white colored food-like debris observed on the table. The [U.S. FOIA] acknowledged that the area was not clean and that it should have been clean.

The surveyor asked the [U.S. FOIA] about the concern of clean dessert bowls being stored on the shelf above the 3-compartment sink and the use of the 5-gallon bins being used to store dishware. The [U.S. FOIA] replied that the clean dishware would be removed from the dishwashing area placed on a cart which was kept between the dishwashing and food prep areas. There was no additional verbal response by the [U.S. FOIA].

8. The surveyor accompanied by the [U.S. FOIA] in the drying rack storage area, observed 1 of 2 long vegetable pans was soiled with dry, solid, food-like debris on the side wall of the pan. The [U.S. FOIA] confirmed the pan was soiled and that it needed to be washed again.

The surveyor requested from the U.S. FOIA (b)(6) for policies on kitchen cleanliness, storage, and hair restraints.

On 12/16/24 at 12:46 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] about if it was expected for

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F 812	Continued From page 65 beard restraint supply to be available in the kitchen for staff. The U.S. FOIA (b)(6) replied "Yes." The surveyor informed the U.S. FOIA (b)(6) of the concern that there was none available as per the U.S. FOIA. The U.S. FOIA (b)(6) stated he would follow up. On 12/17/24 at 10:47 AM, the surveyor with the U.S. FOIA (b)(6)) inspected the nutrition refrigerator on the unit. The U.S. FOIA (b)(6) stated the refrigerator was used to store snacks from the kitchen and resident food items, including food from outside the facility. The U.S. FOIA (b)(6) further explained items were stored for up to 3 days in the refrigerator, U.S. FOIA (b)(6)) would clean the refrigerator, throw away outdated food every 3 days. The surveyor in the presence of the U.S. FOIA (b)(6) observed the following: 9. In the refrigerator, there was a white bag with packaged food items that was labeled with a resident's name and room number. There was no date on the bag to indicate when it was placed in the refrigerator. There was also a fast-food brand bag which had the resident's name and room number written on it. There was no date on the bag to indicate when it was placed in the refrigerator. 10. In the freezer of the refrigerator, there were 3 wrapped foiled food items in a plastic storage bag which had the resident's name and room number written on it. The items were not dated to indicate when it was placed in the refrigerator. Additionally, there was an unopened bag of edadame beans which was dated 12/16/24. The packaging did not have a resident's name or a room number on it. The U.S. FOIA (b)(6) stated that the items should have the appropriate labeling which would include the resident's name, room number	F 812		

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F 812	Continued From page 66	F 812		

and the date the item was placed in the refrigerator. The [U.S. FOIA (b)(6)] stated she would follow up with the residents about the items. She would discard outdated and food items that could not be verified.

On 12/17/24 at 10:57 AM, the surveyor interviewed the [U.S. FOIA (b)(6)]) who stated [U.S. FO] would clean the refrigerator every Friday. The [U.S. FOIA (b)] further explained the refrigerator was cleaned thoroughly inside, anything not labeled with a name or date would be thrown away. The [U.S. FOIA (b)] added that items more than 3 days after their written date would be thrown away. The surveyor asked if the refrigerator was checked by [U.S. FO] on other days besides Friday. The [U.S. FOIA (b)] stated that during the week the refrigerator would be checked periodically by [U.S. FO] staff. The [U.S. FOIA (b)] further explained there was no set schedule besides the Friday and it would not be documented if the refrigerator was checked on other days of the week.

The [U.S. FOIA (b)] stated there was a log for when the refrigerator was cleaned and checked on every Friday. The [U.S. FOIA (b)] added besides the log, he had additional documentation in his office. The surveyor accompanied the [U.S. FOIA (b)] to check the log posted on the refrigerator which read that the refrigerator was to be cleaned every Friday. A review of the log which included the date and the signature of the staff cleaning the refrigerator revealed there was no documentation for 12/13/24 and no signature indicating that the refrigerator was cleaned. The [U.S. FOIA (b)] stated he was the one who cleaned the refrigerator and that he must have forgotten to sign the form. The surveyor accompanied the [U.S. FOIA (b)] to his office to check for any additional documentation of the

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F 812	Continued From page 67	F 812		

refrigerator being cleaned on 12/13/24. The [U.S. FOIA (b)] was unable to provide any additional documentation for the date in question.

On 12/17/24 at 11:03 AM, the [U.S. FOIA (b)(6)] informed the surveyor for the foiled food item in the freezer (Resident #61) it was brought in on Friday and was discarded. The fast-food bag was brought in last night. The [U.S. FOIA (b)(6)] stated she still had to find out who the edamame package belonged to and when the white bag of food items was brought in. The [U.S. FOIA (b)(6)] added if unable to determine the food items would be disposed.

The surveyor asked the [U.S. FOIA (b)(6)] about the protocol for the food storage in the nutrition refrigerator. The [U.S. FOIA (b)(6)] stated it was expected for the food items to be labeled with the resident's name, room number, and date the item was brought in. The [U.S. FOIA (b)(6)] stated [U.S. FO] cleaned out the refrigerator every Friday. The [U.S. FOIA (b)(6)] further explained the staff that placed food items for residents in the refrigerator were responsible for ensuring the food items were labeled appropriately and she was not aware if anyone else was responsible for checking food items in the refrigerator.

On 12/18/24 at 11:14 AM the surveyor informed the [U.S. FOIA (b)(6)] of the above concerns during the kitchen tours and inspection of the nutrition refrigerator on the unit. The [U.S. FOIA (b)(6)] was also informed that the [U.S. FOIA] and [U.S. FOIA (b)(6)] stated they were going to provide supportive documentation that the beverage boxes were good for use 6 months after their best if used by date and no documentation had been provided.

