STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315133	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATION CENTER	**555 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: Recertification CENSUS: 95 SAMPLE: 28 COMPLAINT INTAKE #: NJ145876, NJ149067, NJ154549, NJ155726, and NJ157792. The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		5/22/23

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

Electronically Signed | 04/14/2023

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

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, it was determined the facility failed to ensure a Ex Order 26. 4B1 [redacted] was covered to promote dignity for 1 (Resident #68) of 4 sampled residents reviewed for dignity. Findings included: Review of a facility policy titled, "Quality of Life-Dignity," dated June 2022, specified, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation Residents shall be treated with dignity and respect at all times. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. The policy specified, "Staff shall	F 550	I. Plan of Correction for Affected Residents: The *Ex Order 26. 4B1* [redacted] for Resident #68 was immediately covered to promote dignity. II. Plan of Correction to Identify other Residents Potentially Affected: The Director of Nursing/Designee will review all other residents who use a *Ex Order 26. 4B1* [redacted] to identify any other [redacted] that are not covered to promote dignity. III. Plan of Correction for Systems Changes and Measures to Prevent Recurrence:	

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F 550	Continued From page 2 promote dignity and assist residents as needed by: a. Helping the resident to keep [redacted] covered." Review of an "Admission Record" indicated the facility admitted Resident #68 with diagnoses that included *Ex Order 26. 4B1* [redacted], and need for Ex.Order 26.4(b)(1) [redacted]. The admission Minimum Data Set (MDS), dated 12/29/2022, revealed Resident #68 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had *Ex Order 26. 4B1* [redacted]. Per the MDS, Resident #68 required Ex.Order 26.4(b)(1) with [redacted], Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) and had an *Ex Order 26. 4B1* [redacted]. A review of Resident #68's care plan, initiated 12/19/2022 and revised 03/14/2023, revealed the resident had an *Ex Order 26. 4B1* [redacted]. Interventions instructed staff to position the resident's [redacted] and [redacted] below the level of the resident's [redacted] and away from the entrance door. A review of Resident #68's "Order Summary Report," for March 2023, revealed an order dated 03/12/2023 to cover the resident's [redacted] every shift for dignity and privacy. On 03/20/2023 at 10:44 AM, Resident #68 was observed lying in bed with their *Ex Order 26. 4B1* [redacted] hanging from their bedframe on the left side of the bed. The *Ex Order 26. 4B1* [redacted] was not covered, faced the door and was visible from the hallway. The [redacted]	F 550	The Administrator/Designee will: a) revise the policy regarding quality of life/dignity to emphasize the need for *Ex Order 26. 4B1* [redacted] to be covered to promote dignity, and b) ensure that all nursing staff members participate in skills development sessions regarding this policy. Those staff members who are on vacation or on leave of absence will participate in sessions upon their return. IV. Plan of Correction for Monitoring Corrective Actions: The Director of Nursing/Designee will: a) conduct an audit, at least monthly, of at least 25% of all residents who use a *Ex Order 26. 4B1* [redacted] to ensure that they are covered to promote dignity, and b) compile the results of these audits at least quarterly and submit reports of the results, as well as a correction plan, if indicated, to the facility's Quality Assurance Performance Improvement Committee. After the first six months of audit results have been reviewed, the facility will reevaluate the frequency of monitoring.	

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F 550	Continued From page 3 Ex Order 26. 4B1 contained approximately 100 milliliters (ml) of Ex Order 26. 4B liquid. On 03/20/2023 at 11:24 AM, Resident #68 was observed lying in bed with their Ex Order 26. 4B1 hanging from their bedframe on the left side of the bed. The Ex Order 26. 4B1 was not covered, visible from the doorway, and Ex Order 26. 4B liquid could be seen inside the bag from the doorway. In an interview on 03/20/2023 at 11:26 AM, Licensed Practical Nurse (LPN) #16 stated Resident #68 had a Ex Order 26. 4B1 bag for their Ex Order 26. 4B1, but it was on other side of the bed. The LPN stated the resident's Ex Order 26. 4B1 was uncovered and was visible from the hallway, but the bag should have been covered. LPN #16 stated any staff that observed a Ex Order 26. 4B1 not in a Ex.Order 26.4(b)(1) should put it in a Ex Order 26. 4B1. During an interview on 03/22/2023 at 8:22 AM, Certified Nursing Assistant (CNA) #17 stated Resident #68 had a Ex Order 26. 4B1 and their Ex Order 26. 4B1 should be covered. CNA #17 stated she expected a Ex Order 26. 4B1 to be in a Ex.Order 26.4(b)(1) to maintain a resident's dignity. CNA #17 stated all staff were responsible for ensuring a resident's Ex Order 26. 4B1 was maintained in a Ex.Order 26.4(b)(1). In an interview on 03/22/2023 at 8:34 AM, Registered Nurse (RN) #18 stated Resident #68 had a Ex Order 26. 4B1, and the Ex Order 26. 4B1 should be placed below the Ex Order 26. 4B1 and in a Ex Order 26. 4B1. RN #18 stated she expected a resident's Ex Order 26. 4B1 to be in a Ex Order 26. 4B1	F 550		

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F 550	Continued From page 4 Ex Order to maintain a resident's dignity. During an interview on 03/22/2023 at 11:14 AM, the Director of Nursing (DON) stated Resident #68's Ex Order 26. 4B1 should always be in a Ex Order 26. 4B1, except if the resident went to Ex Order 26. 4B1 and the resident requested a Ex Order 26. 4B1. The DON stated she expected Ex Order 26. 4B1 to be covered to maintain a resident's dignity. She stated the Ex Order 26. 4B1 should not be visible from the hall or doorway. The DON stated CNAs and nurses were responsible for ensuring Ex Order 26. 4B1 had a Ex Order 26. 4B1. She stated CNAs should check to see if the Ex Order 26. 4B1 was in a Ex Order 26. 4B1 when care was provided or placed in a Ex Order 26. 4B1 when care was not being provided. The DON stated nurses should round to check to ensure Ex Order 26. 4B1 had a Ex Order 26. 4B1 as well. In an interview on 03/22/2023 at 1:27 PM, the Administrator stated CNAs and nurses were responsible for placing Ex Order 26. 4B1 in a Ex Order 26. 4B1. The Administrator stated every shift had a supervisor on the floor, and the supervisor should periodically check to ensure Ex Order 26. 4B1 were covered, and the resident's assigned nurse should check as well. The Administrator stated he expected a resident's Ex Order 26. 4B1 to be placed in a Ex Order 26. 4B1 to maintain a resident's dignity. New Jersey Administrative Code § 8:39-4.1(a)(12)	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		5/22/23

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F 580	Continued From page 5 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 6 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, document review, and facility policy review, it was determined the facility failed to report an allegation of *Ex Order 26. 4B1* to the physician and responsible party for 1 (Resident #31) of 6 residents reviewed for abuse. Findings included: Review of a facility policy titled, "Abuse, Neglect, and Exploitation," dated October 2018, indicated, "9. Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: a. Respond to the needs of the resident and protect them from further incident b. Notify the Director of Nursing and Administrator c. Initiate an investigation immediately d. Notify the attending physician, resident's family/legal representative ad Medical Director." Review of an "Admission Record," indicated the facility admitted Resident #31 with diagnoses that included *Ex Order 26. 4B1*	F 580	I. Plan of Correction for Affected Residents: The Director of Nursing/Designee will ensure that the physician and responsible party for Resident #31 are notified regarding the resident□s allegation of *Ex Order 26. 4B1*. II. Plan of Correction to Identify other Residents Potentially Affected: All residents, current and future, have the potential to be affected by this deficient practice. III. Plan of Correction for Systems Changes and Measures to Prevent Recurrence: The Administrator/Designee will: a) revise the policy regarding the regarding abuse prevention and reporting to emphasize the need to notify the physician and responsible party when *Ex Order 26. 4B1* is suspected, and b) ensure that all nursing	

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F 580	Continued From page 7 Ex Order 26. 4B1 . The quarterly Minimum Data Set (MDS), dated 01/08/2023, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had Ex Order 26. 4B1 [redacted]. Review of an incident report, dated 02/09/2023, revealed Resident #31 reported to Licensed Practical Nurse (LPN) #5 that they had had been [redacted] by their roommate. Per the report, there was no notification made regarding the allegation of Ex Order 26. 4B1. In an interview on 03/22/2023 at 12:43 PM, LPN #5 stated Resident #31 told her they had been [redacted] by their roommate. She stated she reported the allegation of [redacted] to the supervisor, completed an incident report, and assessed the resident for injuries, none of which were found. LPN #5 stated she did not notify the physician or the resident's representative of the allegation, because Resident #31 denied being [redacted] and just wanted their own room. During an interview on 03/23/2023 at 1:08 PM, the Director of Nursing (DON) stated the physician and resident's family should be notified of any allegation of [redacted]. The DON stated the allegation of [redacted] reported by Resident #31 was not reported because there was nothing to report. The DON stated Resident #31's allegation that they were [redacted] by their roommate, should have been considered an allegation of [redacted] and should have been reported. In an interview on 03/23/2023 at 3:48 PM, the Administrator stated allegations of [redacted] should	F 580	staff members participate in skills development sessions regarding this policy. Those staff members who are on vacation or on leave of absence will participate in sessions upon their return. IV. Plan of Correction for Monitoring Corrective Actions: The Director of Nursing/Designee will: a) conduct an audit, at least monthly, of at least 25% of any allegations of physical abuse to ensure that the physician and responsible party were notified, and b) compile the results of these audits at least quarterly and submit reports of the results, as well as a correction plan, if indicated, to the facility's Quality Assurance Performance Improvement Committee. After the first three months of audit results have been reviewed, the facility will reevaluate the frequency of monitoring.	

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F 580	Continued From page 8 be reported immediately. The Administrator stated Resident #31 alleged to a nurse that they had been [Ex Ord] by their roommate, but when the nursing supervisor interviewed Resident #31, the resident denied the allegation so there was no allegation of [Ex Order 26. 4B] to report.	F 580		
F 609 SS=D	New Jersey Administrative Code § 8:39-5.1(a) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		5/22/23

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F 609	Continued From page 9 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, document review, and facility policy review, it was determined the facility failed to report an allegation of physical abuse to the state agency for 1 (Resident #31) of 6 residents reviewed for abuse. Findings included: Review of a facility policy titled, "Abuse, Neglect, and Exploitation," dated October 2018, indicated, "13. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation or resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the [events] that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (including the State Survey Agency and adult protected services where state law provides for jurisdiction in long-term care facilities) in accordance with State Law." Review of an "Admission Record," indicated the facility admitted Resident #31 with diagnoses that included *Ex Order 26. 4B1* [redacted]. The quarterly Minimum Data Set (MDS), dated 01/08/2023, revealed Resident #31 had a Brief	F 609	I. Plan of Correction for Affected Residents: During the survey completed March 23, 2023, facility staff discussed with representatives of the New Jersey Department of Health and Human Services Resident #31's allegation of *Ex Order 26. 4B1*. II. Plan of Correction to Identify other Residents Potentially Affected: All residents, current and future, have the potential to be affected by this deficient practice. III. Plan of Correction for Systems Changes and Measures to Prevent Recurrence: The Administrator/Designee will: a) revise the policy regarding the regarding abuse prevention and reporting to emphasize the requirement that for any cases where the events that cause the allegation do not involve abuse and do not result in serious bodily injury, that the allegations are reported to the state agency not later than 24 hours after the allegation is made, and b) ensure that all nursing staff members participate in skills development sessions regarding this policy. Those staff members who are on vacation or on leave of absence will participate in sessions upon their return.	

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F 609	Continued From page 10 Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had *Ex Order 26. 4B1* [redacted]. Review of an incident report, dated 02/09/2023, revealed Resident #31 reported to a nurse that they had had been [redacted] by their roommate. Per the report, there was no notification to the state agency. During an interview on 03/23/2023 at 1:08 PM, the Director of Nursing (DON) stated the state agency should be notified of any allegation of [redacted]. The DON stated the allegation of [redacted] reported by Resident #31 was not reported because there was nothing to report. The DON stated Resident #31's allegation that they were [redacted] by their roommate, should have been considered an allegation of [redacted] and should have been reported to the state agency. In an interview on 03/23/2023 at 3:48 PM, the Administrator stated allegations of [redacted] should be reported immediately. The Administrator stated Resident #31 alleged to a nurse that they had been [redacted] by their roommate, but when the nursing supervisor interviewed Resident #31, the resident denied the allegation so there was no allegation of [redacted] to report.	F 609	IV. Plan of Correction for Monitoring Corrective Actions: The Director of Nursing/Designee will: a) conduct an audit, at least monthly, of at least 25% of cases where the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to ensure that the allegations are reported to the state agency not later than 24 hours after the allegation is made, and b) compile the results of these audits and submit reports of the results, as well as a correction plan, if indicated, at least quarterly, to the facility's Quality Assurance Performance Improvement Committee. After the first six months of audit results have been reviewed, the facility will reevaluate the frequency of monitoring.	
F 655 SS=D	New Jersey Administrative Code § 8:39-5.1(a) Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		5/22/23

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implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

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F 655	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to ensure the baseline care plan indicated 1 (Resident #95) of 5 residents reviewed for [redacted] was at [redacted] Findings included: The facility's policy, titled, "Baseline Care Plan," revised in June 2022, indicated, "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." A review of Resident #95's "Admission Record" revealed the facility admitted the resident with diagnoses that [redacted] A review of the "Nursing Admission-Readmission Screening," dated [redacted], revealed Resident #95 had a current [redacted] of [redacted] upon admission to the facility, which indicated the resident was at [redacted]. A review of Resident #95's undated "Baseline Care Plan" did not specify Resident #95's [redacted] level or interventions to prevent the resident from [redacted]. During an interview on 03/23/2023 at 3:24 PM, the Minimum Data Set (MDS) Coordinator stated, upon admission, the nurse would put together a basic (baseline) care plan for [redacted], [redacted]	F 655	I. Plan of Correction for Affected Residents: The comprehensive care plan for Resident #95 was reviewed to ensure that it indicates that this resident is at [redacted], and that it includes interventions to prevent the resident from [redacted]. II. Plan of Correction to Identify other Residents Potentially Affected: The Director of MDS/Designee will review the baseline care plans of all residents admitted between August 2022 and December 2022, to identify any other residents affected by the deficient practice. III. Plan of Correction for Systems Changes and Measures to Prevent Recurrence: The Director of Nursing/Designee will: a) revise the policy regarding baseline care plans, to emphasize the need for these plans to include [redacted] interventions for residents assessed to be at a [redacted], and b) ensure that all nursing staff members participate in skills development sessions regarding this policy. Those staff members who are on vacation or on leave of absence will participate in sessions upon their return. IV. Plan of Correction for Monitoring Corrective Actions:	

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F 655	Continued From page 13 Ex Order 26. 4B1, and other care needs of the resident. The MDS Coordinator stated if a resident was admitted with a Ex Order 26. 4B1, it should have been included on the resident's baseline care plan. On 03/23/2023 at 3:39 PM, a telephone interview was attempted with Registered Nurse #11, who was the admitting nurse when Resident #95 admitted to the facility. A voicemail message was left, but no return call was received. In an interview on 03/23/2023 at 3:43 PM, the Director of Nursing (DON) stated a resident's Ex.Order [redacted] should be included on the baseline care plan. The DON stated she did not know why it would have been missed Resident #95's baseline care plan. During an interview on 03/23/2023 at 3:48 PM, the Administrator stated if a resident was admitted from the hospital with a Ex Order 26. 4B1 [redacted], Ex.Order 26.4(b)(1) should be included on the resident's baseline care plan.	F 655	The Director of MDS/Designee will: a) conduct an audit, at least monthly, of at least 10% of baseline care plans to ensure that these plans include the minimum healthcare information necessary to properly care for a resident, as required by CFR 483.21 and facility policy, and b) compile the results of these audits at least quarterly and submit reports of the results, as well as a correction plan, if indicated, at least quarterly, to the facility's Quality Assurance Performance Improvement Committee. After the first six months of audit results have been reviewed, the facility will reevaluate the frequency of monitoring.	
F 880 SS=D	New Jersey Administrative Code§ 8:39-11.2(d) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		5/22/23

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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
(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

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F 880	Continued From page 15 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 observations, interviews, record review, and facility policy review, it was determined the facility failed to ensure staff changed gloves during Ex.Order 26.4(b)(1) and Ex Order 26. 4B1 care to reduce the risk of infection for 1 (Resident #20) of 3 residents reviewed for Ex Order 26. 4B1 [redacted]. Findings included: A review of a facility policy titled, "Dressings, Dry/Clean," reviewed February 2022, revealed, "6. Position resident and adjust clothing to provide access to affected area. 7. Wash and dry your hands thoroughly. 8. Put on clean gloves. Loosen tape and remove soiled dressing. 9. Pull glove over dressing and discard into plastic or biohazard bag. 10. Wash and dry your hands thoroughly. 11. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. 12. Using	F 880	I. Plan of Correction for Affected Residents: LPN #1 and CNA #2 participated in skills develop sessions regarding the need to change gloves during Ex.Order 26.4(b) and Ex Order 26. 4B1 care to reduce the risk of infection. II. Plan of Correction to Identify other Residents Potentially Affected: The Infection Preventionist/Designee will conduct skills development assessments of all licensed nurses and certified nursing assistants (CNAs) regarding the need to change gloves during Ex.Order 26.4(b) and Ex Order 26. 4B1 care to reduce the risk of infection. III. Plan of Correction for Systems	

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F 880	Continued From page 16 clean technique, open other products. 13. Pour prescribed cleansing solution over the dry, clean gauze into clean basin section of tray. 14. Put on clean gloves. 15. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. 16. Cleanse the wound." The policy further revealed, "17. Use dry gauze to pat the wound dry. 18. Apply the ordered dressing and secure with tape. 19. Discard disposable items into the designated container. 20. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly." A review of a facility policy titled, "Urinary Incontinence Care," revised June 2022, indicated, "2. Management of Ex Order 26. 4B1 will follow relevant clinical guidelines in how to provide the proper incontinent care to prevent Infection." The policy further indicated, "Use infection control measures and standard precautions during the entire procedure." A review of an "Admission Record" indicated Resident #20 was admitted to the facility with diagnoses that included Ex Order 26. 4B1 [redacted]. The quarterly Minimum Data Set (MDS), dated 03/06/2023, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was Ex Order 26. 4B1 [redacted]. Per the MDS, Resident #20 was [redacted] on staff for toilet use, always Ex Order 26. 4B1 [redacted] and had [redacted]. A review of Resident #20's Care Plan revised 03/23/2022, indicated the resident had	F 880	Changes and Measures to Prevent Recurrence: The Director of Nursing/Designee will: a) revise the policies regarding Ex Order 26. 4B1 Ex.Order 26.4(b)(1) and Ex Order 26. 4B1 care, to emphasize the need to change gloves during Ex Order 26. 4B1 care to reduce the risk of infection, and b) ensure that all nursing staff members participate in skills development sessions regarding this policy. Those staff members who are on vacation or on leave of absence will participate in sessions upon their return. IV. Plan of Correction for Monitoring Corrective Actions: The Director of Nursing/Designee will: a) conduct an audit, at least quarterly, of least 10% of licensed nurses and CNAs to ensure that they change gloves during Ex.Order 26.4(b)(1) and Ex Order 26. 4B1 care, and b) compile the results of these audits at least quarterly and submit reports of the results, as well as a correction plan, if indicated, to the facility's Quality Assurance Performance Improvement Committee. After the first six months of audit results have been reviewed, the facility will reevaluate the frequency of monitoring.	

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Ex Order 26. 4B1 .
Interventions directed the staff to maintain Ex.Order 26.4(b)(1) when providing resident care.

A review of Resident #20's Care Plan, revised 06/20/2022, revealed the resident had a Ex Order 26. 4B1 . Interventions directed the staff to provide Ex Order 26. 4B1 care every shift and as needed with Ex.Order 26.4(b)(1) and keep the resident's Ex.Order 26.4(b)(1)

A review of the "Order Summary Report" indicated Resident #20 had a physician's order to Ex.Order 26.4(b)(1) the resident's Ex Order 26. 4B1 with normal Ex Order 26. 4B , Ex.Order 26.4(b)(1) the Ex Order 26. 4B1 moistened with normal Ex Order 26. 4B , and cover the Ex Order 26. 4B1 with a Ex Order 26. 4B1 daily and as needed.

During an observation of Ex Order 26. 4B1 care on 03/21/2023 at 12:13 PM, Licensed Practical Nurse (LPN) #1 prepared an overbed table with Resident #20's Ex Order 26. 4B1 care supplies. The Infection Preventionist (IP) was present to assist LPN #1 with the resident's care. LPN #1 washed his hands and applied gloves. Resident #20 laid in bed with the IP standing on the resident's right side. Resident #20 was rolled over to their right side and LPN #1 Ex.Order 26.4(b)(1) the resident's Ex Order 26. 4B1 with Ex.Order 26.4(b)(1) with normal Ex Order 26. 4B . At this time, Resident #20 started to Ex Order 26. 4B1 , and LPN #1 stopped Ex Order 26. 4B1 care. At 12:34 PM, Certified Nursing Assistant (CNA) #2 entered the resident's room and LPN #1 stepped out of the room, while the IP remained in the resident's room. CNA #2 washed her hands and applied gloves. CNA #2 removed a Ex Order 26. 4B1 cloth from between the resident's Ex Order 26 and placed the cloth in the trash

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can. CNA #2 wore the same pair of gloves when she provided Ex Order 26. 4B1 care for the resident, applied a Ex Order 26. 4B1 to the resident's Ex Order 26. 4B1, applied a Ex.Order 26.4(b)(1), and covered the resident up. CNA #2 stated she should have changed her gloves after Ex Order 26. 4B1 care was provided before she placed a clean Ex Order 26. 4B1 Ex.Order 26 on the resident.

On 03/21/2023 at 12:40 PM, LPN #1 resumed Resident #20's Ex Order 26. 4B1 care, prepared his supplies, washed his hands, and applied gloves. The IP was present in the resident's room and stood on the right side of Resident #20's bed. LPN #1 Ex.Order 26.4(b)(1) the resident's Ex Order 26. 4B1 with Ex.Order 26.4(b) in normal Ex Order 26. 4B and patted the Ex Order 26. 4B1 area dry. LPN #1 changed gloves and then lightly packed the resident's Ex Order 26. 4B1 with Ex.Order 26.4(b)(1) with normal Ex Order 26. 4B and applied an Ex Order 26. 4B1 Ex.Order 26.4(b)(1). The Ex.Order 26.4(b)(1) did not adhere to the resident's Ex.Order 26 due to the Ex Order 26. 4B1 that had been applied during Ex Order 26. 4B1 care provided by CNA #2. At this time, Resident #20 started to Ex Order 26. 4B1 again. LPN #1 left the Ex.Order 26.4(b)(1) on the resident and called for CNA #2 to again provide Ex Order 26. 4B1 care for the resident.

On 03/21/2023 at 12:51 PM, CNA #2 washed her hands, applied gloves, and provided Ex Order 26. 4B1 care. The IP stated the resident's draw sheet needed to be replaced due to it being soiled. While wearing the same gloves she used during Ex Order 26. 4B1 care, CNA #2 grabbed a clean draw sheet from a chair in the resident's room and opened a cabinet door to get a clean Ex Order 26. 4B1 Ex.Order 26 The clean Ex Order 26. 4B1 Ex.Order 26 was applied to the resident and the draw sheet was put on the resident's bed. CNA #2 never changed her gloves during the care.

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On 03/21/2023 at 1:03 PM, LPN #1 prepared supplies for Resident #20's Ex Order 26. 4B1 care, washed his hands, and put on gloves. LPN #1 removed the previous dressing, threw the dressing away, and changed his gloves. LPN #1 Ex.Order 26.4(b)(1) the resident's Ex Order 26. 4B1 with Ex.Order 26.4(b)(1) in normal Ex Order 26. 4B, patted the Ex Order 26. 4B1 area dry, and Ex.Order 26.4 the Ex Order 26. 4B1 with Ex.Order 26.4(b)(1) in normal Ex Order 26. 4B. LPN #1 did not change his gloves after Ex.Order 26.4(b)(1) the Ex Order 26. 4B1 or before applying the normal Ex Order 26. 4B Ex.Order 26.4(b)(1) inside of the resident's Ex Order 26. 4B1.

During an interview on 03/21/2023 at 1:13 PM, LPN #1 stated he should have changed his gloves after Ex.Order 26.4(b)(1) the Ex Order 26. 4B1 and before applying the Ex Order 26. 4B1 treatment. LPN #1 stated not changing his gloves could lead to infection.

During an interview on 03/21/2023 at 1:07 PM, the Director of Nursing (DON) stated staff should change their gloves after the gloves become soiled. Per the DON, staff should have changed their gloves before applying a new Ex Order 26. 4B1 Ex.Order 26 on Resident #20. The DON stated it was not appropriate to get supplies with the same gloved hands after Ex Order 26. 4B1 care was provided.

During an interview on 03/23/2023 at 1:07 PM, the IP stated CNA #2 should have changed her gloves during Ex Order 26. 4B1 care and washed her hands when the CNA went from dirty to clean. The IP also stated LPN #1 should have changed his gloves before applying the treatment to the resident's Ex Order 26. 4B1.

On 03/23/2023 at 1:22 PM, the Administrator stated if gloves become soiled during care, staff

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F 880	Continued From page 20 should change their gloves. New Jersey Administrative Code § 8:39-19.4(a) (1-6)	F 880		

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S 000	Initial Comments Census: 95 Sample Size: 28 TYPE OF SURVEY: Recertification The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of 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 interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 overnight shifts for the week of 03/05/2023 - 03/11/2023. The facility was deficient in CNA staffing for residents on 6 of 7 day shifts for the week of 03/12/2023 - 03/18/2023. This deficient	S 560	I. Plan of Correction for Affected Residents: No residents were immediately affected by this deficiency. II. Plan of Correction to Identify other Residents Potentially Affected: All residents have the potential to be affected by this deficient practice.	5/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060221	A. BUILDING: _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATIO	555 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 practice had the potential to affect all residents. Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aid to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the week of 03/05/2023 - 03/11/2023, revealed staff-to-resident ratios did not meet minimum requirements. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 overnight shifts as follows:	S 560	III. Plan of Correction for Systems Changes and Measures to Prevent Recurrence: The Director of Nursing/Designee will review the certified nursing assistant (CNA) daily staffing sheets three times a week for eight weeks, to ensure that state-required staffing ratios are met. The Administrator/Designee will ensure that the facility□s recruitment and retention efforts continue, including: a) advertising open positions on online recruitment platforms, b) offering recruitment bonuses to current staff who secure additional CNAs, c) maintaining contracts with staffing agencies and contacting these agencies to provide CNAs, and d) offering overtime pay and other financial incentives to encourage CNAs to work additional shifts. IV. Plan of Correction for Monitoring Corrective Actions: The Director of Nursing/Designee will: a) conduct an audit of CNA staffing levels three times a week for eight weeks, to ensure that state-required staffing ratios are met, and b) compile the results of these audits and submit reports of the results, as well as a correction plan, if indicated, at least quarterly, to the facility's Quality Assurance Performance Improvement Committee for review and determination of any further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060221	A. BUILDING: _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATIO	555 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -03/05/2023 had 11 CNAs for 94 residents on the day shift, required 12 CNAs. -03/06/2023 had 9 CNAs for 93 residents on the day shift, required 12 CNAs. -03/06/2023 had 6 total staff for 93 residents on the overnight shift, required 7 total staff. -03/07/2023 had 7 CNAs for 93 residents on the day shift, required 12 CNAs. -03/08/2023 had 8 CNAs for 93 residents on the day shift, required 12 CNAs. -03/09/2023 had 8 CNAs for 93 residents on the day shift, required 12 CNAs. -03/10/2023 had 9 CNAs for 93 residents on the day shift, required 12 CNAs. -03/11/2023 had 8 CNAs for 93 residents on the day shift, required 12 CNAs. 2. The week of 03/12/2023 - 03/18/2023, revealed staff-to-resident rations that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -03/12/2023 had 6 CNAs for 93 residents on the day shift, required 12 CNAs. -03/13/2023 had 7 CNAs for 93 residents on the day shift, required 12 CNAs. -03/14/2023 had 7 CNAs for 97 residents on the day shift, required 12 CNAs. -03/15/2023 had 11 CNAs for 97 residents on the day shift, required 12 CNAs. -03/17/2023 had 8 CNAs for 95 residents on the day shift, required 12 CNAs. -03/18/2023 had 8 CNAs for 95 residents on the day shift, required 12 CNAs. On 03/22/2023 at 9:28 AM, Staffing Coordinator (SC) #20 stated he was aware some shifts were short for the weeks of 03/05/2023 - 03/11/2023	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060221	A. BUILDING: _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATIO	555 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 and 03/12/2023 - 03/18/2023. He stated the facility had call outs during that time due to a snowstorm and CNAs either went on medical leave or used their vacation time. SC #20 stated he tried aggressively to get staff in the building by way of agency staffing and incentives and bonuses offered. SC #20 stated he expected the state staffing ratios to be followed and maintained. According to SC #20, staffing was a team effort and he, the Director of Nursing (DON), and Administrator were responsible. On 03/22/2023 at 11:18 AM, the DON stated she was aware the facility was short staffed during the two-week period of 03/05/2023 - 03/11/2023 and 03/12/2023 - 03/18/2023. The DON stated she was aware of the state minimum staffing ratios. Per the DON, she was responsible for ensuring the facility was sufficiently staffed in conjunction with SC #20. The DON stated she expected the state minimum staffing ratios to be followed. On 03/22/2023 at 1:31 PM, the Administrator stated he was aware of the state minimum staffing ratios. He stated he was aware the minimum staffing requirements were not met for 03/05/2023 - 03/11/2023 and 03/12/2023 - 03/18/2023. The Administrator stated he made every effort to meet the state minimum staffing ratios but had employee call outs and other factors that occurred that caused the minimum staffing ratios to not meet standards. Per the Administrator, SC #20 scheduled staff for all three shifts seven days a week and when the facility lacked staff, the facility reached out to staff not originally scheduled to work, the staffing agency, and attempted to get nurses to cover CNA shifts. The Administrator stated he expected the state minimum staffing ratios to be followed.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315133 Y1	A. Building B. Wing Y2	5/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATION CENTER	555 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0580	Correction	ID Prefix F0609	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	05/22/2023	LSC	05/22/2023	LSC	05/22/2023
ID Prefix F0655	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	05/22/2023	LSC	05/22/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/23/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060221	A. Building B. Wing	5/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATION CENTER	555 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/22/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/23/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315133	A. BUILDING **01** B. WING _____	**03/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATION CENTER	**555 CHESTNUT RIDGE ROAD** **WOODCLIFF LAKE, NJ 07677**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/23/2023 and Woodcliff Lake Health & Rehabilitation Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Woodcliff Lake Health & Rehabilitation Center is a three-story Type II Protected building that was built in 1972. The facility is divided into 5 smoke zones.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility	K 211	I. Plan of Correction for Affected	5/22/23

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

Electronically Signed | 04/14/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315133	A. BUILDING **01** B. WING _____	**03/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATION CENTER	**555 CHESTNUT RIDGE ROAD** **WOODCLIFF LAKE, NJ 07677**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 1 policy review, it was determined that the facility failed to maintain the means of egress continuously free of all obstructions in the case of emergency in 3 (1st floor, 2nd floor, and 3rd floor) of 3 exit corridors. This deficient practice had the potential to affect 95 residents who resided on the 2nd floor and 3rd floor. Findings included: A review of a facility's policy titled, "Maintenance-Means of Egress: Maintaining Free of Obstructions or Impediments," last reviewed June 2022, specified, "Means of egress shall be continually maintained free of all obstructions or impediments to full instant use in case of fire or other emergency." An observation on 03/22/2023 at 4:32 PM, on the [redacted] floor, revealed the corridor by Room [redacted] was used to store two wheelchairs. An observation on 03/22/2023 at 4:41 PM, on the [redacted] floor, revealed the corridor by Room [redacted] was used to store a high-back wheelchair. An observation on 03/22/2023 at 4:47 PM, on the [redacted] floor, revealed the corridor by Room [redacted] was used to store a wheelchair. An observation on 03/22/2023 at 4:54 PM, on the [redacted] floor, revealed the corridor was used to store a bedside table and trash cans. During an interview on 03/23/2023 at 11:04 AM, the Director of Maintenance (DOM) acknowledged the findings and stated he planned to conduct an in-service to instruct staff to not store items in the corridors. The DOM indicated	K 211	Residents: All items noted to be impeding egress on 03/22/2023 were removed. II. Plan of Correction to Identify other Residents Potentially Affected: The Director of Maintenance/Designee will inspect means of egress in all other exit corridors to ensure that they are free of all obstructions to full use in case of emergency. III. Plan of Correction for Systems Changes and Measures to Prevent Recurrence: The Director of Maintenance/Designee will: a) revise the policy regarding means of egress in exit corridors to emphasize the requirement that these corridors be continuously maintained free of all obstructions to full use in case of emergency, and b) ensure that all staff members participate in skills development sessions regarding this policy. Those staff members who are on vacation or on leave of absence will participate in sessions upon their return. IV. Plan of Correction for Monitoring Corrective Actions: The Director of Maintenance/Designee will: a) conduct an audit, at least monthly, of at least 50% of all exit corridors to ensure that they are continuously maintained free of all obstructions to full	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315133	A. BUILDING **01** B. WING _____	**03/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATION CENTER	**555 CHESTNUT RIDGE ROAD** **WOODCLIFF LAKE, NJ 07677**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 the wheelchairs stored on the [redacted] and [redacted] floors were resident wheelchairs that were not in use. The DOM indicated he was ultimately responsible for maintaining the egress free of all obstructions, but all staff were responsible for monitoring the egress. Per the DOM, he expected the egress to be maintained unobstructed. During an interview on 03/23/2023 at 11:19 AM, the Administrator acknowledged the findings and stated he knew storage of items in the corridor was not allowed. The Administrator stated all staff were trained not to obstruct the corridors and expected the corridors to be maintained per the life safety code. The Administrator indicated the DOM was responsible for maintaining the egress free of obstructions. NJAC 8:39-31.1(c), 31.2(e)	K 211	use in case of emergency, and b) compile the results of these audits at least quarterly and submit reports of the results, as well as a correction plan, if indicated, to the facility's Quality Assurance Performance Improvement Committee. After the first six months of audit results have been reviewed, the facility will reevaluate the frequency of monitoring.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315133	A. Building 01 - MAIN BUILDING 01 B. Wing	5/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCLIFF LAKE HEALTH & REHABILITATION CENTER	555 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677

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 Reg. # NFPA 101 LSC K0211	Correction Completed 05/22/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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
3/23/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO