STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315158	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD CENTER	**330 FRANKLIN TPK RIDGEWOOD, NJ 07450**

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E 000	Initial Comments Survey: 12/8/2023 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ00163026, NJ00162986, NJ00162688, NJ00162321, NJ00161423, NJ00160692, NJ00158209, NJ00158121 Survey Date: 12/8/2023 Census: 72 Sample: 18 + 2 Closed Records = 20 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 578 SS=D	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 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.	F 578		12/21/23

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

Electronically Signed | 12/29/2023

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F 578	Continued From page 1 §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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, record review, and review of other facility documentation, it was determined the facility failed to ensure accurate documentation and review of a resident's advance directives for 3 of 18 residents (Resident #49, #36, #8) reviewed. This deficient practice was evidenced by the	F 578	Resident #49 was found to be coded incorrectly on the social services assessment and did not reflect the current code status. Resident #8 had a change related to life sustaining measures that was not reflected in the care plan. Resident #36 was identified as not having	

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F 578	Continued From page 2 following: 1. On 11/28/23 at 11:51 AM, the surveyor observed Resident #49 sitting in a wheelchair in their room. The resident was EX Order 26.4B1 EX Order 26.4B1 . A review of Resident #49's hybrid (electronic and paper) medical records revealed the following: According to the Admission Record (an admission summary) the resident was admitted with diagnoses that included but were not limited to, EX Order 26.4B1 A physician's order, dated EX Order 26.4B1 read, "EX Order EX Order 26.4B1)". A physician's order dated EX Order 26.4B1 read, EX Order 2 EX Order 26.4B1 The resident's paper chart included: an Advance Directives acknowledgement form dated NJ Exec. Order 26:4.b and signed by the resident's representative, a completed 'PROXY DIRECTIVE- (Durable Power of Attorney for Health Care)" form, dated EX Order 26.4B1 and a DNR form, dated EX Order 26.4B1 . The Social Services Assessment and Documentation, dated EX Order 26.4B1 , EX Order 26.4B1 and EX Order 26.4B1 documented Resident #49 did not have an advance directive and had a full code status. On 11/29/23 at 1:16 PM, the surveyor interviewed the Director of Social Services (DSS) who started NJ Exec. Order 26:4.b.1 ago at the facility. The DSS stated	F 578	up to date information on the Advance Directive orders in the Social Services Documentation and Assessment. 1) How the Corrective action will be accomplished for the residents found to be affected? On 12/21/18 The following residents: #8, #36, and #49 had a full chart review to ensure that all the Advance Directives were documented accurately in the charting, MDS, and individual care plans. 2) How the facility will identify other residents having the potential to be affected The Director of Social Service was educated on the importance that Advance Directives are reviewed quarterly in conjunction with the Care plan meetings with residents and families. In addition, any changes to residents living will or Advance Directive need to be communicated to all departments and MDS coordinator to ensure proper coding. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur A weekly QAPI audit will be conducted by the Director of Social Service and MDS coordinator in correlation with each resident care plan meeting for the next 3 months and be reported on monthly during the center QAPI meeting. 4) How the facility will monitor its corrective actions to ensure compliance	

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F 578	Continued From page 3 upon admission, on a quarterly basis and as needed, advance directives would be reviewed with residents and/or resident representatives. The DSS further explained it would be documented in the Social Services Documentation and Assessment (SSDA) in the electronic health record. The surveyor discussed the concern of the SSDA differing from the resident's advance directives and code status. The DSS documented the SSDA dated 11/9/23. The DSS stated she would review and provide further information. On 11/30/23 at 12:36 PM, the DSS informed the surveyor she followed up and the SSDA was incorrect. The DSS explained she may have documented for the incorrect resident. The DSS was asked about the other SSDA for the resident that also differed from the resident's advance directives. The DSS stated she should have noticed that and stated she could not speak to why the SSDA were not documented accurately. On 12/4/23 at 1:30 PM, the surveyor informed the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), and the regional nurse of the concerns regarding the accuracy of the assessment, documentation, and review of the identified residents' advance directives. On 12/5/23 at 9:57 AM, the LNHA and the DON met with the surveyors and acknowledged the social workers' documentation were incorrect in comparison to the resident's advance directives and code status. A review of the facility provided policy titled, "OPS117 Health Care Decision Making" with a	F 578	The Social Service Director or Designee will conduct a chart review prior to editing the MDS and assessments. When a change in Advance Directive occurs all department heads or designee will be informed so the appropriate changes can be made to the assessments, MDS, and care plans. The audit will be conducted weekly and reviewed at Monthly at QAPI meetings for the next 3 months.	

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F 578	Continued From page 4 revised dated of 3/1/22 read under Practice Standards: " ...2. Throughout the stay, advance care planning conversations will be conducted as part of the care plan process and with significant change in condition to identify, clarify, and review existing advance directives and/or portable medical orders and determine whether the patient wishes to change or continue these instructions ..." 2. On 11/28/23 at 11:51 AM, the surveyor observed Resident #36 in bed with eyes closed. The resident was EX Order 26.4B1. A review of Resident #36's hybrid (electronic and paper) medical records revealed the following: According to the Admission Record (an admission summary) the resident was admitted with diagnoses that included but were not limited to EX Order 26.4B1 [redacted] A physician's order, dated EX Order 26.4B1 read, EX Order 26.4B1 A physician's order dated EX Order 26.4B1 read, EX Order 26.4B1 EX Order 26.4B1 A physician's order dated EX Order 26.4B1 read, 'EX Order 26.4B1 EX Order 26.4B1 The resident's paper chart included: POLST (New Jersey Practitioner Orders for Life-Sustaining Treatment) dated EX Order 26.4B1 and signed by the resident's surrogate, and the Physician.	F 578		

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F 578	Continued From page 5 The Social Services Assessment and Documentation located in the electronic medical record, dated EX Order 26.4B1, and EX Order 26.4B1 documented Resident #36 did not have a separate Healthcare order (POST-Physician Order for Scope of Treatment, POLST-Physician Orders for Life Sustaining Treatment, MOLST-Medical Order for Life Sustaining Treatment, etc.) completed. 3. On 11/28/23 at 11:48 AM, the surveyor observed Resident #8 in the room seated in their wheelchair. The resident was EX Order 26.4B1 EX Order 26.4B1 The surveyor reviewed Resident #8's hybrid medical records. The admission record reflected that Resident #8 was admitted to the facility with medical diagnoses which included but not limited to EX Order 26.4B1 A review of the Q/MDS, an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Ord indicating that the resident was EX Order 26.4B1. A review of the form titled New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) (a written medical order from physician, nurse practitioner or physician assistant that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness) dated and signed by the physician on EX Order 26.4B1 indicated that Resident #8	F 578		

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F 578	Continued From page 6 wishes to be Full Code (patient wasn't resuscitation and all life saving measures during a medical emergency). On 12/2/23 at 11:09 AM, the surveyor reviewed Resident #8's comprehensive care plan (CCP) with a date revised on [redacted] titled, "[Resident #8] has an established advanced directive as [redacted]) which did not reflect the resident's current wishes. On 12/4/23 at 1:24 PM, the surveyor spoke to the Administrator and the Director of Nursing (DON) who verified that Resident #8 was on full code status. There was no further information provided.	F 578		
F 584 SS=D	N.J.A.C. 8:39-9.6 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	F 584		12/21/23

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F 584	Continued From page 7 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00162688, NJ00161423 Based on observation, interview, and record review, it was determined that the facility failed to maintain resident's equipment and living areas in a clean and home like manner. This deficient practice was identified for 2 of 20 residents (Resident #54 and Resident # 67) and was evidenced by the following: 1. On 11/28/23 at 11:40 AM, the surveyor observed Resident #54 in the day room seated in their wheelchair. The resident was EX Order 26.4B1 EX Order 26.4B1.	F 584	On 11/30/23 surveyor observed resident #8 had a ripped curtain lining that was hanging on the floor. On 12/5/23 the surveyor discussed the concern with the Director of Nursing and Administrator. The Administrator investigated and found that the lining was in need of replacement. A replacement was ordered. Resident #54 had a window screen that had cut or rip along the top of the screen. 1) How the Corrective action will be accomplished for the residents found to be affected?	

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F 584	Continued From page 8 The surveyor reviewed Resident #54's hybrid medical records. The Admission Record (AR) reflected that Resident #54 was admitted to the facility with medical diagnoses which included but not limited to EX Order 26.4B1 [redacted] According to Resident #54's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated [redacted], the Brief Interview for Mental Status (BIMS) was not conducted due to resident's [redacted] status which revealed that the resident had EX Order 26.4B1 with EX Order 26.4B1 and EX Order 26.4B1 The surveyor toured the resident's room on 11/30/23 at 11:18 AM and observed Resident #8's curtain lining ripped and was hanging on the floor. On 12/5/23 at 2:48 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON informed the surveyor that during a room cleaning, the condition of the room is also checked. The DON further stated that the facility had no specific policy on regards to room cleaning. There was no further information provided. 2. On 12/4/23 at 12:08 PM, the surveyor observed Resident #67 sitting up in a reclining chair in their room being set up by staff for lunch. The surveyor observed a window in the resident's room. The window screen facing the interior of the resident's room was observed with the top area of the screen bent and pulled back from the	F 584	The Administrator investigated and found that the lining was in need of replacement. A replacement was ordered for resident #8. Resident #54 had a window screen was ripped located on the top of the screen. A replacement screen was ordered. 2) How the facility will identify other residents having the potential to be affected Room cleanings are done daily however; this particular item was not reported to the Maintenance Director or placed into the Maintenance Tels system which informs him of needed repairs. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur As of 12/21/23 Maintenance Director will be doing a weekly room audits to identify any items in need of replacement. All staff will be in-serviced on how to make a Tel□s request in the system to ensure items of need of repair are addressed. 4) How the facility will monitor its corrective actions to ensure compliance The Maintenance Director or Designee will conduct weekly room audits and compare to items requested for repair in the Tels system. His findings will be reported on during Monthly QAPI meetings for the next 3 months to ensure that all items in need of repair are	

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F 584	Continued From page 9 window. On 12/5/23 at 8:58 AM, the surveyor interviewed the Maintenance Director about the process for addressing maintenance issues in resident areas. The Maintenance Director stated that staff would inform him of any issues, he would assess the problem and fix it. If he was not able to fix the issue, then he would hire someone/vendor to fix the issue. The Maintenance Director stated there was an electronic logging system in which maintenance requests were to be put in by staff for maintenance to address. The surveyor requested the electronic logging system report for 2023. On 12/5/23 at 9:34 AM, the Maintenance Director provided the electronic logging system report for 2023. The Maintenance Director stated he did not do formal rounds on resident's rooms, but when walking around in the facility would note any maintenance concerns. A review of the report revealed there were no entries related to the window screen in Resident #67's room and no entries for the ripped curtain in Resident #54's room. On 12/5/23 at 2:32 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the regional nurse about the concerns for the window screen in Resident #67's room. The LNHA, DON and regional nurse stated they were not aware of the damaged window screen. On 12/6/23 at 9:20 AM, the survey team met with the LNHA, DON and former DON. No additional information was provided.	F 584	completed timely.	

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F 584	Continued From page 10 A review of the facility provided policy titled "Accommodation of Needs" with a revised date of 2/1/23 which read under Policy: "The resident/patient (hereinafter "patient") has the right to a safe, clean, comfortable, and homelike environment including, but not limited to, receiving treatment and support for daily living safely." Under Process it read: " ...1. The center must provide ...1.2 Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior ..."	F 584		
F 641 SS=D	N.J.A.C. 8:39-4.1 (a)11; 31.4 (a), (b); 31.8 (e) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00162321 Based on observation, interview, and record review it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 4 of 20 residents reviewed, Resident #18, #69, #8, and #170. This deficient practice was evidenced by the following: 1. On 11/28/2023 at 11:59 AM, the surveyor observed Resident #18 in bed with eyes closed. The surveyor observed the resident with a EX Order 26.4B1 (EX Order 26.4B1	F 641	The following residents: #18, #69, #8, and #170 had various coding errors on their assessments. 1) How the Corrective action will be accomplished for the residents found to be affected? Resident #18 was taken off the EX Order 26.4B1 EX Order 26.4B1 and monitoring book located at reception was updated. Resident #69 was not appropriately coded as a planned discharge. Resident # 8 had EX Order 25 and was improperly coded as EX Order 25 with major injury. Resident # 170 was transferred to another facility for NJ Exec. Order 26:4.b.1 and expected to return and was coded as	12/28/23

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F 641	Continued From page 11 EX Order 26.4B1 as well as alerting the caregiver whenever his or her patient breaches a perimeter or strays too far) worn on their EX Order 26.4B1. The surveyor reviewed Resident #18's electronic medical record (EMR). Review of Resident #18's Face Sheet (FS) (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility on EX Order 26.4B1 with diagnosis that included but were not limited t EX Order 26.4B1 A review of the November 2023 Physician's order (PO) form for Resident #18 revealed an order for EX Order 26.4B1. Review of Resident #18's Quarterly MDS (QMDS), dated EX Order 26.4B1 reflected under Section P (used to assess physical restraints and alarms used during a seven-day look-back period), under the section "Alarms and Restraints. P0200. Alarms - EX Order 26.4B1 alarm", was listed as NJ Exec. Order 26:4.b.1 ." On 11/28/2023 at 12:15 PM, the surveyor interviewed the EX Order 26.4B1 Unit Manager (UM), who stated Resident #18 has a EX Order 26.4B1 due to the resident wandering throughout the unit and their EX Order 26.4B1. On 12/01/2023 at 10:45 AM, the surveyor interviewed the Registered Nurse (RN#1), who	F 641	planned. However, according to the latest version of the Center for Medicare/Medicaid Services it should have been coded as unplanned. The medical records for residents #18, # 69, # 8, and #170 were reviewed and the Assessments were updated to reflect current status of all residents currently residing at the facility. 2) How the facility will identify other residents having the potential to be affected Since all residents could potentially be affected the Interdisciplinary team will be reviewing each resident Prior MDS with the most current at Care Plan meetings to ensure proper coding. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur MDS coordinator will utilize an audit tool identifying any changes in condition that were coded on the current MDS. The interdisciplinary team will review the changes to ensure the accuracy. When incorrect coding is discovered, it will be corrected prior to submitting the MDS. 4) How the facility will monitor its corrective actions to ensure compliance Audits will be used at weekly Care plan meetings. Results will be kept by the MDS Coordinator or Designee and	

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F 641	Continued From page 12 completes the MDS assessment. RN#1 stated they had miscoded Resident #18's EX Order 26.4B1 EX Order 26.4B1 2. On 12/01/2023 at 11:38 AM, the surveyor reviewed the closed medical record for Resident #69, who was MDS coded for an unplanned discharge. The surveyor reviewed the Discharge Plan Documentation (DPD) created on EX Order 26.4B1 by the Licensed Practical Nurse (LPN). The DPD indicated Resident #69's discharge was a planned discharge. A review of the NJ Exec. Order 26:4.b.1 Nursing Progress Note (PN), indicated that Resident #69 "Resident is being discharged to home. Medication list and discharge instruction have been given to resident and wife. Vitals are within normal range." Review of the "A section" of the NJ Exec. Order 26:4.b.1 MDS for Resident #69 revealed that section "A0310 - G. Type of Discharge, " documented, "02. Unplanned." There was another option "01. Planned" which identified the correct discharge for Resident #69 which was not specified. The surveyor reviewed Resident #69's Discharge MDS on EX Order 26.4B1, under section A, Type of Discharge. Resident # 69 was coded as "unplanned discharge." On 12/01/2023 at 11:55 AM, the surveyor interviewed RN#1. RN#1 stated that the discharge was miscoded and should have been coded as "planned." The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) Resident	F 641	reported on during Monthly QAPI meetings for the next 3 Months up to date changes if any.	

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Assessment Instrument (RAI) Version 3.0 Manual updated October 2019. The manual included, "A physical restraint is any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The manual instructed for section P to identify all physical restraints that were used at any time (day or night) during the 7-day look-back period and code the frequency of use; Code 0, not used; Code 1, used less than daily; and Code 2, used daily. The steps for assessment and determining physical restraint use included to review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look back period. It further included that any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition."

On 12/1/2023 at 10:55 AM, the Director of Nursing (DON) provided the surveyor with the two facility policies titled, "Patient Security Bracelet" with a revision date of 6/1/2021 and "Genesis, SNF Clinical System Process - MDS 3.0" with an effective date of 11/29/2021. The Patient Security Bracelet policy states under the policy section, "Resident/Patient security bracelets (e.g., EX Order 26.4B1) will be inspected ...the expiration date, placement checks, and function inspections of the bracelet will be documented in the medical record." The Genesis, SNF Clinical System Process - MDS 3.0 states, "Best practices: CRC/MDS

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Coordinator/Designee, Section C. Coordinating with Social Services, Recreation Director, Nutrition Services. 3. Communicates Assessment Record Date (ARD) for patients being discharged."

On 12/4/2023 at 1:30 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to review concerns. The DON stated the MDS for Resident #18 and #69 should have been coded correctly and those errors will be corrected. No further information provided.

3. On 11/28/23 at 11:48 AM, the surveyor observed Resident #8 in the room seated in their wheelchair. The resident was EX Order 26.4B1 EX Order 26.4B1

The surveyor reviewed Resident #8's hybrid medical records. The FS reflected that Resident #8 was admitted to the facility with medical diagnoses which included but were not limited to EX Order 26.4B1

A review of the Q/MDS, an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order indicating that the resident was EX Order 26.4B1

Further review of the Q/MDS under Section J1900 for number of falls since admission/entry or reentry to the facility revealed that Resident #8 had EX Order 26.4B1 and EX Order 26.4B1 EX Order 26.4B1.

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The surveyor interviewed the facility's Registered Nurse/MDS Coordinator (RN/MDS-C) who stated that the MDS section for [redacted] was coded in error. The RN/MDS-C further stated that Resident #8 only had a [redacted] RN/MDS-C clarified the coding error and informed the surveyor that Resident #8 did not have [redacted].

4. On 12/5/23 at 10:43 AM, the surveyor reviewed a closed record. Resident #170 was admitted to the facility on [redacted] and was discharged to another facility on [redacted]

The surveyor reviewed Resident #170's hybrid medical records. The resident was admitted to the facility with diagnosis that included but were not limited to [redacted].

The surveyor reviewed the discharge MDS assessment dated [redacted] under Section A0310G indicated "2. Unplanned".

A review of the progress notes dated [redacted] documented by the resident's Nurse Practitioner (NP) which indicated that the NP had a discussion with the resident's daughter regarding a recommendation for the resident to be transferred to the [redacted] hospital for medication management due to increase in [redacted] Further review of the progress notes dated [redacted] documented that Resident #170 was transferred to the [redacted] hospital for [redacted].

On 12/4/23 at 1:10 PM, the surveyor interviewed

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F 641	Continued From page 16 the MDS Coordinator who stated that the resident's discharge was considered unplanned. She did not provide any further information. On 12/4/23 at 1:24 PM, the surveyor discussed the above concern to the facility's LNHA and DON. The surveyor questioned if the resident's discharge was considered planned since it was discussed by the NP and the family member 2 days before Resident #170 was transferred to the EX Order 26.4B1 hospital. No further information was provided. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 ... "According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 ... "For unplanned discharge includes, for example: Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or Resident unexpectedly leaving the facility against medical advice; or Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting.)" NJAC 8:39-11.1, 11.2(e)(1)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		12/21/23

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F 656	Continued From page 17 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 18 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint #NJ00158121 Based on observation, interview, and record review it was determined that the facility failed to develop a comprehensive, person-centered care plan for 1 of 20 residents reviewed for comprehensive care plans (Resident #270). This deficient practice was evidenced by the following: 1. The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #270 which revealed the following: The Admission Minimum Data Set (MDS), an assessment tool to facilitate care, dated EX Order 26.4B1 indicated the resident had diagnoses that included but were not limited to, EX Order 26.4B1 he facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored an EX out of 15 which indicated that the resident had EX Order 26.4B1. The MDS documented the resident was NJ Exec. Order 26:4.b.1 with eating, bathing, and locomotion. Resident #270 also required NJ Exec. Order 26:4.b.1 with transfers and bed mobility. A review of the resident's care plan (CP) revealed a care plan, dated EX Order 26.4B1 related to the resident's daily routine which read, "While in the facility resident/patient states it is important that	F 656	Resident # 270 had a care plan which was not personalized and had many blanks. Education was provided to the Department Manager in regards to personalizing the care plan and getting input from various sources such as, the resident, nursing assistants, family, and friends. Recreation Director will be providing an QAPI audit weekly in conjunction with scheduled Care plan meetings for the next 3 months to ensure that interventions are personalized and have input from all parties. The audit will focus on Person Centered Care Plans 1) How the Corrective action will be accomplished for the residents found to be affected? Resident #270 was reviewed with Activities Director and revised to include personalized interventions. 2) How the facility will identify other residents having the potential to be affected? All residents have the potential to be affected by not having updated and personalized care plans. Prior to the weekly Interdisciplinary meetings Department Heads will be completing a review of all care plans to ensure that the interventions are up to date and residents preferences are	

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F 656	Continued From page 19 s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences". There was no goal indicated in the CP. The interventions were not completed, with blank areas and individualized to Resident #270 and included the following: " ...I like to snack between meals and prefer _____...It is important for me to have reading materials such as _____...I keep up with the news by discussions with another person, group discussions, listening to the radio, reading magazines, reading the newspaper, using the computer, watching TV, and/or ____. (Delete all that do not apply) ...I like to participate in _____ (specify leisure options) with groups of people ...I like to use a computer, do crosswords/puzzles/games, listen to music, look out the window, lay down/rest, meditate, pray, read, think, watch TV/movies, and/or other _____. (Delete location information if initial assessment.) ...It is important for me to go outside when the weather is good and enjoy eating/drinking, playing games or sports, gardening, napping, sitting, smoking, talking/visiting, tanning, walking, bird watching/wildlife observing, working, and/or _____. (Delete all that do not apply) ...I would benefit from accommodation for physical limitations by using demonstration, adaptive materials/equipment, physical prompts and/or others _____. (Delete all that do not apply) ..." On 12/6/23 at 11:45 AM, the surveyor interviewed the Director of Nursing (DON) about the concerns for Resident #270's CP not being resident centered omitting any of the resident's preferences. The DON acknowledged the CP was not complete or resident centered as the	F 656	identified. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur MDS coordinator or Designee will be auditing the resident care plans at Interdisciplinary meetings weekly to verify care plans are personalized, reviewed, and updated. 4) How the facility will monitor its corrective actions to ensure compliance. MDS coordinator or designee will report on the accuracy of interventions and that interventions were timely and personalized. Findings will be reported on Monthly for the next 3 Months during QAPI meetings.	

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F 656	Continued From page 20 noted intervention entries were blank. On 12/6/23 at 1:00 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), the DON, the previous DON and the regional nurse were informed of the concerns for Resident #270's CP not being comprehensive, and resident centered. No further information was provided by the facility. A review of the facility's provided facility titled, "Person-Centered Care Plan" with a revised date of 10/24/22, which under Purpose read: "...To attain or maintain the patient's highest practicable physical, mental and psychological wellbeing...To promote positive communication between patient, patient representative, and team to obtain the patient's and resident representative input into the plan of care, ensure effective communication, and optimize clinical outcomes..." NJAC 8:39- 11.2 (d); 27.1 (a)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		12/28/23

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F 657	Continued From page 21 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise a resident's comprehensive care plan for 2 of 20 residents reviewed, Resident #54 and Resident #8. This deficient practice was identified by the following: 1. On 11/28/23 at 11:40 AM, the surveyor observed Resident #54 in the day room seated in their wheelchair. The resident was EX Order 26.4B1 EX Order 26.4B1 The surveyor reviewed Resident #54's hybrid medical records. The Admission Record (AR) reflected that Resident #54 was admitted to the facility with medical diagnoses which included but was not limited to EX Order 26.4B1 [redacted]	F 657	Timely completion of Care Plan Revisions for resident #54 and #8 as it relates to EX Order 26 [redacted] management. 1) How the Corrective action will be accomplished for the residents found to be affected? Resident #54 and #8 care plans were reviewed and updated with new interventions. Since all residents have a potential to be affected a new committee has been developed. 2) How the facility will identify other residents having the potential to be affected. On 12/27/23 staff was provided education on the development of a new Fall Committee which will monitor falls and prevention. The members will include the Director of Nursing, Administration, Director of Therapy, Recreation Director,	

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F 657	Continued From page 22 According to Resident #54's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec. Order 26:4.b.1], the Brief Interview for Mental Status was not conducted due to the resident's [NJ Exec. Order 26:4.b.1] status which revealed that the resident had EX Order 26.4B1 Further review of the Q/MDS under Section J1800 for any falls since admission/entry or reentry to the facility revealed that Resident #54 had EX Order 26.4B1 while a resident at the facility. The facility's Director of Nursing (DON) provided a copy of the EX Order 26.4B1 report to the surveyor. A review of the form revealed that Resident #54 had a EX Order 26.4B1 on EX Order 26.4B1. The surveyor reviewed the residents comprehensive care plan (CP) which reflected a CP for Resident #54 titled, "[Resident's name] is at risk for [EX Order 26]: related to EX Order 26.4B1 [redacted]." with a revision date of [EX Order 26.4B1]. A review of the list of interventions did not reflect that the CP was revised on any of the EX Order 26.4B1 [redacted] nor updated after each [EX Order] incident. 2. On 11/28/23 at 11:48 AM, the surveyor observed Resident #8 in the room seated in their wheelchair. The resident was EX Order 26.4B1 [EX Order 26.4B1] The surveyor reviewed Resident #8's hybrid medical records. The AR reflected that Resident #8 was admitted to the facility with medical	F 657	Unit Manager and Nursing Assistant. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur Meetings will be held on Mondays and Fridays. Fall care plans will be addressed immediately after a fall occurs or in the event someone is identified as fall risk. The care plans will be updated post fall and be individualized and have strategies that coincide with any of the residents condition changes. 4) How the facility will monitor its corrective actions to ensure compliance? Director of Nursing or designee will report on falls on a monthly basis and review any findings that have a pattern and ensure all members have provided input into the fall prevention. Monthly for 3 months.	

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F 657	Continued From page 23 diagnoses which included but was not limited to EX Order 26.4B1 A review of the Q/MDS, an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order indicating that the resident was EX Order 26.4B1 Further review of the Q/MDS under Section J1900 for number of falls since admission/entry or reentry to the facility revealed that Resident #8 had EX Order 26.4B1 while the resident was at the facility. The facility's DON provided a copy of the EX Orde incident report to the surveyor. A review of the form revealed that Resident #8 had a EX Order 26.4B1 on EX Order 26.4B1 The surveyor reviewed the resident's comprehensive CP which reflected a CP for Resident #8 titled, "[Resident's name] is at risk fo EX Order 26.4B1 with a revision date o EX Order 26.4B1. A review of the list of interventions did not reflect that the CP was revised nor updated after the EX Order 26.4B1). A review of the facility's policy and procedure titled, "Falls Management" under Practice Standards "#1. All patients will be assessed for risk of falls upon admission, with reassessments routinely (e.g., quarterly, post-fall) performed to determine ongoing need for fall prevention precautions." "#2. 2.1 Adjust and document	F 657		

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F 657	Continued From page 24 individualized intervention strategies as patient condition changes." The surveyor interviewed the DON who stated that whenever a resident had a fall incident, the facility will hold a care conference to discuss what new interventions should be put in place to prevent further falls. The surveyor requested for a documentation from the care conference for both EX Order 26.4B1 of Resident #54. This was not provided by the facility. On 12/5/23 at 9:56 AM, the surveyor met with the facility's Licensed Nursing Home Administrator and the DON regarding the above concerns. There was no additional information provided.	F 657		
F 658 SS=D	NJAC 8:39-11.2(i) 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: Complaint #: NJ00162986 Based on observation, interview, and record review it was determined the facility failed to consistently follow standards of clinical practice with regards to: accurately documenting the administration of medication for 4 out of 20 residents, Resident #24, #36, and #58 as well as	F 658	Medication documentation was inaccurate for residents #24, #36, #58 and #8 had a physician order that was not transcribed. Resident #8 had an order for a EX Order 26.4B1 to be done every year with a start date of EX Order 26.4B1 that was not started. 1) How the Corrective action will be	12/21/23

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F 658	Continued From page 25 transcribing a physician's order for EX Order 26.4B1 for 1 out of 20 residents reviewed, Resident #8. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as 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 11/30/23, the surveyor reviewed the use of EX Order 26.4B1 for Resident #24. The surveyor reviewed the Controlled Medication Utilization Record (CMUR), a medication declining sheet for Resident #24's EX Order 26.4B1	F 658	accomplished for the residents found to be affected? All nursing staff were in-serviced on Narcotic counts and reconciliation per shift of the CMUR and eMar. Resident #8 will have the order clarified and carried out for NJ Exec. Order 26:4.b.1. Staff were in-serviced on inputting orders with signatures. 2) How the facility will identify other residents having the potential to be affected? All residents have the potential to be affected. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? Staff will be responsible for reconciliation at the start and end of their shift to ensure accuracy of administration. When a discrepancy occurs they will start a discrepancy investigation form and inform the Director of Nursing immediately. 4) How the facility will monitor its corrective actions to ensure compliance Pharmacy consultant will audit the Monthly MAR and CMUR for inconsistencies. Medication regimen Review will be given to the Administrator and Director of nursing for review. Director of Nursing or designee will audit shift counts daily for 2 weeks than, 3 times a week for 2 weeks, and finally 2 times a week for 2 weeks. The Director of Nursing or Designee will report findings to the Performance	

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F 658	Continued From page 26 medication), delivered by the provider pharmacy on EX Order 26.4B1 The surveyor reviewed Resident #24's hybrid medical records. The Admission Record (AR) (an admission summary) reflected that Resident #24 was admitted to the facility with medical diagnoses which included but was not limited to EX Order 26.4B1 [redacted] According to Resident #24's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1, the Brief Interview for Mental Status (BIMS) was NJ Exec. Order 26:4.b.1 due to the resident's cognitive status which revealed that the resident had EX Order 26.4B1 with both EX Order 26.4B1 and EX Order 26.4B1. When comparing the dates documenting on the CMUR and the electronic medication administration record (eMAR) for EX Order 26.4B1 and EX Order 26.4B1 discrepancies were noted. When reviewing the CMUR, the surveyor noted an entry for EX Order 26.4B1 removed from stock for administration to Resident #24 on EX Order 26.4B1 Review of the EX Order 26.4B1 eMAR fails to document the administration of the medication to Resident #24 EX Order 26.4B1 When reviewing the CMUR, the surveyor noted an entry for EX Order 26.4B1 removed from stock for administration to Resident #24 on EX Order 26.4B1 Review of the EX Order 26.4B1 eMAR fails to	F 658	Improvement Committee monthly for three months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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F 658	Continued From page 27 document the administration of the medication to Resident #24 for EX Order 26.4B1 2. On 11/30/23, the surveyor reviewed the use of EX Order 26.4B1 for Resident #36. The surveyor reviewed the CMUR sheet for Resident #36's EX Order 26.4B1 EX Order 26.4B1), delivered by the provider pharmacy on EX Order 26.4B1. The surveyor reviewed Resident #36's hybrid medical records. The AR reflected that Resident #36 was admitted to the facility with medical diagnoses which included but was not limited to EX Order 26.4B1 According to Resident #36's Annual Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 the BIMS was not conducted due to the resident's EX Order 26.4B1 status which revealed that the resident had a EX Order 26.4B1. When comparing the dates documenting on the CMUR and the electronic medication administration record (eMAR) for February 2023 discrepancies were noted. When reviewing the CMUR, the surveyor noted an entry for EX Order 26.4B1 of EX Order 26.4B1 removed from stock for administration to Resident #36 on EX Order 26.4B1 Review of the EX Order 26.4B1 eMAR fails to document the administration of the medication to Resident #36 for EX Order 26.4B1.	F 658		

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F 658	Continued From page 28 3. On 11/30/23, the surveyor reviewed the use of EX Order 26.4B1 for Resident #58. The surveyor reviewed the CMUR sheet for Resident #358's EX Order 26.4B1), delivered by the provider pharmacy on EX Order 26.4B . When comparing the dates documenting on the CMUR and the electronic medication administration record (eMAR) for EX Order 26.4B1 discrepancies were noted. When reviewing the CMUR, the surveyor noted an entry for EX Order 26.4B1 removed from stock for administration to Resident #58 on EX Order 26.4B1 . Review of the EX Order 26.4B1 eMAR fails to document the administration of the medication to Resident #36 for EX Order 26.4B1 The surveyor reviewed Resident #58's hybrid medical records. The AR reflected that Resident #58 was admitted to the facility with medical diagnoses which included but was not limited to EX Order 26.4B1 . According to Resident #58's A/MDS) dated EX Order 26.4B1 , the BIMS was not conducted due to the resident's EX Order 26.4B1 status which revealed that the resident is EX Order 26.4B1 . On 11/30/23 at 12:40 PM, the surveyor interviewed the DON who stated that all	F 658		

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F 658	Continued From page 29	F 658		

controlled substances removed from stock should be signed as removed on the declining CMUR sheet and then signed in the eMAR as administered to the resident.

On 12/6/23 at 10:14 AM, the surveyor interviewed the Consultant Pharmacist (CPHARMD) who stated that she randomly picks CMUR sheets to audit for accuracy of inventory. She explained that she does not compare the documentation on the CMUR with the documentation of the administration on the eMAR to make sure that both are aligned.

4. On 11/28/23 at 11:48 AM, the surveyor observed Resident #8 in the room seated in their wheelchair. The resident was EX Order 26.4B1 EX Order 26.4B1

The surveyor reviewed Resident #8's hybrid medical records. The AR reflected that Resident #8 was admitted to the facility with medical diagnoses which included but not limited to EX Order 26.4B1

A review of the Q/MDS, an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order indicating that the resident was EX Order 26.4B1.

A review of the form titled, "Consultant Pharmacist's Medication Regimen Review" dated EX Order 26.4B and EX Order 26.4B1 indicated 'EX Order 26.4B1 EX Order 26.4B1 can be found in the record. Please consider monitoring a EX Order 26.4B1 next lab day and then once yearly thereafter if NJ Exec. Order 26.

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F 658	Continued From page 30 (Within normal limits)" A review of the Order Summary Report revealed a physician's order dated 1[EX Order 28.4B1] with a start date of [EX Order 26.4B1] for EX Order 26.4B1 one time a day every [EX Ord] month (s) starting on the [EX Order 26.] ...." Further review of Resident #8's medical records did not reveal any laboratory results that the ordered test was done according to physician's order. On 12/4/23 at 1:24 PM, the surveyor discussed the above concern to the facility's Licensed Nursing Home Administrator and Director of Nursing. The DON stated that the [EX Order 26.4B1] was not according to physician's order. There was no further information provided. NJAC 8:39-27.1 (a) NJAC 8:39-29.2 (a) NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		12/21/23

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F 712	Continued From page 31 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face to face visits and wrote progress notes at least once every sixty days. This deficient practice was identified for 2 of 20 (Resident #8 and Resident #1) reviewed for physician visits and was evidenced by the following: 1. On 11/28/23 at 11:48 AM, the surveyor observed Resident #8 in the room seated in their wheelchair. The resident was EX Order 26.4B1 EX Order 26.4B1 The surveyor reviewed Resident #8's hybrid medical records. The Admission Record (AR) (an admission summary) reflected that Resident #8 was admitted to the facility with medical diagnoses which included but were not limited to EX Order 26.4B1 A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order indicating that the resident was EX Order 26.4B1	F 712	Resident #8 and #1 did not receive frequency of physician visits at least every 30 days for the first 90 days or at least once every 60 days thereafter. 1) How the Corrective action will be accomplished for the residents found to be affected? All residents have the potential to be affected by this practice. Medical Director was informed that resident #8 and #1 were in need of a physician visit and it was scheduled for the week of EX Order 26.4B1. Administrator reviewed responsibilities and expectations. 2) How the facility will identify other residents having the potential to be affected? The Medical Records Director will be conducting monthly compliance audits to ensure that residents are being seen within the appropriate timeframes. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? Medical Records Director will be providing a list of residents to be seen the last week of the month for the next month. 4) How the facility will monitor its corrective actions to ensure compliance The visits will be tracked weekly for the	

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F 712	Continued From page 32 A review of the Physician's progress notes reflected the following: 6/23/23 Physician progress notes completed by Advanced Practice Nurse (APN). 7/7/23 Physician progress notes completed by APN. 7/31/23 Physician progress notes completed by APN. 8/30/23 Physician progress notes completed by APN. 9/26/23 Physician progress notes completed by APN. There was no documented evidence that the physician visited and examined Resident #8 at least every 60 days. On 12/4/23 at 1:24 PM, the surveyor discussed the above concerns to the facility's Licensed Nursing Home Administrator and Director of Nursing. 2. On 11/28/23 at 11:39 AM, the surveyor observed Resident #1 lying in bed with their eyes EX Order 26.4B1 . The surveyor reviewed Resident #1's hybrid medical records which revealed the following: According to the AR the resident was admitted to the facility with diagnoses which included but were not limited to, EX Order 26.4B1 [redacted] A review of the Physician Progress Notes revealed that Resident #1's primary physician last documented that he had visited and	F 712	next 3 months. Monthly results will be reported at the QAPI for compliance.	

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F 712	Continued From page 33 examined the resident on 1[NJ Exec. Order 26:4.3] and [NJ Exec. Order 26:4.3]. There was no documentation between March 2023 and October 2023 that the primary physician conducted alternating face to face visits with Resident #1 while working in collaboration with the nurse practitioner (NP) visits. On 12/6/23 at 11:47 AM, the surveyor interviewed the physician via a telephone call who acknowledged that he did not document physician's progress notes at least every 60 days. On 12/6/23 at 1:00 PM, the surveyor discussed the above concerns with the facility's Licensed Nursing Home Administrator and Director of Nursing. No further information was provided by the facility. N.J.A.C 8:39-23.2(d)	F 712		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		12/21/23

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F 755	Continued From page 34 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00162986 Based on observation, interview, and record review, it was determined that the, monitored, and reviewed. This deficient practice was identified for 2 of 2 units reviewed during unit inspections. This deficient practice was evidence by the following: 1. On 11/28/23 at 10:00 AM, the surveyor proceeded to perform unit inspections of the facility. While on the [redacted] Unit, the surveyor examined the declining Controlled Medication Utilization Record (CMUR) sheet for [redacted] belonging to Resident #2.	F 755	Resident #2 had Incorrect information on the facility Controlled Medication Utilization Record. Wasted medication did not have a witnessed signature. Routine Reconciliation of Controlled Substances should be performed by two licensed nurses and authorized and licensed healthcare professional. Facility staff failed to recognize the recent medication order was not the same as the house [redacted] so it could be changed to the appropriate order in the system. 1) How the Corrective action will be accomplished for the residents found to have been affected Controlled Substance Inventory declining sheets on med carts were reviewed and reconciled on 11/30	

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F 755	Continued From page 35 The medication was delivered by the provider pharmacy to the facility on EX Order 26.4B1 The CMUR documented that on EX Order 26.4B1 there were no more tablets left. The CMUR then had an additional line signed with a date of EX Order 26.4B1 that there was EX O tablet left in the inventory. The surveyor interviewed the Licensed Practical Nurse (LPN) #1 who was utilizing the medication cart and asked to see the medication. When LPN#1 inspected the locked control substance area, she could not find the one tablet of EX Order 26.4B1 and could not explain why the sheet had one tablet documented in the inventory. The surveyor informed the Director of Nursing (DON) of this discrepancy. On 11/29/23 at 12:45 PM, the surveyor discussed the matter with the DON who informed the surveyor that the EX Order 26.4B1 was signed off on CMUR sheets for the date of EX Order 26.4B1 at 9:00 AM. The sheet dated with a delivery date of 8/18/23, did not have 1 left even though the "1" was documented after the sheet already showed "0" was left. The DON presented another CMUR sheet dated with a provider delivery date of 9/14/23 showed that "1" was removed from this sheet on EX Order 26.4B1 at 9:00 AM duplicating the documentation on the 8/18/23 sheet. The DON stated that the CMUR sheet with the provider pharmacy delivery date of 8/18/23 should have been removed from the active book. The DON could not explain why this CMUR with	F 755	2) How the facility will identify other residents having the potential to be affected All residents have the potential to be affected by this deficient practice. 3) What measures will be put into place or systematic changes made to ensure the deficient practice will not recur All License nurses will be re in-serviced on controlled substances policy and procedure All License nurses will be re in-serviced on declination shift count sheets. 4) How the facility will monitor its corrective actions to ensure compliance Nursing designee will audit controlled substance shift count is being completed daily x 2 weeks, 3 times a week x 2 weeks then weekly x 2 weeks	

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one tablet listed in the inventory, was still active even though the medication was no longer there.

2. During the facility annual survey, the surveyor investigated a facility reportable that related to the possible loss of a controlled substance, EX Order 26.4B1 belonging to Resident #36.

On 11/28/23 at 12:40 PM, the surveyor discussed a reportable event that was sent to the New Jersey Department of Health (NJDOH) on 2/10/23 at 2:30 PM with the DON. The reportable event related to a medication cart narcotic audit completed by the Consultant Pharmacist (CPharmD) who found that the actual count of the EX Order 26.4B1 was 14 yet the CMUR for Resident #36 showed 15 tablets left.

The DON presented the facility investigation of the incident to the surveyor. The DON explained that the conclusion of the investigation was that the nurse on duty had forgotten to document the removal of the EX Order 26.4B1 the CMUR, as well as not documenting the administration of the EX Order 26.4B1 in the electronic medication administration record (eMAR).

During the interview with the DON, the DON revealed that the Licensed Practical Nurse signed the CMUR for the removal of the EX Order 26.4B1 at EX Order 26.4B1 and documented in the eMAR at 4:55 PM, both after the nurse's shift had ended.

Review of the Consultant Pharmacist Med Room and Med Cart Audit, "Spot check of 3 controlled items for count. Does inventory count match? N." Review of the documentation under, "Comments:

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EX Order 26.4B1 card with 14, count down sheet indicated 15. DON aware."

On 12/5/23 at 1:19 PM, the surveyor interviewed the Consultant Pharmacist (CPHARMD) who recapped the discrepancy. The CPHARMD explained that she picks 3 random controlled substance medication to audit monthly on each unit. The CPHARMD stated, "This should not be happening with narcotics."

3. On 11/28/23 at 12:40 PM, the surveyor reviewed the CMUR sheet for EX Order 26.4B1 belonging to Resident #24. The CMUR sheet was noted having 3 tablets "Wasted" on 7/11/23, 8/17/23 and 9/24/23. Review of the three dates revealed that 7/11/23 and 8/17/23 both had 2 signatures with one of the signatures being a witness to the destruction. The 9/24/23 destruction only had one signature of a nurse.

On 11/29/23 at 12:45 PM, the surveyor discussed the matter with the DON who informed the surveyor that she never noticed that the 9/24/23 "Wasted" did not have a witnessed signature. The DON explained that the nurse who signed the "Wasted" was no longer employed by the facility.

The surveyor reviewed the CMUR sheet with the DON for clarification why the nurses "Wasted" EX Order 26.4B1 on three different occasions and if she was aware of the reason. The DON could not explain why EX Order 26.4B1 was wasted on three different dates.

On 12/6/23 at 10:14 AM, the surveyor interviewed the CPHARMD who stated that she

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did not notice the missing second signature for the "Wasted" EX Order 26.4B1 . If I had noticed, I definitely would have pointed that out to the DON.

Review of the Routine Reconciliation of Controlled Substances under "Procedure 2. The reconciliation should be performed by two licensed nurses or a nurse and authorized and licensed healthcare professional." Under "8. Before destruction or disposal of controlled substances the assigned nurse and witness should count the number of doses to be destroyed to each declining inventory sheet and document the doses to be destroyed as correct."

Review of Controlled Drugs: Management of Destruction: "Two licensed professionals are required to destroy and document destruction of controlled substances per state regulation."
4. On 11/30/23 at 9:40 AM, the surveyor observed LPN#1 administer medication to Resident #53. Resident #53 was due to receive the medication EX Order 26.4B1 . LPN#1 stated it was not in the medication cart and that it was not an available back up medication in the facility. LPN#1 stated she would re-order from the pharmacy and signed the medication on the electronic Medication Administration Record (eMAR) as not given.

The Surveyor reviewed the electronic medical record of Resident #53 which revealed the following:

A physician's order, dated 1 NJ Exec. Order 26:4.B read,

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EX Order 26.4B1 Give EX capsule by mouth EX Order 2 times a day for EX Order 26.4B1 ".

A review of the November 2023 eMAR documented the EX Order 26.4B1 was signed by the nurses as administered to the resident.

On 11/30/23 at 11:09 AM, the surveyor interviewed LPN#1 who stated she re-ordered medication from pharmacy and confirmed the medication was not part of the facility's house stock. LPN#1 stated she could not speak to the previous entries being signed as administered and directed the surveyor to the unit manager for further information.

On 11/30/23 at 11:37 AM, the surveyor interviewed a pharmacist (RPh) at the facility's provider pharmacy about the EX Order 26.4B1 medication order and delivery. The RPh stated the order was placed to the pharmacy for the medication and was cancelled by the pharmacy as it was an over the counter medication not covered by the pharmacy. She further stated the pharmacy's billing dept faxed to the facility on 11/24/23 a form explaining that the medication was not covered. There was not further requests by the facility related to the medication documented by the pharmacy.

On 11/30/23 at 12:55 PM, the surveyor asked the regional nurse to provide further information for the EX Order 26.4B1 medication ordered on 11/24/23 that was not available.

On 12/4/23 at 1:30 PM, the surveyor informed the

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F 755	Continued From page 40 DON, Licensed Nursing Home Administer (LNHA), and the regional nurse of the concerns for the EX Order 26.4B1 medication, that was not delivered and not available in the medication cart. On 12/6/23 9:17 AM, the survey team met with the DON, LNHA, and previous DON. The previous DON stated they have EX Order 26.4B1 EX Order 26.4B1 in stock in the facility and the nurses had been giving that medication. The DON and previous DON acknowledged the NJ Exec. Order 26:4.b.1 was different from the ordered entered on 11/24/23. The previous DON stated the nurse did not select the appropriate EX Order 26.4B1 order when entering it into the electronic medical record. The previous DON stated the order was clarified on 11/30/23 after the surveyor's inquiry. A review of the facility provided policy titled, "6.0 General Dose Preparation and Medication Administration" with a revised date of 1/1/22, under Procedure it read, " ...3.7 Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration order ...4.1 Facility staff should: ...4.1.2 Confirm that the MAR reflects the most recent medication order ..." NJAC 8:39-29.2; 29.7	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		12/21/23

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F 880	Continued From page 41 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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 42 (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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices of appropriately performing hand hygiene and disinfection of a blood pressure cuff used during medication administration for 1 of 4 nursing staff members observed during medication passage on 1 of 2 units observed. This deficient practice was evidenced by the following: On 11/30/23 at 9:02 AM, the surveyor observed Registered Nurse # 1(RN#1) administer	F 880	During observation of medication pass RN#1 was out of compliance with Infection control protocols. RN#1 did not wash hands before and after contact with the resident□s room and did not rub hands vigorously outside the stream of water. He was also observed drying his hands with a towel that was placed on the side of the sink. 1) How the Corrective action will be accomplished for the residents found to be affected? RN#1 was in-serviced on proper hand	

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F 880	Continued From page 43 medication to Resident #41. RN#1 sanitized his hands with alcohol-based hand rub (ABHR) appropriately before entering the room to check the resident's blood pressure. RN#1 did not disinfect the blood pressure machine prior to entering the room and checking Resident #41's blood pressure. Prior to exiting Resident #41's room, RN#1 went to wash his hands at the resident's sink. RN#1 placed paper towels on the side of the sink and turned on the water faucet. He applied soap, wet his hands with water, lathered his hands for 6 seconds outside the running water prior to rinsing, dried his hands with a paper towel that was on the side of the sink, and used another paper towel to turn off the faucet. RN #1 proceeded to exit the room to prepare Resident #41's medication. On 11/30/23 at 9:19 AM, the surveyor observed RN#1 prepare the medication and wash his hands upon reentering the resident's room to administer the medication. RN#1 turned on the faucet, wet his hands with water from the sink, applied soap, lathered his hands for 3 seconds outside the running water prior to rinsing, dried his hands with a paper towel from the dispenser on the wall and used another of the paper towels to turn off the faucet. On 11/30/23 at 9:25 AM, the surveyor observed RN#1 administer the resident's medication and went to get Resident #41 another cup of water from the medication cart. Prior to exiting the room, RN#1 went to wash his hands at the sink. RN#1 turned on the faucet,	F 880	washing technique later the same day by Infection Prevention Nurse. 2) How the facility will identify other residents having the potential to be affected? All residents have a potential to be affected. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? Infection Prevention Nurse will be providing education to all staff on proper hand washing technique. 4) How the facility will monitor its corrective actions to ensure compliance. Infection Prevention Nurse or designee will be conducting weekly random audits of 10 staff from various departments weekly for the next 3 months. Her findings will be reported on during monthly QAPI meetings to ensure all departments are aware of proper handwashing guidelines.	

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F 880	Continued From page 44 wet his hands with water from the sink, applied soap, lathered his hands for 8 seconds outside the running water prior to rinsing, dried his hands with a paper towel from the dispenser on the wall and used another of the paper towels to turn off the faucet. On 11/30/23 at 9:28 AM, the surveyor observed RN#1, upon completing medication passage to Resident #41 and prior to exiting the room wash his hands at the sink. RN#1 turned on the faucet, wet his hands with water from the sink, applied soap, lathered his hands for 3 seconds outside the running water prior to rinsing, dried his hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. RN#1 was observed signing the electronic medication administration record (eMAR) (indicating medication administration to Resident #41 was completed). RN #1 was not observed disinfecting the blood pressure machine after utilizing the blood pressure cuff on Resident #41. On 11/30/23 at 11:15 AM, the surveyor interviewed RN#1 regarding handwashing and disinfecting reusable medical equipment. RN#1 explained that hands should be washed at least 30 seconds and was able to explain to the surveyor the correct steps of handwashing. In addition, RN#1 explained that all reusable medical equipment, such as a blood pressure machine should be disinfected before and after use with residents.	F 880		

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The surveyor shared the observations of washing his hands for less than 20 seconds and not disinfecting the blood pressure cuff with RN#1. RN#1 explained he did not realize his hand washing time was so short and acknowledged the blood pressure machine should have been disinfected.

On 12/4/23 at 1:30 PM, the surveyor informed the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA) and previous DON of concerns related to RN#1 observations of handwashing for less than 20 seconds and lack of disinfecting the reusable blood pressure machine. No verbal response by the facility was noted at this time.

On 12/5/23 at 10:33 AM, the DON provided the hand hygiene policy. The surveyor interviewed the DON who stated that all staff should wash their hands for at least 20 seconds.

A review of the facility provided policy titled "IC203 Hand Hygiene", last revised on 9/29/2020, read under Perform Hand hygiene: "Before and after resident care ...After contact with the resident's environment". Under Hand Hygiene Techniques, it read: " ...Rub hands vigorously outside the stream of water for 15-20 seconds covering all surfaces of the hands and finger ..."

A review of the facility provided policy titled "IC201 Cleaning and Disinfecting", last revised on 10/24/22, read under Purpose: " ...To ensure reusable medical equipment is cleaned and disinfected appropriately ..." Under Practice Standards it read: " ...5.3 multi-patient equipment

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F 880	Continued From page 46 must also be cleaned/disinfected between patients..." On 12/6/23 at 9:17 AM the surveyor met with the LNHA, DON and previous DON for any further information. No further information was provided by the facility. N.J.A.C. 8:39-19.4	F 880		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	Deficient in C.N.A. staffing for 14 out of 14-day shift schedules. 1) How the Corrective action will be accomplished? Recruitment and retention meeting will be held weekly to assist in identifying open positions and recruitment efforts. 2) How the facility will identify other areas of opportunities? Continue weekly recruitment and retention with the corporate recruiter. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? Weekly communication meetings have	12/21/23

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

Electronically Signed | 12/29/23

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S 560	Continued From page 1 requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to	S 560	been established with the recruiter and open shift reports are being distributed to staff who are willing to pick up additional shifts. CSU staffing agency is available to assist with staffing needs until new hires have completed the orientation process. Hiring process has also been streamlined to assist with new hire orientation. Increased advertising efforts to several job boards and have reached out to several nurse training schools for potential partnerships. 4) How the facility will monitor its corrective actions to ensure compliance Facility Administrator or designee will provide monthly updates on recruitment and retention during monthly QAPI meetings for the next 3 months. The report will focus on recruitment efforts and areas of opportunities.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060215	A. BUILDING: _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD CENTER	330 FRANKLIN TPK RIDGEWOOD, NJ 07450

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S 560	Continued From page 2 affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 11/12/23 and ending 11/25/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 14 of 14 day shifts. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/12/23 had 4 CNAs for 72 residents on the day shift, required at least 9 CNAs. -11/13/23 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -11/14/23 had 6 CNAs for 72 residents on the day shift, required at least 9 CNAs. -11/15/23 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -11/16/23 had 6 CNAs for 72 residents on the day shift, required at least 9 CNAs. -11/17/23 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs. -11/18/23 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs. -11/19/23 had 5 CNAs for 73 residents on the day shift, required at least 9 CNAs. -11/20/23 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs. -11/21/23 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs. -11/22/23 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs.	S 560		

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S 560	Continued From page 3 -11/23/23 had 7 CNAs for 73 residents on the day shift, required at least 9 CNAs. -11/24/23 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs. -11/25/23 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs. On 12/1/23 at 10:00 AM , the surveyor discussed the lack of required staff with the Director of Nursing who did not provide any further information.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by:	S1405		12/21/23

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S1405	Continued From page 4 Based on interview and review of facility documentation, it was determined that the facility failed to ensure that all newly hired employees had completed the required 2 step PPD, a tuberculin skin test used to detect individuals with past tuberculosis (TB) infection prior to the first day of employment or upon employment. This deficient practice was identified for 4 of 5 new hired employees whose personnel record were reviewed, as was evidenced by the following: On 12/1/23 at 10:57 AM, the surveyor reviewed the health records for 5 employees hired within the last 4 months that showed the following information: 1. Employee #1 was a Licensed Practical Nurse (LPN) with a date of hire of [NJ Exec. Order 26:3]. There was no evidence of a TST performed or Chest Xray prior to their hire date. 2. Employee #2 was an LPN with a date of hire of [NJ Exec. Order 26:3]. There was only evidence of one TST result dated [NJ Exec. Order 26:3], with a negative result. There was no evidence of a second TST performed. 3. Employee #3 was a Certified Nursing Assistant Licensed with a date of hire of [NJ Exec. Order 26:3]. There was no evidence of a TST performed or Chest Xray prior to their hire date. 4. Employee #4 was a Social Worker with a date of hire of [NJ Exec. Order 26:4.b]. The PE was performed on [NJ Exec. Order 26:3]. There was evidence of only one TST result dated [NJ Exec. Order 26:4] with a negative result. There was no evidence of a second TST performed. Review of the Human Resources Policies and Procedures Employee Health Screening Medical Requirements explains under "Process 2. Tuberculosis TST (Tuberculin Skin Test) testing is	S1405	All new hires must have a physical 2 weeks prior to first day of employment. In addition, all new hires must complete their 2 step TB test prior to reporting for their first day. 1) How the Corrective action will be accomplished? A new hire onboarding process will be put into place. 2) How the facility will identify other potential areas of concern? All new hire health folders will be checked by Director of Nursing or designee for completion prior to employee starting. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur. No new hire will be scheduled to start until they have documented proof of 2 step TB test has been completed and have had a physical. 4) How the facility will monitor its corrective actions to ensure compliance New hire medical files will be checked and monitored by Director of Nursing or designee. New hire process will not continue unless the health file is completed and signed off on by the Director of Nursing or designee. Medical Records will be reviewed every 2 weeks to ensure all information is up to date and reported on monthly at QAPI meetings for the next 3 months.	

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S1405	Continued From page 5 mandatory for employees who interact with residents/patients as required by federal, state, or local law." Review of the Safety and Health Policies and Procedures Tuberculosis (TB) Screening explains under "Process 1. TB screening is conducted for new employees including a symptom evaluation, an individual TB risk assessment, and a screening test (BAMT is a single test procedure or TST is a 2 step test procedure) for those without documented prior TB Disease or Latent TB Infection." On 12/1/23 at 2:58 PM, the survey team met with the facility's Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and discussed the above concerns. On 12/4/23 at 10:05 AM, the survey team met with the facility's Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and no further information was submitted. NJAC 8:39-19.5 (a)	S1405		

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
315158 Y1	A. Building B. Wing Y2	1/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD CENTER	330 FRANKLIN TPK RIDGEWOOD, NJ 07450

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 F0578	Correction	ID Prefix F0584	Correction	ID Prefix F0641	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed
LSC	12/28/2023	LSC	12/28/2023	LSC	12/28/2023
ID Prefix F0656	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	12/28/2023	LSC	12/28/2023	LSC	12/28/2023
ID Prefix F0712	Correction	ID Prefix F0755	Correction	ID Prefix F0880	Correction
Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	12/28/2023	LSC	12/28/2023	LSC	12/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/8/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315158	A. BUILDING **01** B. WING _____	**12/08/2023**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/04/23 and 12/08/23, 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 The facility is a 1-story building with a basement, that was built in 70's, It is composed of Type V protected construction. The facility is divided into 5- smoke zones. The 50 KW generator does approximately 30% of the building. The facility has 90 certified beds. At the time of the survey the census was 72.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		12/21/23

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

Electronically Signed | 12/29/2023

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K 324	Continued From page 1 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, on 12/04/23 and 12/08/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that 1 of 1 kitchen ansul system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10. The deficient practice was evidenced by the following: On 12/08/23 at 11:27 AM, the surveyor and MD observed in the kitchen, that the monthly inspection tag to the ansul fire suppression system, was blank and no required monthly inspection of the ansul system was logged, since the facility vendor completed the semi-annual inspection of the system on 06/23. At that time, the surveyor interviewed the MD, who confirmed that the ansul monthly inspection tag was not completed and left blank. The Administrator was informed of the finding at the Life Safety Code exit conference on	K 324	It was determined that 1 kitchen ansul system was not compliant with monthly inspections. 1) How the Corrective action will be accomplished? The kitchen Ansul system has been added to the monthly testing logs in the Tels system. Kitchen staff will also be informed to check the system during kitchen tours. 2) How the facility will identify other potential areas? Administrator and Maintenance Director will review monthly tasks to ensure that all locations that need to be inspected monthly are signed off and dated each month. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? Maintenance Director or Designee will report on monthly inspection process during safety committee meetings monthly.	

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K 324	Continued From page 2 12/08/23. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324	4) How the facility will monitor its corrective actions to ensure compliance Monthly compliance audit will be reviewed during Monthly QAPI meetings for the next 3 Months.	
K 353 SS=E	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 _____ 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 on 12/08/23 in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and	K 353	The annual sprinkler and standpipe systems inspection and testing were not readily available; several areas were identified as having missing ceiling tiles, one escutcheon plate was missing around the sheetrock ceiling. 1) How the Corrective action will be accomplished?	12/21/23

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K 353	Continued From page 3 NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. During a building tour from 9:30 AM, to 12:25 PM, the Surveyor and MD, observed 3 of 15 verticle ceiling openings in the following areas of the facility: 1). At 11:18 AM, the surveyor and MD observed in the IT closet by the administrative offices, that a drop ceiling tile, approximately 4" x 2' was not in place. The open area was observed to have wires running through the opening and above the drop ceiling. 2). At 11:27 AM, the surveyor and MD observed in the (east) physical therapy closet, that the drop ceiling was missing two tiles. 3). At 12:40 PM, the surveyor and MD observed that outside the nurse station the fire sprinkler head was missing its escutcheon plate. The opening around the sheetrock ceiling was approximately 1" around the missing plate. The MD in an interview confirmed the above observations. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 12/08/23.	K 353	The annual sprinkler and standpipe system inspection was scheduled with our vendor within the next 30 days. Ceiling tiles and escutcheon plate were replaced by the maintenance department. 2) How the facility will identify other areas? Administrator or designee will conduct safety rounds with Maintenance Director weekly. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur again? During weekly rounds areas throughout the building will be checked for ceiling tile replacement or any other item in need of repair. 4) How the facility will monitor its corrective actions to ensure compliance Maintenance Director or designee will report weekly findings monthly at the QAPI meeting monthly for the next 3 Months.	
K 363 SS=E	NJAC 8:39-31.2(e) Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		12/28/23

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K 363	Continued From page 4 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on	K 363	Bedroom doors for 4 rooms 16, 20, 24,	

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K 363	Continued From page 5 12/08/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring complete bedroom door closure for confinement of smoke/fire products was identified in 4 of 35 resident room (RR) doors observed and was evidenced by the following: During the building tour from 9:15 AM to 01:45 PM, the surveyor in the presence of the MD toured the facility and observed the following compromised RR doors: RR 16 top of the door was warped, approximately 1/2" gap RR 20 top of the door was warped, approximately 1/2" gap RR 24 top of the door was warped, approximately 1/2" gap RR 28 top of the door was warped, approximately 1/2" gap At the time of observations, the surveyor interviewed the MD who stated and confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/08/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6,	K 363	and 28 were found to be warped causing a 1/2 inch gaps. A 5) How the Corrective action will be accomplished? Replacement doors were ordered for all rooms 6) How the facility will identify other areas of concern? During weekly maintenance rounds Administrator and Maintenance Director will check to ensure that all doors are shutting properly. 7) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? Weekly audits conducted during rounds will be reviewed for areas of concern with Administration. 8) How the facility will monitor its corrective actions to ensure compliance. Audit results will be reviewed by Maintenance Director at Monthly QAPI meetings or Designee the next 3 months to ensure that all doors are shutting properly and replacements are ordered timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315158	A. BUILDING **01** B. WING _____	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD CENTER	**330 FRANKLIN TPK** **RIDGEWOOD, NJ 07450**

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K 363	Continued From page 6 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, interview and observations on 12/08/23, in the presence of the Maintenance Director (MD), it was determined the facility failed to inspect all fire-rated doors required by National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) 2012 edition sections 8.3.3.1, 19.7.6 and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition sections 5.2.1. This deficient practice was evidenced for 2 of 8 doors observed by the following: 1). At 10:52 AM, the surveyor and MD observed that the set of fire doors by resident rooms 44 and 46 identified as set #4 required full body force to push open the doors as they were stuck into its frame and would delay the evacuation of	K 761	Annual inspection of all fire-rated doors needs to be conducted. 1) How the Corrective action will be accomplished? Vendor was contacted and scheduled for an annual fire door inspection. 2) How the facility will identify other potential areas of concern? Administrator and Maintenance Director will review monthly and Annual inspection for the next month to ensure that all inspections are done timely. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? Inspections will be added to monthly	12/21/23

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	315158	A. BUILDING **01** B. WING _____	**12/08/2023**

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K 761	Continued From page 7 the area in the event of an non-emergency and/or emergency evacuation. 2). At 11:15 AM, the surveyor and MD observed that the fire door identified as #3 by resident room 45 did not open easy as the door was rubbing onto the door frame. The MD confirmed the finding during the observation A review of the facility's life safety code documentation revealed there was no annual inspection of all fire-rated doors for the past 12 months. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/08/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e)	K 761	tasks in the Tels system. 4) How the facility will monitor its corrective actions to ensure compliance Inspection and testing of all life safety equipment compliance will be added to the Monthly maintenance QAPI report for the next 3 months.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 12/14/23 and 12/18/23, in the presence of the Maintenance Director	K 911	1) How the Corrective action will be accomplished? The natural gas provider was contacted and asked to supply a	12/21/23

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	315158	A. BUILDING **01** B. WING _____	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 911	Continued From page 8 (MD), it was determined that the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for one (1) of one (1) generators. This deficient practice was evidenced by the following: At 9:30 AM, the surveyor and MD reviewed all the facility's generator documentation. The facility currently has one (1) interior 50 KW (kilowatt) natural gas generator. The MD and Administrator could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The MD and Administrator both confirmed there was no reliability letter available from the natural gas provider for the 50 KW natural gas generator for the facility to present to the surveyor. No additional information was received. The Administrator was informed of the findings at	K 911	reliability letter to the facility. 2) How the facility will identify other areas of potential concern? All vendors who provide a service should be able to provide a plan in the event your service has experienced an interruption. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? All service providers should have a reliability letter for their services provided in the event of an interruption of service. Maintenance Director will be mailing out letters asking for reliability letters from the vendors. 4) How the facility will monitor its corrective actions to ensure compliance? All returned letters will be added to the facility EPP Manual and originals will be kept in the Maintenance Director binder.	

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	315158	A. BUILDING **01** B. WING _____	**12/08/2023**

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K 911	Continued From page 9 the Life Safety Code exit conference on 12/18/23. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 12/04/23 and 12/08/23, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in	K 914	Annual testing of electrical receptacles. 1) How the Corrective action will be accomplished for the residents found to be affected? Resident rooms have less than hospital	12/21/23

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K 914	Continued From page 10 residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 39 of 39 resident rooms observed by the following: On 12/08/23 from approximately 10:30 AM to 1:30 PM, the surveyor and MD, observed that resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The RPOD and MD, confirmed that the facility had non-hospital outlets installed in resident rooms, but could not provide any documentation or logs indicating the annual inspection was conducted for the current year. The last document provided for the electrical inspection from the facility vendor was dated: 07/29/21. The MD confirmed the electrical inspection was not conducted after 07/29/21. The Maintenance Director was informed of the findings at the Life Safety Code exit conference on 12/08/23. NJAC 8:39-31.2(e) NFPA 99	K 914	grade outlets as such they need to be inspected annually by an electrician. Facility contacted vendor to schedule an electrical inspection. 2) How the facility will identify other areas of concern? Maintenance Director and Administrator will review inspection log for any overdue or upcoming inspections. 3) What measures will be put into place to systematic changes made to ensure the deficient practice will not occur? During monthly safety and QAPI meetings all areas of life safety that require an annual or semiannual inspections will be reviewed. 4) How the facility will monitor its corrective actions to ensure compliance. Maintenance Director or designee will provide updates on any upcoming inspections that are due and report on assigned tasks and completion which will be reported on during QAPI meetings monthly for the next 3 months.	

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
315158 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD CENTER	330 FRANKLIN TPK RIDGEWOOD, NJ 07450

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 K0324	12/28/2023	LSC K0353	12/28/2023	LSC K0363	12/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0761	12/28/2023	LSC K0911	12/28/2023	LSC K0914	12/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/8/2023	☐ YES ☐ NO