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F 812	Continued From page 68 On 12/18/24 at 12:05 PM, during observation of tray line in the kitchen, the surveyor observed DS #2 enter the kitchen from the dining area. DS #2 was observed with hair bangs uncovered with the rest of their hair contained with a hair net. DS #2 walked through the food prep area and went to back area of the kitchen. DS #2 returned the same way, her hair bangs remained uncovered and exited the kitchen to the dining area. The surveyor asked the U.S. FOIA (b)(6) about hair restraint protocol. The U.S. FOIA (b)(6) stated all hair should be covered with a hairnet. The surveyor informed the U.S. FOIA (b)(6) of the observation. The U.S. FOIA (b)(6) acknowledged all of DS #2's hair should be contained with the hairnet. The U.S. FOIA (b)(6) stated she would go to speak with DS #2 and exited the kitchen. On 12/18/24 at 12:41 PM, the surveyor informed the U.S. FOIA (b)(6) of the observed concern of DS #2's hair bangs remaining uncovered while passing through the food prep area during tray line. On 12/19/24 at 11:38 AM, the U.S. FOIA (b)(6)), Regional DON #1, Regional DON #2, and the U.S. FOIA (b)(6) met with the survey team. The U.S. FOIA (b)(6) stated for the nutrition refrigerator that the U.S. FOIA (b)(6) forgot to sign off the log and that he cleaned all refrigerators including the break room refrigerator in which he had signed the log. The surveyor asked the U.S. FOIA (b)(6) if it was expected for the U.S. FOIA (b)(6) to have signed the cleaning log for the nutrition refrigerator after cleaning. The U.S. FOIA (b)(6) acknowledged that it should have been signed by	F 812		

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F 812	Continued From page 69 the [redacted].	F 812		

The [redacted] stated for the fiber strand found on the food processor machine, stated that it was outside of the machine not inside and that there was no food in the machine. The surveyor asked if there would be a concern for something like that being found in a food prep area. The [redacted] replied that staff wore hairnets in the kitchen. There was no additional response provided by the facility.

The [redacted] stated for the pans found soiled in the clean drying rack storage areas, the items were cleaned by the [redacted] after the observations [redacted] acknowledged it would be expected that the items were cleaned.

The [redacted] stated DS #2 was in-serviced on use of hairnet and that a restraint did not have to be used unless it was longer than ½ inch. The surveyor asked the [redacted] about the guidance followed for kitchen policies. The [redacted] replied that the references for their hair restraint policy was provided. The surveyor asked if the references and facility policies were based on regulations and from nationally recognized organizations and based on regulations. Regional DON #2 stated that the regulations did not specify the length and only indicated facial hair should be covered. The surveyor asked if the regulations did not specify the length of facial hair that should be restrained, was it ok for less than ½ inch to be without a beard restraint. There was no additional response by the facility.

The [redacted] stated the clean dishware were removed from the dishwashing area and would be stored in another area for drying storage.

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The [redacted] stated for the nutrition refrigerator that items from the kitchen to the refrigerator were labeled every day prior to delivering. The [redacted] stated that resident visitors sometimes brought food and forgot to date the food items. The [redacted] added the staff regularly checked food items for dates and discarded when not dated. There was no additional information provided by the facility.

There was no documentation provided by the facility to indicate that the beverage boxes were okay to be used up to six months after their best if used by date.

A review of the facility's Hair Restraints Policy, with a last reviewed date of June 2024 revealed:
Under Policy: "All Dietary Staff shall wear hair restraints such as hats, hairnets and beard restraints if you have any facial hair growth, to keep their hair from contacting exposed food, clean equipment's, utensils and linens."
Under Procedure: "1. Always cover all head hair with hair restraint ...2. Always cover all facial hair with beard net ...3. Never leave bangs or other part of your hair hanging outside of hair restraint."

A review of the facility's Cleaning and Sanitation Equipment Policy, with a date of June 2023 revealed:
Under Policy: "Cleaning and sanitation of equipment is to remove food debris that bacteria need to grow and to kill those bacteria that are present. It is important that the clean and sanitized equipment are stored dry so as to prevent bacteria growth."

A review of the facility's Food Storage Policy, with a last reviewed date of October 2024 revealed:

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F 812	Continued From page 71 Under Policy: "Food storage areas shall be maintained in a clean, safe, and sanitary manner". The policy did not further address use of food items by manufacturer best if used by dates. A review of the facility's Food Brought in for Patients and Residents Policy, with an effective date of 1/5/24 revealed: Under Purpose: "To ensure the safe consumption of food brought in to patients/residents". Under Procedure: for food brought in that required refrigeration: " ...1.2 Food items that require refrigeration must be labeled with the patient/resident's name and the date the food was brought in ...1.5 Food will be held in the refrigerator for 3 days following the date on the label and will be discarded by staff upon notification to patient/resident".	F 812		
F 842 SS=D	NJAC 8:39-17.2(g) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		2/5/25

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F 842	Continued From page 72 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain-	F 842		

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F 842	Continued From page 73 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint NJ#169518 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 1 of 24 residents reviewed (Resident #239). This deficient practice was evidenced by the following: On 12/18/24 at 9:01 AM, the surveyor reviewed Resident #239's closed hybrid (paper and electronic) medical record. A review of Resident #239's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]	F 842	How the corrective action will be accomplished for any resident affected by deficient practice U.S. FOIA (b) (6) was immediately in serviced to upload her report to resident electronic medical record timely and to ensure we have an accurate medical record. Unable to assist resident # 239 due to being discharged from the facility No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future).	

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F 842	Continued From page 74 NJ Exec Order 26.4b1 A review of Resident #239's Universal Transfer Form (UTF) from the return to the facility after the first rehospitalization, indicated that the resident did not have any NJ Exec Order 26.4b A review of Resident #239's progress notes (PN) included a NJ Exec Order 2 note written by a U.S. FOIA (b)(6) dated NJ Exec Order 2, which was approximately a week after return to the facility, included the following: being seen today for a follow up NJ Exec Order 26 evaluation ...patient with NJ Ex Order 26.4(b) . I was asked to evaluate and manage NJ Ex Order 26.4 care for this patient .... Further review of the NJ Exec Order 26 notes written by the PA indicated that the next visit was NJ Exec Order 26. There were 3 weeks of NJ Ex Order 26.4 notes that were not in the resident's medical record. The next NJ Exec Order 26 note written by the U.S. FO was dated NJ Exec Order 26.4b The surveyor also did not observe any documented measurements or appearance of the NJ Exec Order 26.4b during those 3 weeks in Resident #239's medical record. On 12/18/24 at 01:53 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the process of NJ Exec Order 26U.S. FO visits. The U.S. FOIA (b)(6) stated that the NJ Exec Order 26U.S. FO visited weekly if the resident had a NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1. The surveyor asked the U.S. FOIA (b)(6) about the missing 3 weeks of the NJ Exec Order 26 notes by the U.S. FO. The U.S. FOIA (b)(6) stated that it was not followed up by the NJ Exec Order 26 doctor because there were no changes to the NJ Exec O and that the NJ Exec Order 2 nurse observed it weekly. The surveyor then asked the U.S. FOIA (b)(6) if the wound nurse had documented the size and appearance of the NJ Exec O in the resident's	F 842	Measures to ensure were/will be put into place to assist this area of concern. All Licensed Nurses were re In-service on wound documentation and resident assessment on admission on 12/16/24 All wound documentation will be reviewed by Unit managers before it is filed to Resident Electronic Medical Record. Wound Physician Assistant will assess and document in electronic medical record resident skin condition weekly. Any developed pressure injuries will be investigated, Family and Physician will be notified for any change in condition. How the concern will be monitored and title of person responsible for monitoring. Unit Manager or designee will review wound notes for documentation weekly x 30 days then x 90 days and thereafter. Director of Nursing or designee will review 5 charts weekly x 30 days than 90 days and thereafter for Family and Physician notification in resident changed in condition. Results of this audit will be discussed in morning clinical meeting for immediate resolution and this will be discussed in	

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F 842	Continued From page 75 medical record. The [U.S. FOIA (b)(6)] stated that she had the weekly measurements on her tracking form. The surveyor asked the [U.S. FOIA (b)] if her tracking form was part of the medical record. The [U.S. FOIA (b)(6)] stated that the tracking form was not part of the medical record. On 12/18/24 at 3:00 PM, in the presence of the survey team, the surveyor notified the [U.S. FOIA (b)(6)]) the concern that the complete medical record was not accessible in the computer system. On 12/19/24 at 9:59 AM, in the presence of the survey team, the [U.S. FOIA (b)(6)] stated that the wound [U.S. FO] had the missing 3 weeks of [NJ Exec Order 2] [U.S. FOIA] but that she had not placed them in the electronic medical record. The [U.S. FOIA (b)(6)] stated that she had not checked in the computer prior to surveyor inquiry. The [U.S. FOIA (b)(6)] stated that she had uploaded the missing notes that day under the "miscellaneous tab" of the resident's electronic medical record. The [U.S. FOIA (b)(6)] provided the surveyor a copy of the [NJ Exec Order 2] notes that she uploaded into the medical record. The surveyor then reviewed the resident's electronic medical record and observed that there was an upload of '[NJ Exec Order 26] Care PN" dated [NJ Ex Order 26.4(b)(]. On 12/19/24 at 12:31 PM, in the presence of the survey team, [U.S. FOIA (b)], Regional DON #1, Regional DON #2 and [U.S. FOIA (b)(6)], the [U.S. FOIA (b)(6)] stated that the [U.S. FO] had done the [NJ Exec Order 26] notes. The surveyor asked if the [NJ Exec Order 26] notes should have been in the medical record prior to surveyor inquiry. The Regional DON #1 stated that they did not know what happened to the notes.	F 842	monthly Quality Assurance and Performance Improvement and this will be a part of quarterly Quality Assurance.	

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F 842	Continued From page 76 A review of the facility provided policy titled, "Medical Records" with a reviewed date of 11/2024, included the following: Policy Statement Medical records shall be retained by the facility in accordance with current applicable laws. Policy Interpretation and Implementation 1. Medical records of discharged residents will be retained for a period of 10 years. ... The facility did not provide any additional information. N.J.A.C. 8:39-35.2	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		2/5/25

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F 880	Continued From page 77 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 78 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for 5 of 11 staff (1 Housekeeper,1 Recreation Aide, 2 Dietary Staff, and 1 Physician), b.) disinfect the examination area after use, and follow appropriate infection control practices during meal observation, environment tour, and kitchen tour, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site on the same patient ... After touching a patient or the patient's immediate environment	F 880	How the corrective action will be accomplished for any resident affected by deficient practice? U.S. FOIA (b) (6)) was immediately reeducated on proper wearing of surgical mask by the Infection Preventionist. The nose will be fully covered with a surgical mask U.S. FOIA (b) (6) was immediately in serviced regarding proper disposal of used hand wipes after use. U.S. FOIA (b) (6) was immediately in serviced regarding Infection Control of proper hand hygiene, cleaning/ disinfecting table before and after placing equipment. Administrator sent to all Consultant Visiting Physicians and vendors regarding facility Policy and Procedure of Enhanced Barrier Precaution. Administrator sent the Enhanced Barrier Precaution Policy and Procedure to licensed physician, and Vendors via care feed – an application for mass communications. Physician was immediately in-serviced on house protocol regarding Enhance Barrier precautions.	

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F 880	Continued From page 79 After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 12/15/24 at 11:58 AM, the surveyor observed the U.S. FOIA (b)(6)) with a surgical mask in use while distributing lunch trays in the recreation room. The U.S. FOIA (b) nose was not fully covered by the surgical mask and it was pulled below his mouth. The surveyor interviewed the U.S. FOIA regarding the surgical mask. The U.S. FO stated that the surgical mask kept going down his nose and the U.S. FOIA acknowledged that the surgical mask should be properly worn and cover his nose. The U.S. FO further stated that he received education on proper hand hygiene and the use of PPE. On that same date at 12:05 PM, the surveyor observed the U.S. FOIA took the tray of the resident from the table. Afterward, the U.S. FO used hand wipes to clean his hands. The U.S. FO did not discard the used hand wipes, went to the next dining room, left the dining room, and re-entered the recreation room with the same hand wipes in his hands. The surveyor asked the U.S. FO what was on his hands, and he responded that was the hand wipes he used for cleaning both hands. The surveyor asked the U.S. FO why he did not dispose of the used hand wipes and whether should he dispose of them immediately after use, and the U.S. FO responded, "I guess not." A review of the Handwashing/Hand Hygiene Policy with a revised date of April 2010 that was provided by the U.S. FOIA (b)(6) on 12/16/24 at 9:37 AM revealed: Policy Interpretation and Implementation: 5. Employees must wash their hands for at least	F 880	HK#1; DS#1, DS #2, DS#3 and U.S. FOIA (b) (6) were immediately educated on Infection Control, personal protective equipment, hand hygiene, and facility policies on Enhanced Barrier Precautions. Affected staff HK#1, DS#1, DS#1, DS#2, DS#3 performed a return demonstration on proper hand hygiene after being educated. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. All staff were in-serviced regarding Infection Control on proper hand hygiene on 12/17/24. Receptionist will give consulting Physicians and Vendors a list of residents on Enhanced Barrier Precaution (EBP) Director of Nursing or designee in-service the Consultant Physicians and Vendors on Enhanced Barrier Precaution (EBP) on 12/16/24. Infection Preventionist or designee will	

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F 880	Continued From page 80 20 seconds using antimicrobial soap and water under the following conditions: g. Before and after assisting a resident with meals... 2. On 12/17/24 at 8:58 AM, Surveyor #1 (S#1) observed the provider (a Physician) and the U.S. FOIA (b)(6)) inside room NJ Ex O The U.S. FOIA talked to the Physician and left the room. The surveyor observed the Physician with a luggage bag inside the room and attended to Resident #241, the Physician performed handwashing inside the room, and the she donned (put on) gloves. The Physician took an alcohol individual pack, disinfected the lenses of two equipment, and placed them on top of the resident's table without disinfecting the table. During an eye examination, S#1 observed the Physician interchange the two pieces of equipment on top of the table without disinfecting the entire equipment. There was a personal belonging on top of the resident's table near the equipment. After the examination, the Physician discarded the used gloves in the garbage receptacle near the sink, put back the equipment inside the luggage bag, exited the resident's room without disinfecting the table, and did not perform hand hygiene. Outside the resident's room, S#1 interviewed the Physician. The surveyor asked the physician what she did inside the room and the physician stated that she examined the resident's NJ Ex O with the use of a NJ Ex Order 26.4(b)(1)) which was used for NJ Ex Order 26.4(b)(1) and black equipment was the NJ Ex Order 26.4(b)(1). The surveyor asked the Physician why she did not perform hand hygiene after she doffed off her	F 880	observe visiting Consultant Physicians and Vendors for proper cleaning and disinfecting examination area when they are in the facility. Infection Preventionist or designee will observe 5 Dietary staff daily X 2 weeks, then Monthly and thereafter. Housekeeping staff will be observed for proper hand hygiene in resident care areas and use of personal protective equipment weekly for 90 days and monthly thereafter. Recreation staff will be observed for proper hand hygiene in resident care areas and use of personal protective equipment weekly for 90 days and monthly thereafter. Unit manager and designee will observe staff wearing mask to ensure it is worn properly. How the concern will be monitored and title of person responsible for monitoring. Infection Preventionist or designee will observe 5 recreation staff and 5 housekeeping staff weekly for proper Hand hygiene, wearing mask X 30 days, then every 90 days thereafter Results of this audit will be discussed in morning clinical meeting for immediate resolution and this will be discussed in monthly Quality Assurance and	

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F 880	Continued From page 81 gloves and when she left the room. The Physician stated that when she grabbed all her stuff, it did not make any sense for her to perform hand hygiene even when she exited the room. She acknowledged that after she removed gloves inside the room, she did not perform hand hygiene. In the nursing station, S#1 asked the Physician if she was aware of the posted sign for EBP (enhanced barrier precautions; an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission MDROs [multidrug-resistant organism]) in room [redacted] and what was the EBP for, and the Physician responded that she did not know. Immediately, S#1 notified the [redacted] of the concerns that the Physician did not perform hand hygiene and did not disinfect the table used for putting the equipment. The [redacted] stated that staff, visitors, and vendors should perform hand hygiene before and after gloves use and follow the posted sign and she stated that she would talk to the Physician about it. On 12/17/24 at 9:50 AM, S#1 and Surveyor #2 (S#2) interviewed the [redacted]. S#1 asked the IPN about Standard Precaution or Universal Precaution, and the [redacted] responded that it applied to everyone (all staff, visitors, and vendors) and that gloves, after use, should be discarded and perform hand hygiene and that was "basic." S#2 asked the [redacted] if the facility provided disinfecting wipes or PPE to the Physicians and vendors when they come to provide services. The [redacted] stated that she had to check first and would get back to the surveyors. S#1 asked if the facility	F 880	Performance Improvement and this will be a part of quarterly Quality Assurance.	

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F 880	Continued From page 82 provided education or information to the Physician about the facility's practice and policy about EBP or other infection control guidance that the facility followed, and the [U.S. FOIA] responded that she was unsure. S#2 asked the [U.S. FOIA] if that was something she should know as part of infection control. The [U.S. FOIA] stated that she started in April this year and unsure if that was provided to the Physician before her starting in the facility as [U.S. FOIA]. On 12/17/24 at 12:22 PM, S#1 and S#2 met with the Regional Director of Nursing #1 (RDON#1) and [U.S. FOIA (b)(6)]. The surveyor notified the [U.S. FOIA (b)(6)] and RDON#1 of the above concerns with the Physician. S#1 asked what the facility's practice was about disseminating information to providers and vendors with regard to the facility's policy and practice with EBP and other infection control practices. RDON#1 stated that she knew that the Physicians of the facility especially the Medical Director and the Infectious Disease Doctor were aware of the facility's practice and protocol with regard to infection control and was unsure about the other providers and vendors. RDON#1 acknowledged that the facility had the responsibility to notify the vendors and providers about it. RDON#1 further stated that hand hygiene should be done before gloves and after gloves use, disinfect the area to be used and used for treatment and examination. On 12/17/24 at 2:00 PM, the survey team met with the U.S. FOIA (b)(6) and the owner of the company (vendor) where the Physician who provided an eye examination to Resident #241. The vendor informed S#1 that it was not part of their protocol and policy to disinfect the table where the Physician placed "our" equipment. The vendor further stated that the Physician "certainly	F 880		

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F 880	Continued From page 83 for this day," removed her gloves and did not wash her hands. On 12/18/24 at 11:14 AM, the survey team met with the U.S. FOIA (b)(6) S#1 notified the U.S. FOIA (b)(6) of the above findings and concerns regarding the U.S. FOIA and the Physician. On 12/19/24 at 01:48 PM, the survey team met with the U.S. FOIA (b)(6), RDON#1 and RDON#2, U.S. FOIA (b)(6) and U.S. FOIA (b)(6) for an exit conference. The facility did not provide additional information. 3. On 12/15/24 at 10:40 AM, the surveyor observed Housekeeper #1 (HK #1) exit a resident room (Resident #5 and Resident #84), remove their gloves while standing in front of their cart outside the room door. HK #1 disposed their gloves in a garbage bin on the cart and retrieved cleaning supplies from the cart. The U.S. FO returned inside the room without performing hand hygiene. The surveyor observed HK #1 inside the resident room apply gloves and cleaned inside the room. On 12/15/24 at 10:43 AM, the surveyor observed HK #1 exit the resident's room, removed their gloves while going to their cart located at the door. HK #1 disposed of their gloves in the garbage bin on the cart, went into their cart for more cleaning supplies, and returned inside the room. The surveyor observed the U.S. FOIA did not perform hand hygiene. On 12/15/24 at 10:45 AM, the surveyor interviewed HK #1 about hand hygiene upon their exit from the resident's room. HK #1 stated that hand hygiene should be performed when entering a resident room, when finished cleaning up, and	F 880		

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F 880	Continued From page 84	F 880		

when putting on gloves, when removing gloves, and in between changing gloves. The surveyor informed HK #1 of the above observations. The HK acknowledged she did not wash her hands between changing gloves and stated it was supposed to be done.

On 12/15/24 at 1:46 PM, the surveyor interviewed U.S. FOIA (b)(6) about hand hygiene. The U.S. FOIA (b)(6) stated hand hygiene should be performed between changing gloves and when exiting rooms. The surveyor informed the U.S. FOIA (b)(6) of the above observations of HK #1. The U.S. FOIA (b)(6) acknowledged she should have washed her hands in between changing gloves and when exiting the room. The U.S. FOIA (b)(6) stated she would follow up with the HK to provide re-education.

On 12/18/24 at 11:14 AM, the surveyor informed the U.S. FOIA (b)(6) of the observed concern of HK #1 not performing hand hygiene during changing of gloves.

On 12/19/24 at 11:38 AM, the U.S. FOIA (b)(6), RDON#1 and RDON#2 met with the survey team. The U.S. FOIA (b)(6) stated in-service education was provided to HK #1.

4. On 12/18/24 at 11:32 AM, the surveyor observed Dietary Staff (DS) #1 (DS#1) with gloves on for the start of tray line service of the lunch meal. DS#2 moved a wet floor sign to the hallway area between the food prep and dishwashing area. DS #2 removed their gloves, disposed of gloves, and put on a new pair of gloves. The surveyor observed DS #2 did not perform hand hygiene. The surveyor asked the U.S. FOIA (b)(6)) present

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F 880	Continued From page 85 in the kitchen about hand hygiene. The [U.S. FOIA (b)(6)] stated hands should be washed when changing gloves. The surveyor informed the [U.S. FOIA (b)(6)] of the above observation of DS #2 and stated states hands should be washed when changing gloves. The [U.S. FOIA (b)(6)] instructed the staff to remove their gloves and perform hand hygiene, and re-educated DS #2 that hand hygiene should be performed when gloves were changed. On 12/18/24 at 11:45 AM, during tray line the surveyor observed DS #3 while serving the food, removed their gloves and placed new gloves without washing their hands. The surveyor informed the [U.S. FOIA (b)(6)] of the observation. The U.S. FOIA (b)(6) instructed DS #3 to remove their gloves and wash their hands. On 12/18/24 at 12:41 PM, the surveyor informed the U.S. FOIA (b)(6) of the hand hygiene concerns observed during tray line in the kitchen. There was no additional information provided by the facility. A review of the facility's Handwashing/Hand Hygiene Policy, last reviewed in May 2024 revealed: Under Policy Statement: "This facility considers hand hygiene the primary means to prevent the spread of infections." Under Policy Interpretation and Implementation: 5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions ...u. after removing gloves... 6. If hands are not visibly soiled, use an alcohol-based hand rub containing at least 70% ethanol or isopropanol for all of the following situations ...j. After removing gloves ...	F 880		

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F 880	Continued From page 86 7. Hand hygiene is always the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing/hand hygiene. N.J.A.C. 8:39-19.4(a)(1,2),(l,n)	F 880		

New Jersey Department of Health

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	060207	A. BUILDING: _____ B. WING _____	C 12/19/2024

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S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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

Electronically Signed | 01/09/25

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
315129 Y1	A. Building B. Wing Y2	2/20/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	532 FARVIEW AVE PARAMUS, NJ 07652

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0578	Correction	ID Prefix F0580	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed
LSC	02/05/2025	LSC	02/05/2025	LSC	02/05/2025
ID Prefix F0584	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	02/05/2025	LSC	01/30/2025	LSC	02/05/2025
ID Prefix F0677	Correction	ID Prefix F0684	Correction	ID Prefix F0695	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(i)	Completed
LSC	02/05/2025	LSC	02/05/2025	LSC	02/05/2025
ID Prefix F0698	Correction	ID Prefix F0732	Correction	ID Prefix F0812	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	02/05/2025	LSC	02/05/2025	LSC	02/05/2025
ID Prefix F0842	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	02/05/2025	LSC	02/05/2025	LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/19/2024	☐ YES ☐ NO

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE** **PARAMUS, NJ 07652**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 12/17/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 12/17/24 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Dellridge Health and Rehabilitation Center is a one-story building with a basement built in the 1970's. It is composed of Type V protected construction. The facility is divided into six - smoke zones. The generator powers approximately 100 % of the building per U.S. FOIA (b)(6) . The current occupied beds are 86 of 96.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour.	K 311		1/31/25

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

Electronically Signed | 01/09/2025

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

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	315129	A. BUILDING **01** B. WING _____	**12/19/2024**

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K 311	Continued From page 1 An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 7.2.1.7.2. This deficient practice had the potential to affect 86 residents who resided at the facility. Findings include: An observation on 12/17/24 at 2:24 PM revealed the stairway exit doors in the basement were equipped with panic hardware which violated the listing of the rated fire door assembly. Only approved panic hardware shall be used on door assemblies that are not fire-rated door assemblies. During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed the panic hardware was installed on the stairway doors in the basement. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 311	How the corrective action will be accomplished for any resident affected by deficient practice. Maintenance Director or Designee identified a fire rated panic bar that is appropriate for the stairway exit door in the basement and was purchased on December 18, 2024 and installed December 26, 2024 to the door. This fire rated panic bar meets NFPA 101 regulatory standards. The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. An audit by the Maintenance Director or	

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K 311	Continued From page 2	K 311	Designee will be conducted for all fire exit doors in the facility to be to ensure the appropriate fire rated panic hardware is in place to meet NFPA 101 Life Safety Code (2012 Edition) Sections 7.2.1.7.2. Education to all staff will be conducted by Maintenance Director, Regional, and Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance within the 101 Life Safety Code. Audits will be conducted monthly for three months and then quarterly by the facility Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed.	

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K 311	Continued From page 3	K 311		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure low voltage wiring under seven feet was in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 760.130 (B) (1). This deficient practice had the potential to affect all 86 residents who resided at the facility. Findings include: Observations on 12/17/24 at 1:31 PM revealed low voltage wiring under seven feet for the fire alarm system tamper and flow switches were not	K 341	01/31/25 How the corrective action will be accomplished for any resident affected by deficient practice Maintenance Director or Designee identified that the wiring that was not protected in the wall and conduit will be protected by a wrap - around cable sleeve to preserve the integrity of the wiring and meet National Fire Protection Association (NFPA) 70 National Electrical Code (2011 Edition) Article 760.130 (B) (1).	1/31/25

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K 341	Continued From page 4 protected in the interior walls or in conduit at the main fire alarm panel in the mechanical room. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the low voltage wiring was not protected in the walls or in conduit. NJAC 8:39-31.2(e) NFPA 70	K 341	The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. An audit by the Maintenance Director or Designee will be conducted for all low voltage wiring under 7 feet in the facility that connects the fire alarm system tamper and flow switches to the main fire alarm panel will be assessed and identified in the facility to meet NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8. Education to all staff will be conducted by Maintenance Director, Regional, and Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to ensure all low voltage wiring under 7 feet in the facility that connects the fire alarm system tamper and flow switches to the main fire alarm panel meet the NFPA 70	

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K 341	Continued From page 5	K 341	National Electrical Code (2011 Edition) Article 760.130 (B) (1) Audits will be conducted monthly for three months and then quarterly by the facility Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 01/31/25	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351		1/31/25

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K 351	Continued From page 6 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure no external loads were on the sprinkler piping and the spare sprinklers were listed in the spare sprinkler cabinet in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) Section 5.2.2.2. and NFPA 13, Standard for the Installation of Sprinkler Systems (2010 Edition) Section 6.2.9.7. This deficient practice had the potential to affect all 86 residents who resided at the facility. Findings include: An observation on 12/17/24 at 12:40 PM in the laundry near the dryers revealed two aluminum braces, one approximately six feet long and one approximately three feet long that were attached to the wall and to the 1-inch sprinkler pipe. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. During an observation on 12/17/24 at 1:18 PM of the spare sprinkler cabinet revealed no list of	K 351	How the corrective action will be accomplished for any resident affected by deficient practice Maintenance Director or Designee identified the external load on the 1-inch sprinkler head and was immediately removed. The aluminum braces that were connected to the sprinkler pipe were affixed to only the wall away from the sprinkler head. A list of the spare sprinklers in the spare sprinkler cabinet will be created and affixed to the spare sprinkler cabinet. Spare sidewall sprinklers will be added to the cabinet. The list will include these spare sidewall sprinklers as well. The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas that could potentially be affected.	

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K 351	Continued From page 7 spare sprinklers that were used in the building was in the spare sprinkler cabinet. Observation of the sprinkler box revealed no sidewall sprinklers heads were in the sprinkler box. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed a spare sprinkler list was not present in the sprinkler cabinet and no sidewall heads were present. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. An audit by the Maintenance Director or Designee will be conducted for all Sprinkler Heads in the facility to ensure no external loads are on the sprinkler heads to meet NFPA 13, Standard for the Installation of Sprinkler Systems sections 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1). Education to all staff will be conducted by Maintenance Director, Regional, and Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to ensure there are no external loads on any sprinkler heads in the building as well as ensuring the spare sprinkler cabinet has all appropriate spare sprinkler heads including sidewall sprinkler heads and the created list is accurate and affixed to the spare sprinkler cabinet which will be in compliance with NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25. Audits will be conducted monthly for three months and then quarterly by the facility	

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K 351	Continued From page 8	K 351	Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 01/31/25	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		1/31/25

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K 353	Continued From page 9 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinklers were not painted in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection (2011 Edition) table 5.2.1.1.4. This deficient practice had the potential to affect all 86 residents who resided at the facility. Findings include: An observation on 12/17/24 at 1:19 PM revealed a sprinkler behind the nurses' station near the supply closet was painted with white paint. During an interview at the time of observation, the U.S. FOIA (b) (6) confirmed the sprinkler was painted. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	How the corrective action will be accomplished for any resident affected by deficient practice Maintenance Director or Designee identified the sprinkler head behind the nurses station near the supply closet with paint and was immediately replaced. The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. An audit by the Maintenance Director or Designee will be conducted for all Sprinkler Heads in the facility to ensure none of them are painted to meet the NFPA 101 9.7.5, 9.7.7, 9.7.8, and NFPA 25 code.	

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K 353	Continued From page 10	K 353	Education to all staff will be conducted by Maintenance Director, Regional, or Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to ensure there are no sprinkler heads with paint on them to ensure we are in compliance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection (2011 Edition) table 5.2.1.1.4. Audits will be conducted monthly for three months and then quarterly by the facility Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review Dates when concern will be completed. 01/31/25	

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K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire extinguishers were installed at the proper height and that the fire extinguishers were serviced every six years or hydrostatic tested every 12 years in accordance with NFPA 10, Standard for Portable Fire Extinguishers (2010 Edition) Section 6.1.3.8.1 and 7.3.1.2.1. This deficient practice had the potential to affect all 86 residents who resided at the facility. Findings include: Observations on 12/17/24 between 12:15 PM and 3:00 PM revealed the fire extinguishers were mounted more than 5-feet above the finished floor. An observation on 12/17/24 at 12:54 PM revealed a 5-lbs. fire extinguisher in the kitchen hallway had a manufacturer's date of 2012 and was not serviced in 2018, was not hydrostatic tested in 2024, and was not equipped with a service collar. The fire extinguishers in the facility were inspected in January 2024 by [Name of Contract Company]. During an interview at the time of the observations, the[redacted]	K 355	How the corrective action will be accomplished for any resident affected by deficient practice Maintenance Director or Designee identified the fire extinguishers out of compliance in relation to height will be changed and lowered to meet NFPA 101. Maintenance Director or Designee will identify all fire extinguishers that need to be hydrostatically tested and have them tested by the appropriate parties. The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into	1/27/25

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K 355	Continued From page 12 confirmed the fire extinguishers were higher than 5-feet and stated that the fire extinguishers are above the handrails because if they were lower, they would interfere with the patients using the handrails. He also confirmed the fire extinguisher in the kitchen hallway did not have a service collar, and it was most likely was not serviced. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	place to assist this area of concern. An audit by the Maintenance Director or Designee will be conducted for all fire extinguishers in the facility for height requirements and lowered to meet the NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 An audit by the Maintenance Director or Designee will be conducted of all fire extinguishers in the facility for being hydrostatically tested and hydrostatically tested if not completed already. Education to all staff will be conducted by Maintenance Director, Regional, or Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to ensure all fire extinguishers are at the proper height and have been hydrostatically tested to meet NFPA 10, Standard for Portable Fire Extinguishers (2010 Edition) Section 6.1.3.8.1 and and 7.3.1.2.1. Audits will be conducted monthly for three months and then quarterly by the facility Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be	

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DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE** **PARAMUS, NJ 07652**

(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 355	Continued From page 13	K 355	submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 02/27/2025	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING 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. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barrier walls were not penetrated and were sealed in accordance with NFPA 101, Life Safety Code (2012 Edition) Section 19.3.7.6. This deficient practice had the	K 372	How the corrective action will be accomplished for any resident affected by deficient practice Maintenance Director or Designee	1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING **01** B. WING _____	**12/19/2024**

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K 372	Continued From page 14 potential to affect all 86 residents who resided at the facility. Findings include: An observation on 12/17/24 at 2:06 PM revealed a two-inch penetration above the smoke barrier doors near room 19. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the two-inch hole above the smoke barrier doors. NJAC 8:39-31.1(c), 31.2(e)	K 372	identified the 2 inch penetration in the wall at the smoke barrier doors near room 19 and will be filled with fire caulk also known as firestop sealant, to meet the NFPA 101, Life Safety Code (2012 Edition) Section 19.3.7.6. The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. An audit by the Maintenance Director or Designee will be conducted for all smoke barriers in the facility for any penetrations and sealed with fire caulk also known as fire stop sealant to meet NFPA 101, Life Safety Code (2012 Edition) Section 19.3.7.6. Education to all staff will be conducted by Maintenance Director, Regional, or Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to	

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K 372	Continued From page 15	K 372	ensure all smoke barriers in the facility are sealed with fire caulk also known as fire sealant to meet NFPA 101, Life Safety Code (2012 Edition) Section 19.3.7.6. Audits will be conducted monthly for three months and then quarterly by the facility Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 01/31/25	
K 500 SS=F	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 500		1/31/25

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K 500	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure clothes dryers were kept free from excess lint build up accordance with NFPA 1, Fire Code (2012 Edition) Section 11.5.1.11.1. This deficient practice had the potential to affect all 87 residents who resided at the facility. Findings include: Observations on 12/17/24 at 12:06 PM of the facility's clothes dryers revealed lint buildup from the dryers near the fire box of the dryer. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the buildup of lint in the dryers. NJAC 8:39-31.2(e), 31.7(e)	K 500	How the corrective action will be accomplished for any resident affected by deficient practice Maintenance Director or Designee identified the lint build up in the facility□s clothes dryer near the fire box and will be cleaned thoroughly to remove all lint found in the dryer. The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. An audit by the Maintenance Director or Designee will be conducted for all dryers in the facility for lint build up near the fire box and in the entirety of the dryer to ensure no lint build up is evident to ensure compliance with NFPA 1, Fire Code (2012	

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K 500	Continued From page 17	K 500	Edition) Section 11.5.1.11.1. Education to all staff will be conducted by Maintenance Director, Regional, or Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to ensure all dryers are free of any lint and to ensure compliance with NFPA 1, Fire Code (2012 Edition) Section 11.5.1.11.1. Audits will be conducted monthly for three months and then quarterly by the facility Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review Dates when concern will be completed. 01/31/25	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		1/31/25

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	315129	A. BUILDING 01 B. WING _____	12/19/2024

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DELLRIDGE HEALTH & REHABILITATION CENTER	532 FARVIEW AVE PARAMUS, NJ 07652

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K 511	Continued From page 18 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure nonmetallic sheathed cable (brand name [redacted] was concealed within walls, floors, or ceilings that provided a thermal barrier of material that had at least a 15-minute finish rating as identified in listings of fire-rated assemblies and the proper use of multi-plug adaptors in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 334.10 (3) (5) and NFPA 1 Fire Code (2012 edition) section 11.1.5.1. This deficient practice had the potential to affect all 86 residents who resided at the facility. Findings include: An observation on 12/17/24 at 12:25 PM revealed unconcealed nonmetallic sheathed cable from the junction box in the ceiling going to the ceiling heater in the hallway outside maintenance room. An observation on 12/17/24 at 12:52 PM revealed a six-outlet multi-plug adaptor in the kitchen near the exhaust hood with upper and lower ovens and a microwave plugged into it.	K 511	How the corrective action will be accomplished for any resident affected by deficient practice Maintenance Director or Designee identified the unconcealed nonmetallic sheathed cable (Brand Name [redacted] from the junction box in the ceiling going to the ceiling heater in the hallway outside the maintenance room and will be protected by a 15 minute fire rating covering. Maintenance Director or Designee identified the six outlet multi plug adaptor in the kitchen near the exhaust hood with upper and lower ovens and a microwave plugged into it will be removed. The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas	

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K 511	Continued From page 19 During an interview at the time of the observations, the U.S. FOIA (b)(6) verified the nonmetallic sheathed cable was not protected by a 15-minute fire rating and the multi-plug adaptor was in use in the kitchen. NJAC 8:39-31.2(e) NFPA 70	K 511	that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. An audit by the Maintenance Director or Designee will be conducted to ensure all unconcealed nonmetallic sheathed cables are protected by 15 minute fire rating covering to meet NFPA 54, National Fuel Gas Code. An audit by the Maintenance Director or Designee will be conducted to ensure all outlets in the facility do not have multi plug adapters to meet NFPA 70, National Electric Code sections 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2. Education to all staff will be conducted by Maintenance Director, Regional, or Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to ensure all unconcealed nonmetallic sheathed cables are protected by 15 minute fire rating covering and all outlets in the facility do not have multi plug adapters. Audits will be conducted monthly for three	

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K 511	Continued From page 20	K 511	months and then quarterly by the facility Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 01/31/25	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		2/13/25

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K 918	Continued From page 21 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 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the emergency generator was equipped with a remote manual stop station in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 5.6.5.6. This deficient practice had the potential to affect all 86 residents who resided at the facility. Findings include: An observation on 12/17/24 at 12:05 PM of the external emergency generator revealed the generator was not equipped with a remote manual stop station (Emergency Stop Switch) anywhere on the premises to prevent inadvertent	K 918	How the corrective action will be accomplished for any resident affected by deficient practice Maintenance Director or Designee identified the Generator which will be assessed and a remote manual stop station will be installed by a professional generator company. The current 86 residents in house were assessed and were not affected with this deficient practice. How we identified other residents/areas	

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K 918	Continued From page 22 or unintentional operation. During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed the generator was not equipped with a remote manual stop station. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. An audit by the Maintenance Director or Designee will be conducted to ensure all generators have a remote manual stop station installed to meet NFPA 10 and 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70). Education to all staff will be conducted by Maintenance Director, Regional, or Designee to discuss the importance of this concern. Administrator or designee will conduct daily rounds x 90 days and thereafter to ensure all generators for the facility are equipped with a manual stop station. Audits will be conducted monthly for three months and then quarterly by the facility Maintenance Director or Designee. How the concern will be monitored and title of person responsible for monitoring. The results of these audits will be submitted to the (Quarterly Assurance	

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K 918	Continued From page 23	K 918	Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 02/27/25	

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
315129 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/20/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	532 FARVIEW AVE PARAMUS, NJ 07652

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 K0311	01/31/2025	LSC K0341	01/31/2025	LSC K0351	01/31/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	01/31/2025	LSC K0355	01/27/2025	LSC K0372	01/31/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0500	01/31/2025	LSC K0511	01/31/2025	LSC K0918	02/13/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO