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	315263	A. BUILDING ______ B. WING ______	C 06/05/2023

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PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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F 000	INITIAL COMMENTS Survey Date: 06/05/23 Census:157 Sample: 31 + 19 = 50 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. Complaint #: NJ 00160152 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint 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	F 550		6/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/27/2023

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 practices regarding transfer, discharge, and the provision of services under the State plan for all 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 observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to ensure a.) Resident Rights were not violated, and b.) promote the dignity of one resident by ensuring residents who were [redacted] and [redacted] were provided with regular clothing to wear and ensure their belongings were being protected. This deficient practice was identified for 1 resident reviewed, Resident #8. The deficient practice was evidenced by the following: On 05/22/23 at 9:54 AM, the surveyor observed Resident #8 standing at the resident's room door in the hallway undressed. Resident #8 had no [redacted] on. Resident #8 had a shirt covering his/her [redacted]. The surveyor	F 550	ELEMENT ONE: CORRECTIVE ACTION Resident #8 Clothing was purchased for resident on 5/26/2023 and labeled. All resident received a copy of resident rights June 1, 2023 Resident council meeting held specific to the grievance process which was reviewed with resident. council and questions encouraged. For residents do not present at the council meeting Social Worker, admissions and medical records visited resident rooms and educated those residents who does not present at the meeting on grievances. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:	

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observed several staff ambulating back and forth in the hallway entering and exiting other resident's room. Resident #8 attempted to get the staff's attention but no staff stopped and asked Resident #8 if he/she needed assistance.

The surveyor continued to ambulate further in the hallway on the right side and was intercepted by Resident #8. Resident #8 was upset and stated, "I tried to tell them I do not have any clothes to wear, I spoke with the nurses, the Social Worker, the administrator, no one listened to me. Please come and I will show you. Other residents just come to the room and stole my clothing." The resident escorted the surveyor to the room and opened the dresser's door. The surveyor observed some clothes hangers hung in the closet. The resident opened the bottom drawers and they were also emptied.

That same day at 10:18 AM, the surveyor left the room and observed the Director of Nursing (DON) in the hallway. The surveyor and the DON both observed again Resident #8 standing in the hallway undressed. Resident #8 escorted the DON to the room and opened the empty dresser. The DON told the surveyor that the facility was aware of the concerns with stolen clothing. The DON continued and stated that some of the residents did not have families and funds to buy clothing so they just helped themselves by stealing clothing from other residents. When the surveyor asked the DON what had been done to protect the vulnerable residents, she declined to comment.

On 05/23/23 the surveyor returned to the B-Wing and observed Resident #8 in bed and resting. There were no clothes in the dresser.

F 550

All residents have the potential to be affected.

ELEMENT THREE: SYSTEMIC CHANGES:

1. Social Worker in-serviced Nursing staff on completing inventory sheet upon admission and quarterly; on notifying Housekeeping Supervisor when clothing noted missing, damaged and in need of labeling; on the process for new and unlabeled clothing and on the grievance process.
2. Facility conducted and audit of all residents’ closets and itemized all their belongings updating inventory sheet. Any unlabeled clothing was sent to the laundry department for labeling.
3. Social Worker offered all residents locks to secure their belongings.
4. House wide completion of inventory sheets will be done annually and as needed.
5. Quarterly at each resident’s interdisciplinary care plan meeting any grievances will be discussed and reviewed in addition to review of their inventory list.
6. Unit manager will review inventory list of all newly admitted residents within 24 hours of admission at the daily clinical meeting.
7. The Housekeeping/Laundry Director will be given clothing of newly admitted resident within 24 hours of admission for labeling.
8. Nursing staff will update inventory sheets with all new clothing and send them down to laundry for labeling.
9. Housekeeping/Laundry Director to

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On 05/24/23 at 8:59 AM, the surveyor interviewed the Housekeeping Director (HD) in charge of the laundry. The HD revealed that most of the personal clothing were not labeled and after being washed, were kept in a bag in the laundry room or placed on the rack. The HD further stated that the CNA could come and retrieve some clothing for residents if needed. There was no system in place to return the unlabeled clothing to the residents.

On 05/24/23 at 9:10 AM, the surveyor interviewed the Social Worker (SW) regarding the missing clothing specifically for Resident #8. The SW informed the surveyor that she was aware of the issue with other residents stealing clothing from some residents. The SW added that currently the facility did not have a process in place to address the missing clothing. The SW worker further added that the facility could install locks to correct the situation but could not explain why it had not been done.

The surveyor then made the SW aware of Resident #8 standing in the hallway undressed and reported that he/she did not have clothing to wear. The SW informed the surveyor that she was in charge of ordering clothing for some of the residents. She further stated that she ordered clothing for Resident #8 last year and Resident #8 should have some clothes in the room.

On 05/24/23 at 9:30 AM, the surveyor requested the PNA (Personal Needs Allowance) account and any invoice for clothing for Resident #8.

On 05/25/23 at 9:10 AM, during an interview with the surveyor, the CNA assigned to Resident #8

F 550

bring all unlabeled laundered clothing to each unit weekly for staff and residents' identification then prompt labeling by laundry department.
10. Personal needs accounts will be utilized to purchase resident clothing as permitted by resident and resident representative if additional clothing is needed.
11. All "stolen" clothing will be investigated with a grievance form initiated.

ELEMENT FOUR: QUALITY ASSURANCE:
1. Unit Managers/designee will audit all residents' belongings and verify completion of the inventory sheet. For 2 months and quarterly thereafter.
2. Social Worker will discuss any grievances during the morning meetings addressing all departments involved.
3. Social Worker will audit grievances for completion weekly times 4 weeks and then monthly thereafter to the Quality assurance performance improvement committee.
4. All Audit results will be reported to the monthly Quality Assurance committee for review and recommendations for 3 months.

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revealed that Resident #8 did not have any clothing in the dresser this morning, she had to go and retrieve one set of clothing from the laundry.

On 05/25/23 at 11:30 AM, the surveyor reviewed Resident #8's medical record. According to the admission face sheet, Resident #8 had diagnoses which included but were not limited to, [redacted].

The Annual Minimum Data Set (MDS) an assessment tool, dated [redacted], revealed that Resident #8 was [redacted]. Resident #8 scored an [redacted] on the Brief Interview for Mental Status (BIMS). Resident #8 was able to communicate his/her needs and was independent with care.

The Comprehensive Care Plan (CP) dated [redacted], reflected a focus for [redacted] to [redacted]. The Goal was for Resident #8 to communicate needs without frustration. The following interventions were to be implemented:
Allow adequate time for response. Initiated [redacted]
Ask resident to repeat words as needed. Initiated [redacted]
Ask simple yes or no questions. Initiated [redacted]
Assist resident to build up [redacted]. Initiated [redacted]

On 05/26/23 the SW provided the PNA account balance along with the invoices.
An invoice dated [redacted] revealed that the SW

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bought clothing in the amount of [redacted] from [name redacted] clothing store for Resident #8.

A second invoice dated [redacted] revealed that the SW bought clothing in the amount of $[redacted]9 cents from [name redacted] clothing store for Resident #8.

On 05/27/23 the SW provided another invoice for [redacted] from [name redacted] store. She stated that she used her card to buy clothing for Resident #8 and the facility would reimburse the money for purchase from [name redacted] store.

The SW then reported that all clothing from [name redacted] clothing store was labeled prior to shipping. She could not provide the rationale for Resident #8 missing clothing since they were already labeled. Upon inquiry she stated that some residents who helped themselves to other residents clothing, would remove the labels. The SW could not provide any grievance that was done to address Resident #8 issue with stolen clothing.

On 05/26/23 at 10:16 AM, during an environmental round some of the dressers in other residents' room were noted with a lock. Upon inquiry, the CNA stated that the family would provide a lock to prevent other residents from entering the rooms and stealing their belongings.

The facility although aware of the concerns with missing clothing, did not implement any measures to protect Resident #8's belongings.

The administrative staff was made aware of the above concerns on [redacted], and again on

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On 06/01/23 at 1:45 PM, the SW stated that moving forward, the issue with missing clothing would be addressed through grievance. The facility did not have any additional information to provide on the exit day.

A review of the facility's policy for Resident Rights indicated in "Exhibit 5" under physical and personal environment the following:
Resident has the right to be treated with courtesy, dignity and respect.
To wear your own clothes, unless this would be unsafe or impractical. All clothes provided by the nursing home must fit you properly.
To keep and use your personal property, unless this would be unsafe and impractical, or an infringement on the rights of other residents. The nursing home must take precautions to ensure that your personal possessions are secure from theft, loss and misplacement. You cannot be required to sign a waiver removing the facility's liability for lost property.

It is further stated under "Protection of Your Rights":
To be given a copy of and informed about the facility's grievance policy which should include specific information on how to file a complaint orally, in writing and anonymously and should include a timeframe for the facility to review and respond.
To retain and exercise all the constitutional, civil and legal rights to which you are entitled by law. The Nursing Home is required to encourage and help you to exercise these rights.

The Facility on the first day of the survey was

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F 550	Continued From page 7 informed and made aware of the issue with Resident #8's missing clothing. The facility did not implement measures to protect Resident #8's possessions nor assisted the resident to file a grievance and exercise his/her rights. N.J.A.C. 8:39-4.1(a)12	F 550		
F 565 SS=F	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		6/23/23

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F 565	Continued From page 8 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to have a process in place to ensure that all recommendations, grievances and concerns presented by the residents during the monthly resident council meetings were consistently addressed. This deficient practice was identified for 6 of 6 residents who attended a resident council meeting and was evidenced by the following: A review of the Resident Council Meeting 02/22/23, included the following: Maintenance: Issues in some bathrooms have been fixed; asking again not to flush paper towels, Dietary: Residents are requesting banana cream pie. A review of the Resident Council Meeting minutes from 03/24/23, included the following: Repair has begun in the rooms and painting; Rooms too cluttered need to downsize; Social Worker is the only one that can go shopping, Social Services will assist resident buying container to help with decluttering. We ask all residents to stop giving their [type of card name redacted] money card to other people; and Residents requesting to have more fresh fruit and would like to have more hot dogs and hamburgers. Requesting liver be removed from the menu. There was no documented follow up from the 02/22/23 resident Council Meeting minutes, including the request	F 565	The Palace Rehabilitation and Center Facility ID 315263 Survey Date 6/5/23 F565 SS F ELEMENT ONE: CORRECTIVE ACTION: 6/1/2023 All residents of the facility were given residents rights and grievance forms. The Resident Food Committee was established which included menu review and review of residents requests such as more hot dogs and hamburgers, fresh fruit and Banana Cr¿me pie, and removing liver from the menu. An audit was completed by the Social Worker on all resident rooms that would benefit from a storage container and residents that needed and wanted a container were provided with a container. An audit was completed by Social worker on all past grievances x 6months to ensure grievance was corrected to residents satisfaction. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents with unresolved grievances/concerns have the potential to be affected.	

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for the banana cream pie.

A review of the Resident Council Meeting minutes from 04/19/23, included the following: Social Services will assist residents in buying containers to help with decluttering; and Social Worker is the only one that can go shopping, we ask all residents to stop giving their [name redacted] money card to other people. The Residents are asking if we could add filet mignon to the menu, they love when we make fried chicken. There was no documented follow up from the 03/24/23 Resident Council minutes, including the request for the more fresh fruit, more hot dogs and hamburgers, the removal of liver from the menu and the banana cream pie that was requested in the February 22, 2023 meeting. There was also no documented follow up regarding the status of Social Services providing containers for decluttering documented in the Resident Council Meeting minutes dated 03/24/23 .

On 05/24/23 at 10:36 AM, the surveyor was present for a Resident Council Meeting with six residents. At that time, 6/6 residents requested that they wanted fresh fruits and vegetables to be served, and this request was consistent with what was documented on the 04/19/23 Resident Council minutes. One resident stated the food was inedible, he/she had lost weight and talked to the dietitian twice about food preferences and there had been no resolution and no follow-up. The resident added he/she had eaten very few vegetables because the vegetables were frozen and then steamed. The resident stated he/she would "be happy with one piece of celery and a carrot, just fresh". Another resident stated that the fruit was mostly canned and was served at room temperature which was warm. Another resident

F 565

An audit was completed by the Regional Social Worker on all known past grievances, and past resident council meetings to ensure resolution to the resident□s satisfaction, including group concerns.
An audit was completed by the Facility Social Worker on all resident rooms that would benefit from a storage container and residents that needed and wanted a container were provided with a container.
An audit was completed by VP of clinical services on residents likes and dislikes regarding menu options.
ELEMENT THREE: SYSTEMIC CHANGES:
Resident council meeting was held specific to the grievance process including how to file a grievance, how to alert someone of a grievance verbally, and who to contact if the grievance has not been resolved to their satisfaction. Those to contact include Administrator, Director of Nursing and Social Worker. An overhead announcement was placed daily x 2 prior to special resident council meeting, and announced overhead and at smoking breaks x 3 on day of meeting encouraging all residents to attend, residents that require assistance to transfer were offered assistance to attend the meeting.
Resident Food Committee was established, and menu review initiated, and follow-up meetings scheduled.
Residents were educated that as many changes as we could make would be accommodated, however, sometimes due to global supply issues, banana cr¿me pie or specific fruits may not be available.

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stated that the soda and snack machines were broken. A resident stated that any resolutions from the Resident Council was addressed a "one on one" thing (group concerns were not addressed by the facility).

On 05/25/23 at 8:20 AM, the LNHA was interviewed by surveyors who asked about the process regarding follow-up from the concerns expressed during the Resident Council meetings. The LNHA stated there was no documentation or "follow- ups" from the resident council meetings. When asked about the bins requested for the clothing that was cluttering the rooms, the LNHA stated she had looked at the minutes and "did not see any need to address the bins." The Social Worker was present during the interview and stated that only a "few people needed" the bins so it was "not done on a form that would be used to address a concern in the resident council." The LNHA stated that if there was a problem brought up by an individual resident, that the individual concern would be addressed through the grievance form. The LNHA, in the presence of the Social Worker, was unable to specify a policy or process that addressed the group concerns, and provided a response/action plan for the concerns that were voiced by the residents during the resident council meeting.

On 05/25/23 at 10:00 AM, the surveyors conducted environmental rounds on all three units. The surveyors observed multiple rooms with clothing in plastic bags that were lying on the floor, or on a chair and there were no observations of the bins identified in the resident council minutes, and as clarified by the Social Worker, as being needed for only a "few" of the residents.

F 565

The menu was changed to include as many requests as possible including increasing fresh vegetables and fruit as well as adding banana cr¿me pie as a dessert at times.
Resident council issues concerns and grievances will be addressed if possible, during the council meeting
A form was created specific to grievance follow-up that reviews grievance with resident and ensures it is resolved to residents□ satisfaction. The follow up form is then placed in grievance binder with original grievance and signed by resident and SW/designee.
Resident grievances/concerns are reviewed at residents Interdisciplinary Care Planning meeting held quarterly and acted upon as soon as possible.
SW will meet with the administrator weekly to review grievances with no stop date.
All grievance follow up will be discussed with the resident in person to ensure resolution is agreeable with resident and resolution documented.
ELEMENT FOUR QUALITY ASSURANCE:
Resident council follow up forms that were created will be used and reviewed by the Administrator weekly x 4 and monthly thereafter with no stop date, to ensure completeness and resolution of the grievance.
Results of the grievances and follow up will be reported to Quality Assurance Performance Improvement Committee monthly x12 months for review and revision as necessary.

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A review of the facility provided, untitled and undated, Procedure: 1. Grievance form will be used to document all resident related problems, complaints or grievances. 2. The grievance form can be completed by anyone with knowledge or a resident problem or complaint. 3. The grievance form asks for the name of the person reporting but this is not required if the individual addressing the problem/complaint wishes to remain anonymous. 4. Social Worker will review the grievance form with the administrator. 5. The Administrator/Social worker will review the problem/complaint to determine validity of grievance, root cause of grievance, and action plan. 6. The summary & action plan will be reviewed with the person completing the grievance form by the Administrator or his designee upon completion of the form.

A review of the facility provided, "Administrator" job description, reviewed 7/20/22, included but was not limited to maintains a fundamental knowledge and awareness of the status of all residents; and ensures accurate documentation, implementation and compliance of all issues.

The facility provided, "Facility Assessment Tool", reviewed 10/2022, included but was not limited to 1.6 Residents have the right to be treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Each resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident, this includes but is not limited to food and nutrition.

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F 565	Continued From page 12 On 05/25/23 at 8:20 AM, the LNHA and Social Worker were made aware of the fact there were no follow ups for the three months of resident council meeting minutes. The facility had no additional information to provide. NJAC 8:39-4.1 (a)(29), 27.1(a)	F 565		
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		6/23/23

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§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:
Based on observation, interview and review of other facility documentation it was determined that the facility failed to maintain the resident environment, equipment and living areas in a safe, sanitary, and homelike manner. This deficient practice was evidenced on 3 of 3 resident Wings (Wing A, B, & C) and was evidenced by the following:

Observations conducted by Surveyor #1 revealed:

On 05/23/23 at 12:35 PM, during a tour of the [redacted] hallway, while the lunch meal was being distributed, and in the presence of Surveyor #2. Both surveyors smelled a [redacted] in the hallway outside of Room #54. Residents were observed eating meals in both Room #54 and the adjacent Room [redacted]. At that time, the Director of Nursing (DON) was in the hallway and Surveyor #1 asked the DON if she could smell anything in the hallway. The DON stated she could not, and walked away from the surveyors.

On 05/23/23 at 12:36 PM, both surveyors

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Element One - Corrective Action:
This deficiency was reviewed, work-orders were created, and the interdisciplinary team is working through and addressing the concerns noted below which were completed on 6/26/23
" Rooms [redacted] were carbolized to eliminate the urine odor
" Room/Resident [redacted] were provided privacy curtains. Repairs are being made to the missing closet drawers
" Wall repairs are being made to R28 s ripped/stained wall paper
" Room [redacted] ceiling was repaired
" Room [redacted] drawer is being repaired and had their bedside table has been cleaned
" The handrail outside of Room 16 was repaired
" Room [redacted] broken nightstand is being repaired/replaced
" The [redacted] Day room is being repaired to ensure the air conditioning unit has a cover, the knobs are replaced/repaired, and the unit is cleaned. The window sills and blinds were cleaned

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interviewed the -Wing Registered Nurse (RN) regarding any noticeable odors in the hallway. The RN stated yes "]." The RN stated, "it needs to be cleaned."

On 05/23/23 at 12:42 PM, Surveyor #1 interviewed two unsampled residents who were eating at their bedside in Room . Both residents confirmed that the room was and told the surveyor they would also see roaches, especially at night in the bathroom. The surveyor did not observe any at that time when entered the bathroom.

On 05/23/23 at 12:50 PM, Surveyor #1 & #2 observed Room . The surveyors observed that there was a missing privacy curtain over Resident #50's bed and the closet appeared broken and was missing two bottom drawers and was soiled inside. There was an unidentified person painting the wall behind the bed and he had identified himself as a maintenance person (MP) who worked at another facility. The MP stated he was "pulled in" to help during the survey. The surveyors inquired about the broken closet and the missing curtain. The MP stated to the surveyors that he was "only" painting and acknowledged that there was a missing privacy curtain and broken closet.

On 05/23/23 at 12:53 PM, Surveyor #1 & #2 observed Resident in bed in his/her room located on Wing. The resident was alert and greeted the surveyors. There was a large ripped and stained piece of wallpaper approximately 1-2 feet in length which exposed the wall underneath and was adjacent to the closet.

On 05/23/23 at 12:54 PM, Surveyor #1 asked the

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" Resident room was deep cleaned.
" Room unit was cleaned
" Room was deep cleaned, the ceiling tile is the bathroom was replaced.
" Room was deep cleaned
" Room was deep cleaned, repairs are being made to the walls
" Room was deep cleaned, a soap dispenser was installed into the bathroom, the walls are being repaired, and the sprinkler head will be secured
" Room was deep cleaned, the hole is the wall is being repaired
" Room was deep cleaned, the exposing TV cables were secured
" Room was deep cleaned
" Room was deep cleaned, the holes in the wall are being replaced, and a cover was placed on the radiator
" Room was deep cleaned
" Room was deep cleaned The cable wires secure to the wall
" Room was deep cleaned, the AC unit was properly sealed
" Room bathroom door was secured, the closet door will be repaired/replaced as needed
" Room was deep cleaned, a soap dispenser was installed in the bathroom, the hole in the ceiling is being repaired, walls are being repaired
" Room was deep cleaned, repairs are being made to the wall(s)
" Room was deep cleaned , A bed had their mattress replaced, the exposed wires were secured, the radiator is being repaired.
" Room was deep cleaned, the faucet was repaired, the exposed wires

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Licensed Nursing Home Administrator (LNHA) to view Resident #50s room and the broken closet that was missing the drawers. The LNHA stated the resident "pulls things out" and should be care planned for that. The surveyor asked the LNHA if having a closet with missing drawers was safe and she stated "no, it is not acceptable for the doors to be left like that". Surveyor #1 inquired how often the LNHA would make rounds of the resident rooms. The LNHA stated every morning she would make rounds with the Maintenance and Housekeeping Director.

On 5/23/23 at 12:59 PM, the LNHA accompanied Surveyor #1 into Resident #28's room to view the ripped wallpaper and asked the LNHA if she had been aware of it. The LNHA stated "no, never noticed it" and the surveyor asked if the wallpaper was okay to be left like that. The LNHA stated "it has to be fixed."

On 05/23/23 at 1:02 PM, Surveyor #1 and #2 accompanied the LNHA into Room [REDACTED] Wing) to show the LNHA the writing that was in multiple colors and was all over the walls, a large, approximately 1-to-2-foot hole lengthwise in the wall opposite of the front of the bed and was close to the baseboard. There was also a hole in the ceiling above the closet on the opposite side of the room. The LNHA observed the holes and stated she had not been aware that there were holes in the walls. The LNHA stated the resident wrote on the walls and the facility repainted them. The LNHA stated it would be taken care of "right away." Surveyor #1 asked why it needed to be taken care of right away, and the LNHA stated, "because it is a problem."

On 05/23/23 at 1:14 PM, Surveyor #1 and #2

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were secured, and repairs/replacements are being made to the furniture as needed
" Room [REDACTED] furniture is being repaired/replaced as needed, the light switch cover was repaired/replaced, the walls are being repaired
" Room [REDACTED] was deep cleaned, and repairs/replacements are being made to the room
" Room [REDACTED] was deep cleaned, a paper towel dispenser was placed in the bathroom
" Room [REDACTED] light switch is being repaired/replaced
" Repairs are being made to 2 out of the 3 shower rooms to address the broken/missing ceiling tiles, holes in the walls, and exposed wires
" Day room on [REDACTED] wing [REDACTED] heater was cleaned
" The ceiling tile outside of room [REDACTED] was replaced
" The med-cart on [REDACTED] side of [REDACTED] wing was cleaned
" The [REDACTED]r inside of Room [REDACTED] was cleaned
" The PPE bin by the exit-door on C-wing was cleaned
" The area across from the nursing station on [REDACTED] Wing had the ceiling tiles replaced and the protective strip was secured
" Room [REDACTED] was deep cleaned and the drawer will be repaired/replaced
" Room [REDACTED] was deep cleaned and repairs/replacements are being made to the furniture
" Room [REDACTED] bedrail was repaired, the sink was repaired, and the curtain was

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continued the observations and observed an unsampled resident in room . The unsampled resident, who was sitting in a wheelchair in the room, was facing a broken lower drawer on the nightstand which was next to a tray table that was soiled on the base and dusty on the top.

Outside of the resident room #16 and across from the nurse's station in the -Wing hallway, there was a handrail that was loose and one with a broken end cap that had sharp edges. The opposite side of the nurse's station had a broken handrail end cap which had a missing piece. A Certified Nurse Aide (CNA #3) was at the nurse's station at that time. The LNHA was present, and the Surveyors showed her the handrail that was loose and the LNHA then stated she was unaware of the loose handrail. The CNA #3 stated a resident was pulling the handrail yesterday, and when asked CNA #3 about the missing end cap, she stated "I don't know". The LNHA stated that "just so you know it could have happened a couple of minutes ago, we have behavioral people here."

Surveyor #1 then asked the LNHA about rounding on the units. The LNHA stated to the surveyor "you do realize the whole building is behavioral?" The LNHA stated every morning she completed rounds on the units and then gave a "list" to maintenance regarding items that needed repair. When asked for documentation regarding the lists, the LNHA stated she "doesn't have a copy of the list".

At that time, both surveyors escorted the LNHA to room and showed her the broken nightstand and asked the LNHA if she had been aware. The LNHA stated "no, I was not aware". The LNHA

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hooked back up
" Room floorboard was repaired
" Room bedrail was repaired, the room was deep cleaned, and repairs/replacements are being made to the furniture
" Room was deep cleaned, and the sink was repaired
" Room faucet and door handle were repaired, the room was deep cleaned
" Room was deep cleaned
" Room was deep cleaned, including the r
" Room was deep cleaned, repairs were made to the AC unit
" Pest control issues with addressed with the vendor
" Room was deep cleaned, repairs/replacements are being made to the furniture
" Room was deep cleaned, the sink was fixed, repairs are being made to the wall, and the baseboard is being repaired
" Room was deep cleaned, the bedrail was repaired, and the dirty ceiling tile was replaced
" Room was deep cleaned, repairs are being made to the walls and baseboard
" Room was deep cleaned, repairs are being made to the furniture and baseboard
" Room was deep cleaned, the dirty ceiling tile was replaced, repairs are being made to the walls and baseboards
" Room was deep cleaned
" Room was deep cleaned, the bathroom window was repaired, repairs

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could not provide a list of items that were identified for repair and stated maintenance would verbally tell her if items had not been fixed.

On 05/23/23 at 1:18 PM, Surveyor #2 asked the LHNA if she had been aware of the conditions observed inside of the resident rooms. The LNHA stated she was not aware of the issues with the furniture in the resident rooms.

On 05/23/23 at 1:22 PM, Surveyor #1 asked CNA #3 what the process was if there were items identified that needed repair. CNA #3 stated that if something was broken, she would put the information into the maintenance book. CNA #3 then showed the surveyor the maintenance book. CNA #3 stated that maintenance would come every morning and review the maintenance book and then would fix the items that were documented in the book. At that time, the surveyor reviewed the maintenance book. The last entry in the book was dated [redacted] days prior) and the handrails and broken furniture were not documented.

On 5/24/27 at 9:03 AM, two surveyors proceeded through a resident day room by [redacted] Wing and on the way to the kitchen. There were three residents sitting in the day room. One resident was sitting next to a window air conditioner that had a broken cover, missing knobs, was soiled with dust like debris throughout the vents, window, and the blinds were also soiled. There was an out of service empty snack vending machine and stains were on a wall next to a copy machine.

On 05/25/23 at 8:59 AM, Surveyor #1 interviewed Resident #49, on [redacted] Wing inside the resident's

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are being made to the walls and baseboard
" Room [redacted] isolation cart was cleaned, repairs are being made to the baseboard
" Room [redacted] was deep cleaned, a privacy curtain was provided, ceiling tiles were secured, and repairs/replacements are being made to the furniture
" Room [redacted] was deep cleaned, the chair was replaced

Element Two -Identification of at Risk Residents:
All residents whose environment is dirty or in need of repair have the potential to be affected .

The interdisciplinary care team completed all room audit to ensure residents were provided with a safe, clean, comfortable, and homelike environment.

Element Three Systemic Change:
The maintenance and housekeeping director were educated on providing residents with a safe, clean, comfortable, and homelike environment.
The administrator/designee and director of nursing/designee inserviced Maintenance ,Housekeeping and Nursing staff on identifying and reporting maintenance and/or housekeeping issues, and the proper protocol for notifying the Interdisciplinary team to address the concerns.
The Interdisciplinary team created a monthly Resident Survey that will identify resident issues ensuring each resident is provided with a safe, clean, comfortable,

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F 584	Continued From page 18 room. The resident stated that he/she "cannot wait to get the "[exploitive redacted] out of here, this place is so filthy it is making me more sick." Resident #49 proceeded to point to the windowsill which the surveyor observed as being visibly soiled with dust like dark colored various debris on the length of the windowsill, and the window air conditioner unit had dark dust like debris throughout the vents. The blinds also had dust like debris and the resident then pointed to the window which was visibly cloudy and exclaimed, "I cannot even see through the window." The window air conditioner unit also was not sealed and there were open gaps. The wall heat/ air conditioner unit was also soiled with debris on the unit and inside the vents. Resident #49 then pointed to the tray table bottom which was visibly soiled with various colored debris. There was also a soiled and stained fabric colored board located behind the resident's bed. Resident #49 then exclaimed "this place is a [exploitive redacted] dump." On 05/25/23 at 10:06 AM, the surveyor initiated a tour with the LNHA on ██ Wing and observed a hallway ceiling vent outside of Room #7 that had visible dust like debris in the vent. The surveyor asked about the vents and pointed to the debris on the vent. The LNHA stated the maintenance person cleaned the vents weekly, and at that time, the LNHA stated she needed a bigger pad and left the tour with the surveyor. At that time the surveyor entered Room ██ where two unsampled residents resided. One resident was sleeping in bed, and the other resident conversed with the surveyor. The corner wall area by the bathroom had a stained wall, and the surveyor asked the unsampled resident if the facility cleaned that area. The unsampled resident	F 584	and home-like environment. Element Four - Quality Assurance: Maintenance director and housekeeping director will perform environmental rounds on 5 random rooms each. room audit will be completed weekly x4,then monthly thereafter to ensure residents are provided with a safe, clean, comfortable, and homelife environment and safe equipment. Needed corrections will be addressed as they are discovered. Results to be reported monthly x 12 months to the Quality Assurance Performance team for review and revision as necessary.	

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F 584	Continued From page 19 stated, "they don't touch that." At that time, the surveyor observed the blinds were soiled, the air conditioner unit was dusty with debris in the vents. Dust like debris was stuck to the wall by the tray table and the base of both tray tables was soiled. The area over the sleeping unsampled resident had what appeared to be a circular ceiling stain by the sprinkler head. Observations conducted by Surveyor #3 revealed: On 05/25/23 at 10:00 AM, Surveyor #3 conducted a tour of the █- Wing, in the presence of the facility Licensed Practical Nurse Infection Preventionist (LPN IP) and observed the following: Room ██ In the area of the closet and room door, a white substance stained the floor. The LPN IP looked at the substance and stated, "no, not clean." The bathroom had a black substance on the floor by the sink and the blinds were visibly covered with a black substance. The LPN IP stated it "shouldn't be like that." There was dust like clusters stuck to the ceiling, ripped curtains on the windows, the dressers were soiled and there was a dusty floor mat that was positioned next to a resident bed. The LPN IP stated, it was "supposed to be cleaned." The wardrobe closet drawers were hanging off the hinges. The LPN IP stated "Housekeeping and Administration were supposed to tour" the resident rooms. Room ██ A white paint like substance was on the floor. The LPN IP stated she was "unsure" of what it was. The wallpaper was ripped, the light switch was soiled and there was a black substance on the bathroom floor.	F 584		

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F 584	Continued From page 20 Room ██-The air conditioner unit was soiled with a dust like substance, the side covers were not properly covered and had aluminum tape around the edges. The windowsill had layers of dust like, black substance with multiple dead insects. The closets had missing doors, and the bedside table base had layers of embedded stains and a dust like debris. The bathroom had black stains on the floor and sink, the soap dispenser was un-mounted and lying on the toilet, there was broken tile on the wall with an exposed hole, and the sprinkler head appeared loose. Both privacy curtains were visibly soiled and stained. Room ██- There was an open hole in the corner of the bottom portion of the wall where it met the floor. Both privacy curtains were soiled, and the LPN IP stated they were "not clean." The air conditioner unit had a dust like debris on it and there was a black substance on the bathroom floor and toilet. The LPN IP confirmed it was "not clean." Room ██-The base of the bedside table was soiled and visibly stained. The air conditioner unit was soiled with debris, there was a crack in the wall below the privacy curtain, and there were long exposed loose cable wires. Room ██ The base of the bedside table was soiled and visibly stained. Both privacy curtains were soiled. The windowsill had layers of dust like debris, cobwebs were present along with a black substance and dead insects. Room ██, at 10:17 AM, the LNHA and two additional maintenance staff joined the tour. The base of the over bed tables were visibly soiled,	F 584		

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both bed frames were visibly soiled, the heat radiator was missing a base plate cover, the window blinds and air conditioner unit were both visibly soiled, there was a hole by the vent in the bathroom, and the light above the bathroom mirror had a hole behind it.

Room ██- The wall by the call bell by the door was visibly soiled, the air conditioner unit and window blinds were visibly soiled.

Room ██- the base of both beds were visibly soiled, the air conditioner unit was visibly soiled, the window blinds were visibly soiled with dust like debris and the blind was cracked. There were wires hanging from the ceiling, the base of both beds were visibly stained, the call bell by the door was visibly stained, the wall closet by the door was visibly stained, the bathroom toilet had a visible rust colored substance around the base, the wall paper was ripped and discolored, and both privacy curtains were visibly soiled.

Room ██- There were wires hanging from the ceiling, the air conditioner unit was not sealed and was open to the outside environment, both dressers were visibly soiled, the ceiling sprinkler unit was rusted and portions of it were missing.

Room ██- The wall closet by the door bed had pieces missing and the bathroom door did not close shut.

Room ██- The dresser by the door bed was visibly soiled and areas were chipped away, the dresser by the window bed had a drawer was hanging off, the windows were visibly soiled, the toilet was visibly soiled, the bathroom had no soap or soap dispenser, the wall had a large hole

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F 584	Continued From page 22 where the toilet paper holder used to be, there was a large hole in the ceiling of the bathroom. Room ██- The wall by the door was visibly stained, the closet was visibly stained, wires were hanging from the ceiling, there was an unfinished wall patching on the wall by the bathroom, the air conditioner unit had visible cobwebs and dust like substance, the blinds were visibly soiled, there was a cooler with juice in it and small fruit type flies all over both sides of the room. Room ██- The bed by the door was bare and there was visible white discoloration towards the foot of the mattress, there were wires hanging from the ceiling, a visible hole in the radiator top with a towel draped over it, the bathroom call bell was hanging down via wires, the bathroom floor had a visible black substance. Room███ the window curtains were visibly soiled, the wall by the door was visibly stained, the closet by the door bed was missing one door and had no drawers, the corner molding was missing by the window bed were multiple wires hanging from the ceiling, visibly soiled walls, the air conditioner unit and window blinds were visibly soiled with a dust/dirt like substance, the bathroom floor was visibly soiled, there was a leaking faucet, and there were several bugs stuck to the floor. Room ██- The baseboard by the door was missing, the chair covering was ripped, the LNHA stated, "we need to throw that out", there was a missing drawer on the dresser, the light on the wall behind the bed was not secure to the wall and leaning over the head of the bed, there was a lock on top of the bathroom door, the LNHA stated "the resident in the room needed a CNA to	F 584		

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assist them to the bathroom", there was a missing call bell, there was a fall mat next to the window bed that was ripped, the LPN IP stated "you can't clean the mat when it is ripped", there was a hole in the top of the radiator, the air conditioner unit and window blinds were visibly soiled.

Room [redacted] There was writing on the door, the light switch covered was cracked, and the doors of the closet were missing.

Room [redacted]- The air conditioner unit was visibly soiled, the window sill and window blinds were visibly soiled and dusty, the bathroom paper towel dispenser was rusted, the toilet and bathroom floor were visibly soiled.

Room [redacted]- The light switch was not working.

One shower room had missing tiles in the first stall where the toilet was, the second stall for the shower had a hole on the bottom right side, and eight tiles were cracked.

The second shower room located by the nursing desk had cracked tiles by the toilet handle, the first shower stall had visibly rusted areas, and the second shower stall had exposed wires and cracked tiles.

Observations conducted by Surveyor #4 & #5 revealed:

On 05/25/23 at 10:05 AM, Surveyor #4 and Surveyor #5 entered the [redacted]-Wing and requested the Licensed practical Nurse Unit Manager (LPN UM #1) to accompany the surveyors on an environmental tour of the unit. While waiting for

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the LPN UM #1, Surveyor #4 observed the following in the hallway of the Wing

10:06 AM The heating grate by nurse desk and in the Wing- dayroom contained dust like particles.

From 10:08 AM through 10:13 AM, the following was observed: water stains on the ceiling outside of room , the medication cart for the had a brown substance splattered on the cart by the trash can, the oxygen concentrator in room contained dust on top of the concentrator, In the area by the exit door on Wing- the wallpaper was missing around , the white 3 tier personal protective equipment bin outside of room had white streaks and black stains on the top.

During that time Surveyor # 5 observed the following:
Next to the housekeeping closet in hallway across form the nurses' station, a protective strip was partially lifted off of the wall. Ceiling tiles in the hallway had a black and brown substance.

On 05/25/23 at 10:14 AM, Surveyor #4 and Surveyor # 5 completed a tour of Wing- with LPN UM # 1 and observed the following:

Room Bed : Bedside Tabletop drawer broken. Over bed tables soiled with stains and debris/paint missing on bottom part of over bed tables.

Room Bed : Drawers in bottom of bedside table was missing. Bed : Bottom drawers of closet were missing. Curtains were soiled.

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F 584	Continued From page 25 Room - Bed Had a broken bed rail, the sink inside the room had a leaking faucet. The curtain was broken and off of the track. The LPN UM stated that the curtains were cleaned or replaced as needed. Room Bed The floor molding/floorboard was missing behind bed. Room - Bed The side rail was broken on the bed, the closet door was missing and both bottom drawers were broken. Bed : Window blinds were broken/missing. Room Blinds were soiled, and gnat type bugs were flying in room. Room -Bed The front plate from the air conditioner was missing and the sink in the room had a leaking faucet . Room -The bed side table drawer and handle was broken. The faucet in bathroom was leaking and the UM was unable to turn off. The air conditioner was soiled with a dust like debris. Room The air conditioner and blinds were soiled with a dust like debris. Room - Bed The oxygen concentrator was soiled. The wall was broken by the bed and the air conditioner front plate missing. The wall by bathroom sink had an open area/cracked wall. bugs were flying in the room near the resident. Room - Bed The oxygen concentrator was soiled. Bed : Baseboard with heater unit completely ripped off the wall.	F 584		

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Room [redacted] Observed [redacted] bugs flying in the hallway outside of the room.

Room [redacted] Bed [redacted]: The closet door was broken and the air conditioner was soiled.

Room [redacted]- Bed [redacted] The oxygen concentrator was soiled, faucet was leaking in the sink inside the room, the wall in the outside bathroom was broken and missing tile/plaster, and baseboard heater vent was broken and soiled.

Room [redacted]- Bed [redacted] The ceiling tile above bed A was stained with blackish substance. Bottom of bedside table was missing. There was a broken bed rail.

Room [redacted]- Outside of the room the wallpaper was lifted. The LPN UM #1 stated that the resident pulled off the wallpaper. Bed [redacted] crayon drawings and markings all over the walls. Heating baseboard was lifted and the air conditioner was soiled. The bottom of the wall and baseboard outside the bathroom was coming apart.

Room [redacted]- The air conditioner plate was missing. Bed [redacted]: The closet handle was broken, and the window in bathroom was soiled with a film and baseboards had debris.

Room [redacted] Bed [redacted] Bedside table was soiled with a reddish substance. A brown and black substance was on the ceiling tile above the bed. The smoke detector had holes surrounding it. Bed [redacted] The baseboard heater was coming off wall and the bedside table was soiled.

Room [redacted]- Both bedside tables were soiled with

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debris. Bed [redacted] unsampled Resident #17 had been in hospital since [redacted] and food/drink cartons were on the bed with [redacted] bugs flying in room.

Room [redacted] Bed [redacted] wood was located in the windowsill, and LPN UM #1 stated it was probably used to keep the window from opening all the way.

Room [redacted] Unoccupied resident room. The area near the air conditioner on both sides was open to the outside. The faucet was leaking, the bathroom window was broken and open to the outside area. There was no cover over the baseboard heater. The ceiling light in the bathroom did not have a cover.

Room [redacted]-The isolation cart outside the resident room was soiled, baseboard heater under sink with red rust like stains.

Room [redacted]-Three-person resident room, [redacted] bed- Was missing a drawer of the bedside table and missing window curtains, missing the middle drawer in three drawer dressers. The ceiling tile above Room [redacted] door, in the hallway, was loose and open. Behind the exit sign in the hallway by Room [redacted] tile had an opening.

Room [redacted] The blue seat was stained on the seating area, the bathroom had drain type [redacted], and there was a brown substance on air conditioner unit.

On 06/02/23 at 10:53 AM, in the presence of the survey team, and in response to the environmental rounds that were completed by the survey team. The Regional Administrator (RA #2)

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F 584	Continued From page 28 addressed the survey team. The RA #2 stated that every concern that was provided to the facility, he took "personally" and called on sister facilities to provide assistance. The RA #2 further stated that "when you look at the building and the clients it doesn't take long for everything to go to [exploitive redacted]." The RA #2 further sated he was called into the facility for support as the RA #1 was responsible for checking on the facility. The RA #2 stated that the facility maintenance staff should have identified all of the environmental concerns that the surveyors identified. The Admission Agreement, undated, and was provided to the survey team during the entrance conference on [redacted] at 12:02 PM revealed the following: Exhibit 5, Resident Rights: ... Physical and Personal Environment ... To live in a safe, clean comfortable and home-like environment ... NJAC 8:39-4.1 (a)11; 31.2(e)	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		6/23/23

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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 appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to follow the facility policy and report to the New Jersey Department of Health (NJDOH) a facility reportable event for a resident with a history of [redacted] with injury which included an unwitnessed fall on [redacted] at 18:40 (6:40 PM), resulting [redacted], required transfer to emergency room on [redacted], with a diagnosis of an [redacted]. A subsequent unwitnessed [redacted] occurred on [redacted] and required 911 transport to the emergency room, and resulted in a [redacted] to the [redacted] measuring [redacted] and a [redacted] per a [redacted], that sustained an injury of an unknown origin. This deficient practice was identified for 1 of 3

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ELEMENT ONE: CORRECTIVE ACTION:
A full investigation was completed on resident #23 with results showing the allegation of abuse was unsubstantiated. The incident was reported to the Department of health.
ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:
All residents that have an unwitnessed incident/accident have the potential to be affected.
An audit was completed by the Administrator and Director of nursing of the last 30 days of incidents to ensure that all incidents with the potential for abuse were investigated and reported to the New Jersey Department of health and the Ombudsman office.
ELEMENT THREE: SYSTEMIC CHANGES:

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residents reviewed for [redacted] with injury and was evidenced by the following:

On 05/22/23 at 10:40 AM, the surveyor observed Resident #23, positioned on the right side, in a bed that was against the wall and the resident was facing the wall. The surveyor observed a pad on the floor next to the bed. Resident #23 was unable to maintain a conversation with the surveyor and the resident also had a blanket covering the head.

On 05/24/23 at 1:05 PM, the surveyor returned to the room and observed Resident #23 in bed, on his/her back with head elevated. At that time, the surveyor observed [redacted] A Licensed Practical Nurse (LPN), who later identified herself as the Infection Preventionist (LPN IP) was in the room and assisted Resident #23 with the lunch meal. Upon surveyor inquiry regarding the observed injury on Resident #23's forehead, the LPN IP stated that the injury was from a fall the resident sustained and she would not elaborate further on the observed injury.

On 05/24/23 at 1:25 PM, the surveyor reviewed Resident #23's electronic medical record and could not locate any documentation regarding the observed injury that the LPN IP confirmed the Resident #23 sustained when [redacted] at the facility. According to the Admission Face Sheet, Resident #23 was admitted to the facility with diagnoses which included but were not limited to, [redacted].

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All staff were educated following facilities policy Prohibition of Resident Abuse & Neglect which included:
1.The definition of abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.
2.Types of abuse-Physical, verbal, sexual, mental/emotional/psychological, involuntary seclusion, neglect, exploitation, and misappropriation of resident property.
3.Prevention which includes employee and volunteer screening, training, which is completed upon hire, and minimally quarterly to employees. Re-education is also completed when/if there is an allegation of abuse.
4. Reporting abuse- Abuse must be reported to immediately to supervisor. The supervisor will then report to the Abuse Coordinator Administrator. If the abuse coordinator is unavailable the next highest administrative position is made aware Director of Nursing. The administrative team will then run the investigation.
5. Protection-Immediately remove the resident(s) from the situation, assess and treat, accused employees (if applicable) will be suspended immediately pending further investigation.
6. Investigation: a full investigation is completed with a comprehensive review of the situation, interviews with staff,

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F 609	Continued From page 31 The Comprehensive Care Plan (CP) initiated , last revised , had a "Focus" "At Risk for due to ", Date Initiated: and Date Revised: . The Goal was "Minimize risk for through next review", Date Initiated: , Date Revised: Interventions Included: Maintain bed in lowest position Date Initiated:); Provide assistance to transfer and ambulate as needed, Date Initiated: Reinforce the need to call/ring for assistance, Date Initiated: Reinforce wheelchair safety as needed such as locking brakes, Date Initiated: , and Therapy evaluation and treatment as ordered, Date Initiated: . Resident #23's CP revealed a Focus "[Resident #23] had a l was found lying on the floor in [his/her] room". "Resident during care when [he/she] was turned to the side of the bed, it happened so fast, staff unable to prevent Date Initiated: , Date Revised: . The Goal was to "Risks for will be mitigated", Date Initiated: Date Revised: and Target Date: The following interventions were documented: assist during care, Date Initiated ; 911 Was called and sent to hospital for evaluation, Date Initiated ; Assess for and medicate as needed, Date Initiated ; Assessment Completed, Date Initiated ; Complete assessment with on , Date Initiated Continue at risk for intervention, Date Initiated Epic Evaluation of meds, Date Initiated Floor mat at Bedside, Date Initiated:	F 609	residents, and any witnesses to the event and statements are recorded, statement review, environmental review, and medical record review. Education was also completed with the Licensed Nursing Home Administrator and the Director of Nursing on abuse including facility policy, reporting abuse to the appropriate agencies in a timely manner as per policy. In addition, Director of nursing/designee will monitor all incidents /accidents and 24 hour report including progress notes, daily (with no stop date) at clinical morning meeting for any indication of abuse and investigate and report accordingly. QUALITY ASSURANCE To maintain and monitor ongoing compliance, Administrator/designee will audit completed investigations daily x 14 days, twice weekly x4weeks and then monthly thereafter. Needed corrections will be addressed as they are discovered. All audit findings will be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 609	Continued From page 32 ; Monitor every shift X 72 hours, Date Initiated: Initiated, Date Initiated check X 72 hours, Date Initiated ; Notify MD of the incident and for any significant changes, Date Initiated: appt scheduled, Date Initiated ; management adjustment, Date Initiated applied, Date Initiated , Primary physician made aware of the event, Date Initiated Resident returned to the facility with dose and days, Date Initiated: ; Sent to Hospital for evaluation of , Date Initiated ; Sent to hospital, missed due to transportation. Returned same day with no new order, Follow up with . applied, Date Initiated , Date Initiated: On 06/01/23 at 11:30 AM, the surveyor interviewed the DON regarding the incident dated . The DON stated that she was told that Resident #23 during care. She was not aware that the Hospitality Aide reported that he found the resident on the floor. Another surveyor then asked the DON if a resident was found on the floor, would that be considered as an injury of unknown origin. The DON hesitated and then replied, "yes". The DON stated," the facility always reported and investigated all incidents." The DON stated that she was "sorry" and confirmed that the she did not report the incident to the Department of Health. On 06/05/23, the facility did not provide any additional information and the incident had not been reported to the NJDOH.	F 609		

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F 609	Continued From page 33 Review of the facility's undated "Prohibition of Resident Abuse and Neglect" policy, reflected, "Any witnessed, alleged, or suspected violations involving mistreatment, neglect or abuse, including injuries of an unknown source and misappropriation of resident property, must be reported immediately to the employee's supervisor. The supervisor must immediately notify the Administrator and/ or the Director of Nursing. Abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) will be reported to the appropriate authorities by the Administrator and/or Director of Nursing including not limited to, local law enforcement agencies, NJDOH, and Ombudsman in compliance with regulatory requirements." The policy further reflected that "Reports must be submitted in writing, which may include incident report, employee statement, grievance/concern form, or other written documentation." Under Investigation the policy reflected, "The investigation shall consist of: A comprehensive of the event or incident. An interview with the person(s) reporting the incident. Interview with any witness of the incident; An interview with the resident if possible; Review of the resident's medical record; An interview with staff members (on all shift as appropriate) having contact with the resident/patient during the period of the alleged incident; Interviews with the resident's/patient's roommate, family members, and visitors; if applicable; and a review of all circumstances surrounding the incident." Under Quality Assurance the policy reflected that	F 609		

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F 609	Continued From page 34 the Abuse Coordinator /designee will interview residents, staff members and witnesses as appropriate and document the additional investigation. The Abuse Coordinator /designee completes the investigation file to include the required Reportable Event Form, copies of the resident record as appropriate to investigation, staff assignments and all other documents appropriate to the investigation. The policy reflected that Injuries of an unknown source, will be reported immediately to the appropriate authorities by the administrator and/or Director of Nursing as indicated in this facility's policy titled, "Prohibition of Resident Abuse and Neglect". The policy was not followed. The Hospitality Aide clearly stated via a telephone interview in the presence of all the surveyors that he found Resident #23 on the floor with [redacted] at around 6:00 AM. He further stated that he reported it to the nurses and discussed the incident with the Director of Nursing on [redacted] NJAC 8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		6/23/23

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§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and document review, it was determined that the facility failed to conduct an investigation for an injury of unknown origin for Resident #23. This deficient practice was identified for 1 of 31 residents reviewed for incident investigations and was evidenced by the following:

On 05/22/23 at 10:40 AM, the surveyor toured the [redacted]-Wing of the facility and observed Resident #23 in bed positioned on the right side, facing the wall.

On 05/24/23 at 8:16 AM, the surveyor observed Resident #23 in bed and again was positioned in the same manner, facing the wall.

On 05/24/23 at 1:05 PM, the surveyor returned to the room and observed Resident #23 in bed positioned on the back side. The surveyor observed a [redacted] [redacted]. The Licensed Practical Nurse (LPN) who was at the bedside assisting Resident #23 with the lunch meal, revealed that the observed injury was from a [redacted]

On 05/24/23 at 1:25 PM, the surveyor left the room and reviewed both the electronic and paper medical records which reflected that Resident #23 was admitted to the facility with diagnoses

ELEMENT ONE: CORRECTIVE ACTION:
Resident #23 no longer resides at the facility.

ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:
All residents with unwitnessed falls and injuries of unknown origin have the potential to be affected by this practice.
Director of Nursing/Designee performed an audit x last 30 days on 6/23 of all residents with unwitnessed falls to determine if facility investigated including obtaining statements from staff.
Director of Nursing/Designee performed an audit x last 30 days on 6/23 of all residents with injury of unknown origin to determine if facility investigated including obtaining statements from staff.

ELEMENT THREE: SYSTEMIC CHANGES:
Director of Nursing/Designee in-serviced all staff on Prohibition of Resident Abuse and Neglect. Regional director of Nursing in serviced the Interdisciplinary team on how to complete investigations on injuries of unknown origin and unwitnessed [redacted]

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which included but were not limited to;

A review of the Significant Minimum Data Set (MDS), an assessment tool, indicated the resident's cognitive skills for daily decision making were . The resident required the total assistance of and total dependence upon staff for all activities of daily living (ADL).

The surveyor reviewed a Progress Note dated, and timed 06:40 PM, which revealed that the nurse was notified by the aide that Resident #23 was found on the floor while aide was passing out dinner trays. The nurse went to the room and observed the resident on the floor on the side of the bed facing the right side. The resident verbally informed the nurse that his/her . I asked him/her what happened, and he/she said, "I was trying to leave."

Further review of the Progress Notes dated revealed that Resident #23 was transferred to the hospital for increased the The was unwitnessed, the facility did not investigate the incident. There were no employee statements included in the report.

On 05/25/23 at 9:40 AM, the surveyor reviewed a "late entry" in the electronic medical record dated and timed 21:37:06, which revealed that Resident #23 sustained another with injury.

F 610

Director of Nursing/Designee in serviced Nursing staff on facility Accidents and Incidents-Investigating and Reporting Policy including need to remain with resident pending arrival of help when found on the floor, not touching residents found on floor pending nurse assessment, and need to obtain staff statements to include residents location at time of and how and who transferred the resident. Director of Nursing/Designee will be reviewing All resident incidents and accident including unwitnessed and injuries of unknown origin for completion of investigation daily in the Clinical Meeting with prompt calls placed to staff for statement collection via phone as needed.

ELEMENT FOUR: QUALITY ASSURANCE:
Director of Nursing/Designee will audit all unwitnessed falls and all injury of unknown origin to determine if facility conducted an investigation including obtaining statements from staff weekly x 4 then monthly thereafter. Needed corrections will be addressed as they are discovered. All audit results will be reported monthly to Quality Assurance Performance Improvement team for review and revision as necessary.

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The Registered Nurse (RN) documented that Resident #23 was found in bed [redacted] [redacted]. Upon entering the room, Resident #23 was observed in bed [redacted] from the [redacted] and a [redacted] dressing was applied, the MD (Medical Doctor) was made aware, 911 activated. Resident sent out for evaluation. The RN stated that the Certified Nursing Assistant (CNA) reported that Resident #23 had a fall. However, Resident #23 was transferred to bed prior to being assessed by the nurse. The facility did not investigate to identify who transferred Resident #23 into bed.

On 05/26/23 at 11:30 AM, the Director of Nursing (DON) provided [redacted] reports and there were no statements from the staff who worked the days of the [redacted]. During an interview with the DON on 05/30/23 at 10:30 AM, regarding the [redacted] report dated [redacted], she stated that she could not locate any investigation regarding the [redacted] dated [redacted] The DON stated that she was told that Resident #23 [redacted] during care. She did not investigate further. When asked if someone was found on the floor [redacted] would that be considered as an injury of unknown origin and should abuse be ruled out, the DON hesitated and then replied, "yes". The DON further stated the facility always investigate and report all. She stated, "I am sorry, I was told that the resident [redacted] during care."

On 06/01/23 at 9:53 AM, the surveyor conducted a telephone interview with the RN who worked the 11:00 PM-7:00 AM shift. In the presence of the survey team, the RN confirmed that she was made aware around 6:45 AM, by the TNA (temporary nursing assistant) that Resident #23 sustained a [redacted] She went to the room and

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F 610	Continued From page 38 observed Resident #23 in bed. She was not aware of the exact time of the [REDACTED] or who transfer Resident #23 to bed. On 06/02/23 at 9:53 AM, during a telephone interview with the Hospitality Aide, in the presence of the survey team, the hospitality aide stated that he went to the room around 6:00 AM to distribute linen and found Resident #23 laying on the floor [REDACTED]. He left the room and reported the incident to the nurse. The facility protocol was to remain with the resident and call for help. Another telephone interview on 06/02/23 at 10:07 AM, with the Licensed Practical Nurse who also worked the 11:00 PM- 7:00 AM shift on [REDACTED], confirmed that she was informed of the [REDACTED] by the Hospitality Aide at the end of the shift, she did not go to the room. She was assisting the RN with the paper work to transfer Resident #23 out to the hospital. The LPN provided the staff name who reported the [REDACTED]. She stated that she did not know who or how Resident #23 was transferred into the bed. The LPN was made aware of a statement dated [REDACTED]3 provided by the facility from a CNA. The LPN confirmed that the hospitality aide was assigned and cared for Resident #23 and not the CNA. A review of the hospitality aide's punch card and the [REDACTED]-Wing assignment sheet confirmed that the hospitality aide worked and was assigned to the [REDACTED]-Wing. The CNA who wrote the statement clocked in on [REDACTED] at 7:02 AM and was not at the facility when the hospitality aide reported that Resident #23 was on found on the floor [REDACTED]. On 06/02/23 at 11:15 AM, the DON was made aware of the discrepancies regarding the [REDACTED] report, the CNA statement dated [REDACTED], and	F 610		

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F 610	Continued From page 39 the telephone interviews with staff who worked on the 11:00 PM-7:00 AM shift. The DON maintained that she was told that Resident #23 [redacted] during care and she did not investigate further nor collect any statement from staff who worked the 11:00 PM-7:00 AM shift on [redacted]. There was no statement from the Hospitality Aide although the hospitality aide had informed the surveyors that he discussed the incident briefly with the DON on [redacted]. There was no investigation to rule out abuse. Resident #23 required [redacted] The facility did not investigate to identify who transferred Resident #23 into bed after the hospitality aide reported that he found Resident #23 laying on the floor [redacted] A review of the facility's policy titled, "Accidents and Incidents-Investigating and Reporting reflected under Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and results reported to the appropriate department manager and the Administrator. (The policy was not being followed.) A review of the facility's policy titled, "Prohibition of Resident Abuse & Neglect", undated, included but was not limited to; Reporting 1. Any witnessed, alleged, or suspected violaitons..,including injuries of an unknown source...must be reported immediately to the employee's supervisor. 4. Reports must be submitted in writing which may include...employee statement. 7. Upon receiving	F 610		

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F 610	Continued From page 40 reports....the charge nurse and/or nursing supervisor shall immediately examine and interview the resident. 13. An immediate investigation will be conducted. Investigation 1. .... the nursing supervisor / designee will appoint a representative to investigate the incident. 3. the investigation shall consist of: a. a comprehensive review of the event; b. interview with the person (s) reporting the incident; c. interviews with any witness; f interview with staff members (on all shifts as appropriate) having contact with the resident during the period of the alleged incident. 4. a review of all circumstances surrounding the incident. (The policy was not being followed.) NJAC 8:39-27.1 (a)	F 610		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 636		6/23/23

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F 636	Continued From page 41 (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization	F 636		

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or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to complete a resident assessment that accurately reflected the resident's status of [redacted]. This was identified during a review of the Comprehensive Minimum Data Set (MDS), an assessment tool to facilitate the management of care, for (Resident # 128) 1 of 31 residents reviewed for MDS.

This deficient practice was evidenced by the following:

On 05/24/23 at 10:30 AM, the surveyor observed Resident #128 during a Resident Council Meeting. At that time, Resident #128 stated that he/she had been [redacted] because of [redacted] of [redacted]".

A review of Admission Record, an admission summary revealed diagnoses which included but were not limited to [redacted]

A review of the facility provided, [redacted]s and Vitals Summary", undated, indicated Resident #128 had the following [redacted] which included but were not limited to:

an admission [redacted] dated 01/31/23, of [redacted] pounds (lbs.)
dated 02/01/23 of [redacted].5 lbs.
dated 02/08/23 of [redacted] lbs.

F 636

ELEMENT ONE: CORRECTIVE ACTION:
Resident #128 Minimum Data set modified to accurately reflect the resident s weight status.
Resident #128-person centered care plan was updated to reflect resident s [redacted] status.

ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:
All residents with [redacted] have the potential to be affected by this practice.
Minimum data set coordinator /Designee performed an audit on [redacted] days of all residents with weight loss to verify if their MDS accurately reflected their [redacted] status.
Director of Nursing/Designee performed an audit on [redacted] days on residents with [redacted] to verify if their resident centered care plan was updated to reflect their [redacted] status.

ELEMENT THREE: SYSTEMIC CHANGES:
Director of Nursing /Designee in serviced MDS Nurse on reviewing section K0300 to verify accuracy.
Director of Nursing /Designee in serviced Facility Register Dietitian on reviewing section [redacted] of Minimum data set to verify accuracy of Minimum data set coordinator assessment and to verify comprehensive care plan is updated.

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F 636	Continued From page 43 dated 02/13/23 of lbs. with a notation change [comparison 1/31/23, lbs. - lbs.] dated 02/20/23 of lbs. with a notation change [comparison lbs, - lbs.] dated 02/22/23 of lbs. with a notation change [comparison 01/31/23, lbs., lbs.] dated 03/06/23 of lbs. with a notation change [comparison 02/01/23, lbs., lbs.]; change [comparison 01/31/23, lbs., lbs.] A review of the person-centered comprehensive care plan revealed no focus area, no goals, no interventions to indicate Resident #128's A review of the MDS revealed a Brief Interview of Mental Status (BIMS) of which indicated the resident had . ( ) indicates: Loss of 5% or more in the last month or loss of 10% or more in the last 6 months. This section indicated "0" meaning no weight loss or unknown. listed as lbs. Upon admission on Resident #128 weighed in at lbs. and with the most recent on the resident weighed in at lbs. According to the MDS guideline as stated above the resident over 10% in less then 6 months. The resident had a total of since admission on . On 06/02/23 at 9:33 AM, during an interview with the surveyor, the MDS coordinator stated, "I just modified the area". She also stated, "the	F 636	Residents with will be reviewed at weekly Nutrition Meeting to ensure comprehensive care plan and Minimum data set assessment is accurate with modifications completed as needed. ELEMENT FOUR: QUALITY ASSURANCE: Minimum data set coordinator /Designee will audit all residents with weekly x 4 then monthly x 2 to ensure Minimum data set section and comprehensive care plan is updated. Audit results will be reported to Quality assurance Performance improvement team monthly x 3 for review and revision as necessary.	

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F 636	Continued From page 44 dietitian entered the wrong information, and it did get missed". The MDS coordinator acknowledged it was her responsibility to review the MDS's and that she was unaware until surveyors brought it to the attention of the facility. A review of the facility provided, "Electronic Transmission of the MDS", revised [redacted], included but was not limited to 6. The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data. The dietitian was unavailable for interview during the survey. The facility did not follow its policy. NJAC 8:39-11.1, 11.2	F 636		
F 656 SS=E	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 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	F 656		6/23/23

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F 656	Continued From page 45 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. §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: Based on interview, observation, and record review it was determined the facility failed to develop person-centered comprehensive care plans to address the residents medical, physical, mental, and psychosocial needs. This deficient practice was identified for 4 of 31 residents reviewed (Resident #33, #49, #128, #138), for 1 of 2 closed records reviewed (Resident #157) for care plans and was evidenced by the following: 1.) On 05/22/23 at 11:00 AM, during the initial tour	F 656	ELEMENT ONE: CORRECTIVE ACTION Resident #33 On [redacted]3 care plan was updated to reflect [redacted] use Resident #49 On [redacted]3 Care Plan was updated to reflect his dietary concerns Resident #128 On [redacted] Care Plan was updated to reflect his desire to [redacted] Resident 138 On [redacted] Care Plan was updated to reflect [redacted]	

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F 656	Continued From page 46 of the facility, the surveyor observed Resident #33 in bed and was wearing a [redacted] The surveyor observed that the [redacted] was connected to an [redacted] that was set to [redacted]. The resident stated that he/she was on [redacted] most of the time. On 05/23/23 at 12:19 PM, the surveyor observed Resident #33 lying in bed with their eyes closed. The surveyor observed that the resident was wearing the [redacted] and that the [redacted] was set to [redacted]. On 5/24/23 at 08:41 AM, the surveyor observed Resident #33 lying in bed awake. The surveyor observed that the resident was wearing the [redacted] and that the [redacted] was set to [redacted]. The resident stated that he/she was usually on [redacted]. According to the Admission Record, Resident #33 was admitted to the facility with diagnoses which included, but were not limited to, [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated that Resident #33 had a Brief Interview for Mental Status score of [redacted], which indicated that the resident had a [redacted]. The MDS also revealed that Resident #33 had	F 656	[redacted] ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: Interdisciplinary care plan team in serviced on chart auditing, quarterly assessments, and care planning/updating care plan. Interdisciplinary care plan team will meet to review 20 charts and care plans for all residents in house to reflect all issues/concern/problems/likes or dislikes until all charts have been audited. Thereafter Interdisciplinary care plan team will maintain quarterly review and adjust /update care plans as necessary. Schedule will be given to the Interdisciplinary care plan team on a monthly basis by the end of the month prior to the upcoming months schedule all care plan/Interdisciplinary care plan team meetings (once initial review is complete) to ensure all problems/issues/concerns are captured, addressed and care planned . Element Four - Quality Assurance Social Worker/Minimum Data Set manager/Designee will complete an audit of 5 charts per unit to ensure care plans are updated and Interdisciplinary care plan team is completing, weekly x4, monthly x4 needed corrections will be addressed as they are discovered. Audit Results to be reported monthly times 3 to Quality assurance performance improvement team for review and revision	

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F 656	Continued From page 47 from two staff members to transfer (from the bed to a wheelchair) and did not walk in their room during the assessment window of the MDS. Review of the Physician's Order Form indicated that Resident #33 had an active physician order for) prn (as needed) for dated Review of Resident #33's current and active comprehensive care plan did not include therapy as part of the resident's care plan. During an interview with the surveyor on at 1:16 PM, Resident #33's assigned Licensed Practical Nurse/Unit Manager (LPN/UM #1) stated that if someone was on , they should have a care plan for A care plan was for whatever the person has, such as ongoing , ongoing , anything. It was important to care plan because you need to know what is going on with the patient to give good care and would need to have interventions in place to help the residents and if the interventions are not working need they needed to be changed. During an interview with the surveyor on 05/31/23 at 11:56 AM, in the presence of the Vice President of Clinical Services (VPCS), the Director of Nursing (DON) stated that when a resident was on it should be included in the resident's care plan. Review of the facility's policy titled "Interdisciplinary Care Planning Protocol," dated	F 656	as necessary.	

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11/22, revealed that problems established by the team with the resident/family input must be specific and individualized.

2.)On 05/24/23 at 10:59 AM, the surveyor observed Resident #49 at the nurses cart outside of the resident's room. Resident #49 was using [redacted] and telling the nurse about the poor quality of the food at the facility.

On 05/25/23 at 8:59 AM, the surveyor interviewed Resident #49, who stated, "I can't eat this [exploitive redacted]. Resident #49 stated he choked on freezer burned chicken and then went to the hospital and they found out that he/she had a tumor. Resident #49 stated he/she used to be [redacted] pounds. Resident #49 stated again, "I cannot eat this [exploitive redacted]", and added "I would not give it (food served) to a pig." The resident stated that the facility food was so bad, and there were no other food options offered, that he/she would rather just drink a supplement than eat the horrible food.

The surveyor reviewed Resident #49's medical record which revealed the following:

The Admission Record revealed a diagnosis of [redacted].

A Nursing Progress Note dated [redacted] at 17:30 [4:30 PM] revealed "Resident not happy with meal [he/she] received this PM. Resident is on [redacted] and states [he/she] can eat regular food as long as its soft. This nurse explained we can only give what was recommended after [redacted] evaluation. This [nurse] will put in for another consultation with

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dietitian so dietary can be aware of what specific foods resident would like to eat. Resident is receiving] will recommend for an increase in supplement.

A Dietary Note dated 5/18/2023, 18:01 [6:01 PM] revealed Resident #49's May weight was pounds. A desirable days. [His/her] was texture last month but [he/she] expressed to DON (Director of Nursing) [he/she] "does not like meals" and will prefer to drink more supplements. Writer visited resident and [he/she] confirmed preference of commercial supplements to present texture of food ... Continue to provide trays for oral gratification rather than nutrition ...

A Physician Progress Note Narrative dated 11:49 revealed ... pounds, "s/p [status post] removal on pt [patient] upgraded to diet with supplements, wt [weight] stable" ...

The Care Plan (CP) for Resident #49 was reviewed which revealed a Focus of At risk for secondary to and increasingly . I am also at risk because of my refusal to take provided through a , Date Initiated . Goal: I will maintain my through and utilizing my when h) diet. Target Date: . Another goal revealed, I will work with my dietician and medical team to understand my needs for diet adjustment including or Target Date: The

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F 656	Continued From page 50 Interventions, Initiated [redacted] included: Educate on diet supplementation intake, Educate on proteins and nutrients necessary to maintain [redacted], encourage participation in [redacted] studies and compliance with recommendations, [redacted] eval and treat. (The CP was not reflective of the residents status and there were no interventions regarding specific preferences and concerns with dislike of food, or follow-up regarding food preferences.) On 05/30/23 at 12:17 PM, during an interview with the surveyors and upon requests made by the survey team to interview the Dietitian, the LNHA stated she would have to see who was covering for the dietitian. The LNHA stated the Dietitian was on vacation from [redacted] through [redacted]. The LNHA stated that since the Dietitian was only going to be gone for one week that there would not be a dietitian covering. Dietitian job Description, reviewed 06/10/2022 Responsibilities: revealed: ... Maintains nutritional care plans ... Listens attentively to patient complaints and resolves or refers to appropriate individuals. 3.) On 05/24/23 at 10:30 AM, Surveyor #3 observed Resident #128 as he/she attended the Resident Council Meeting (RCM). During the RCM, Resident #128 stated that the food was "inedible" and that he/she had lost weight. Resident #128 stated that he/she had spoken to the Dietitian "twice" about food preferences such as requesting fresh vegetables and fruit. Also, that the canned fruit was always served at room temperature and not cold.	F 656		

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On 05/31/23 at 1:00 PM, Surveyor #3 observed Resident #128 in their room with their lunch tray on the over bed table. Resident #128 informed the surveyor that he/she had only eaten one chicken thigh. He/she stated that the Dietitian knew about the weight loss but that he/she wanted to [redacted] a healthy way "not because of (facility) food choices." Resident #128 stated "I just want better food choices".

A review of Resident #128's Admission Record revealed he/she was admitted on [redacted], with diagnoses which included but were not limited to, [redacted].

A review of the facility provided, "Weights and Vitals Summary", dated [redacted] revealed the following dates / [redacted]

01/31/23 weight [redacted] pounds (lbs.)
02/01/23 weight [redacted].5 lbs.
02/08/23 weight [redacted]2 lbs.
02/13/23 weight [redacted] lbs. '[redacted]% change [comparison [redacted]t 01/31/23, [redacted] lbs., -[redacted] -[redacted] lbs.]
02/20/23 weight [redacted] lbs. '[redacted] change [comparison [redacted] 01/31/23, [redacted] lbs., -[redacted] lbs.]
02/22/23 [redacted] lbs. '[redacted] change [comparison [redacted] 01/31/23, [redacted] lbs., [redacted] lbs.]
03/06/23[redacted] lbs. [redacted] change [comparison [redacted]t 02/01/23, [redacted] lbs., [redacted], [redacted] lbs.]; '[redacted] change [comparison [redacted] 01/31/23, [redacted] lbs., [redacted] lbs.]
05/08/23 [redacted] lbs.

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A review of the person-centered comprehensive Care Plan provided by the facility and printed on [redacted], revealed no focus area regarding Resident #128's [redacted], no goals regarding the [redacted], and no interventions regarding the [redacted].

A review of the most recent Quarterly MDS dated [redacted], revealed under Section K, a weight of [redacted], loss of 5% or more in the last month or loss of 10% or more in the last 6 months was documented as "0" "No or unknown."

A review of a Physician's Progress Note, dated [redacted], revealed a weight of [redacted] lbs. on [redacted] admission weight of [redacted] lbs. "progressive [redacted] from [redacted] lbs. to [redacted] lbs." The Progress Note went on to include to schedule follow up [redacted], to monitor intake, a dietary evaluation, and to consider a medication used for appetite stimulation.

On 05/30/23 at 1:29 PM, during an interview with surveyors, the DON stated that she had a good relationship with the Dietitian and that every Monday weights would be done and reweighs. The DON stated that she and the Dietitian had a weekly weight meeting on Thursdays to discuss significant weight changes and interventions. The DON stated that weight concerns should be documented on the care plans "so everyone knows".

A review of the facility provided, "Dietitian" job description, dated 06/10/22, included but was not limited to maintains nutritional care plans.

4.) On 05/22/2023 at 9:46 AM, during the initial tour of Unit [redacted] the surveyor observed Resident

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#138 awake and alert, lying in bed. The surveyor was unsure if the resident understood the surveyor and then asked the resident understood [redacted] and the resident stated no. When asked if he/she understood some [redacted] the resident stated "yes".

At that time, the surveyor interviewed the Director of Nursing (DON) who stated that some residents were [of [redacted] descent] and some spoke [a [redacted]]. The DON stated that some residents could understand and speak basic [redacted] and the staff would use simple words so they would understand.

Review of the Admission Record revealed Resident #138 was admitted to the facility with medical diagnoses included, but not limited [redacted]

Review of the Annual Minimum Data Set (MDS), an annual assessment tool dated [redacted], indicated the resident had a Brief Interview of Mental Status of [redacted] meaning the resident severely impaired cognition. [redacted] revealed the resident had [redacted] could make him/herself understood and had the ability to understand others. [redacted] of the MDS, functional status showed the resident was a set up/supervision for hygiene, eating, and ambulation.

Review of Resident #138's current and active care plan did not include communication as part of the resident's care plan.

On 05/23/23 at 11:49 AM, the surveyor observed

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Resident #138 awake and alert sitting in bed. The surveyor greeted the resident with "Good Morning" and the resident replied back "Good Morning."

On 05/24/23 at 8:43 AM, the surveyor observed Resident #138 standing in the hallway waiting to go outside to the smoking area. The resident stated "Good Morning" to the surveyor.

During an interview with the surveyor on 05/25/23 at 9:26 AM, CNA #2 stated that Resident #138 [redacted] and there was usually an interpreter in the building if needed. CNA #2 further stated that the resident could understand basic [redacted] and was able to tell us if he/she was hungry or needed to use the bathroom.

Review of the social service note, dated 04/29/23, revealed that the resident was a [redacted] old [of [redacted]] and the social service notes from [redacted] did not reveal any documentation regarding speaking a primary language that was not [redacted]

Review of the progress notes form [redacted] - [redacted] revealed two physician progress notes, dated [redacted] and [redacted], which indicated that the translator reported that that the resident used to live with a [redacted] but due to his/her [redacted] [redacted] the resident could no longer live there and had no place to go.

During an interview with the surveyor on 05/30/23 at 1:14 PM, the LPN UM #1 stated that if a resident spoke a [redacted], it should be care planned. LPN UM #1 further stated that the care plan was important because the staff needed to know what is going on with the

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resident. The care plan needed to have interventions to help the residents and if the interventions were not working then the interventions needed to be revised.

During an interview with the surveyor on 05/31/23 at 11:51 AM, in the presence of the VPCS and Regional Nursing Director, the DON stated that if a resident spoke another language, then it should be documented on the care plan. The DON further stated that it was important to care plan for communication because "we need to know how to communicate with them and to understand what they are trying to tell us."

During an interview with the surveyor on 06/01/23 at 11:34 AM, the Director of [redacted] Care Services confirmed that Resident #138 primary language was [a foreign language], and that an [redacted] was available for assessments and team meetings.

During an interview with the surveyor on 06/01/23 at 11:47 AM, the VPCS stated that if a resident had a [redacted] it should be documented in the care plan.

Review of the facility's policy titled "Interdisciplinary Care Planning Protocol," dated [redacted] revealed that problems established by the team with the resident/family input MUST be specific and individualized.

5.)On 05/24/23, a surveyor reviewed the closed medical record for Resident #157.

A review of the Admission Record revealed Resident #157 had been admitted and readmitted to the facility with diagnoses which included but

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F 656	Continued From page 56 were not limited to, . A review of the Quarterly MDS, dated , included but was not limited to ( ) medications and indicated administered while a resident. A review of the facility provided, "Order Summary Report", active orders as of included but was not limited to, an order dated change IV and on admission or 24 hours then Q (every) 7 days and PRN (as needed) for) every 4 hours for until ; and ours for until A review of the facility provided, "Skilled Charting", dated 02/23/23, included but was not limited to, L. medications/orders medication was checked off as in use. A review of the facility provided Care Plan for Resident #157, care plan closed date included all areas as closed reason being discharge. A review of the entire 10 pages provided by the facility indicated there was no focus area, goal, or interventions related to the resident having an intravenous access or the use of for NJAC 8:39-11.2 (e)(i) ;27.1(a)	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		6/23/23

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F 677	Continued From page 57 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure a.) a resident dependent on staff for Activities of Daily Living (ADL) received nail care, and b.) a resident dependent on staff for ADLs received [redacted] and was [redacted] This deficient practice was identified for 2 of 3 residents (Resident #35 and #28) reviewed for ADL care. The deficient practice was evidenced by the following: a.) On 05/24/23 at 8:31 AM, Surveyor #1 observed Resident #35 in their room sitting in a wheelchair. Resident #35 reached towards Surveyor #1 and slightly scratched the surveyors right arm. Surveyor #1 requested to see Resident #35's [redacted]. The surveyor [redacted] were [redacted] of the [redacted], and there was a visible [redacted] On 05/25/23 at 8:53 AM, Surveyor #1 observed Resident #35 in the hallway in their wheelchair. The resident's [redacted]s were still in the same condition. At that time, Resident #35 stated that he/she needed help to cut and clean his/her [redacted] and would like his/her [redacted] and	F 677	ELEMENT ONE: CORRECTIVE ACTION: Resident #35 [redacted] were cleaned and [redacted] Resident #28 nails were cleaned, [redacted]. The facility will review Activities daily living books in clinical meeting twice weekly to verify Certified Nursing Assistant documentation reflects provision or refusal of [redacted] and [redacted] for dependent residents. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All dependent residents have the potential to be affected by this practice. Director of Nursing/Designee performed an audit on 6/23 x last 30 days of all dependent residents to verify provision or refusal of [redacted]. ELEMENT THREE: SYSTEMIC CHANGES: Director of Nursing/Designee in-serviced nursing staff on facility Activity of Daily Living Policy including need to document acceptance or refusal of all [redacted] and [redacted]s on shower days or as needed on Activities of daily living Kardex s or resident shower sheets Staff also in-serviced on refusal process including	

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[redacted].

On 05/23/23 at 9:10 AM, during an interview with the surveyor, the Certified Nursing Assistant (CNA) caring for Resident #35 stated that it was her responsibility to set up the resident to clean and wash him/herself. The surveyor asked about [redacted]. The CNA stated she "could not answer" that and that the resident "probably refused". When asked the process when a resident refuses care, the CNA stated she would let the nurse know. The CNA stated that there was only one place to document [redacted] and that was if a resident needed their [redacted] and they had to call the podiatrist. Surveyor #1 and the CNA went to observe Resident #35's [redacted] The CNA stated, "to me yes they (the [redacted]) need to be done but only during shower days."

On 05/25/23 at 9:13 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) caring for Resident #35 stated that if a resident refused [redacted], the staff should wait and try to encourage the care later on. She stated if the resident did not allow their [redacted] to be cut, the staff should ask if they could file the resident's [redacted]. If the resident refuses, the staff need to let the nurse know so it could be documented. The nurse would let the doctor know. The LPN stated she was never informed that Resident #35 refused [redacted].

A review of Resident #35's Admission Record (an admission report) revealed that the resident had diagnoses which included but were not limited to [redacted].

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need to reapproach and encourage and also ask to file [redacted] is refused. The charge nurse should be notified of all refusals so they may include it in their documentation also. Nurses are also to check [redacted] and shaves as part of resident [redacted]
Resident Activities of daily living Kardex s and/or shower sheets will be reviewed by Unit manager twice weekly to ensure documentation reflects residents dependent on staff for Activities of Daily Living refusal or provision of [redacted] and [redacted] on scheduled shower days and as needed.

ELEMENT FOUR: QUALITY ASSURANCE:
Director of Nursing /Designee will audit all dependent residents to determine if resident received or refused [redacted] and/or [redacted] on scheduled shower days and as need it weekly x 4 then monthly x 2. Needed corrections will be addressed as they are discovered. Results to be reported monthly to Quality assurance performance improvement team x 3 for review and revision as necessary.

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A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool to facilitate care, dated [redacted] included but was not limited to a Brief Interview for Mental Status (BIMS) of [redacted] out of [redacted] which indicated the resident had [redacted], Functional Status indicated that Resident #35 required supervision and set up help for personal hygiene.

A review of the person-centered comprehensive care plan, printed on [redacted], included but was not limited to a focus area of ADL deficit, needing supervision/limited assistance with ADLs date initiated [redacted] and revised [redacted] Interventions included bed bath daily and shower at least 2 x (times) a week.

A review of the facility provided, "Order Summary Report", dated active orders as of [redacted], included an order dated [redacted] for weekly skin checks on shower days [redacted] and [redacted].

A review of the facility provided, "IDCP (Interdisciplinary care plan) Team Care Conference", dated [redacted], included but was not limited to 2. B. requires extensive assist and direction with ADLs.

A review of the facility provided Progress Notes (PN) ranging from [redacted] through [redacted], contained no documentation that Resident #35 had refused any ADL care.

A review of the ADL Worksheet, dated [redacted] ([redacted] included but was not limited to a section for bathing. The worksheet indicated that every day on the 7 am to 3 pm shift from [redacted]

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through [redacted], Resident #35 had been given a bed bath. The worksheet indicated that on the 3 pm to 11 pm shift from [redacted] through [redacted], Resident #35 was provided either a bed bath or shower every day. The worksheet included an area for the staff to document their initials, full signature, and title, but those areas were left blank.

A review of the CNA Assignment for [redacted] wing dated [redacted] (Wednesday) and dated [redacted] (Thursday), both indicated the same CNA on both days. The Assignment sheet further indicated "shave all residents, [redacted] on shower days". The resident had not received [redacted] care during his/her shower on [redacted] and there were no PN to indicate any refusal of care.

b.) On 05/22/23 at 9:49 AM, the surveyor toured the [redacted]-Wing of the facility and observed Resident #28 lying in bed. Resident #28 was [redacted] and [redacted] The [redacted] was rested on the blanket and observed with [redacted] and with a [redacted]h the [redacted] Resident #28 was unshaven. At the surveyor's request, the resident was able to use the [redacted] to pull the cover and exposed the [redacted]. The [redacted] was observed to be [redacted] and the [redacted] were [redacted] and [redacted] with a [redacted] the [redacted]

On 05/23/23 at 2:13 PM, the surveyor observed Resident #28 in bed. Resident #28 was [redacted] and [redacted] with a [redacted] [redacted] the

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F 677	Continued From page 61 On 05/24/23 at 10:27 AM, the surveyor observed Resident #28 out of bed in the . Resident #28 already received morning care, the were observed in the same condition, When asked about the and the Resident #28 stated that he/she would like to be On 05/24/23 at 12:15 PM, the surveyor reviewed Resident #28 clinical record. The Admission Face sheet revealed that Resident #28 was admitted to the facility with diagnoses which included but were not limited to, . The Quarterly Minimum Data Set (MDS) an assessment tool dated , coded Resident #28 as scoring a out of a possible on the Brief Interview for Mental Status (BIMS) which indicated that Resident #28 had some . of the MDS which referred to ADL's, indicated that Resident #28 was totally dependent on staff for all activities of daily living. The MDS further coded Resident #28 with no rejection of care exhibited. (Section The surveyor reviewed the electronic progress notes from and could not find any documentation regarding that personal care was offered and Resident #28 refused. The comprehensive care plan dated 1 , documented a focus area for Resident #28 with ADL related to ( ). history of	F 677		

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[redacted], history of [redacted].

The goal: Will maintain current ability without decline and participate daily to level of capacity. Some of the interventions to manage the goal included:
Bed bath daily and shower at least twice a week. Initiated [redacted]
Converse during care. initiated [redacted]
Ensure all assistive devices are in reach. Initiated [redacted].
If [redacted], leave Resident #28 alone and return at a later time. Initiated 08/03/21.
Explain to Resident #28,what you are doing before beginning activity. Initiated [redacted].

Resident #28's ADL worksheet (form CNAs and staff used to document the care provided) for the month of May was reviewed and revealed that Resident #28 received a bed bath almost daily. The documentation revealed that hygienic care was completed, but there was no specific entry for [redacted]l and [redacted] care.

On 05/26/23 at 7:40 AM, the surveyor observed the resident in bed[redacted] with [redacted] [redacted] [redacted] the [redacted]

An interview was conducted on [redacted] at 8:30 AM, with the CNA who cared for Resident #28 over the last 3 days. The CNA acknowledged Resident #28 was dependent on staff for care. The CNA stated that she provided care to Resident #28 this morning and she could not recall if the [redacted] needed to be [redacted]

On 05/31/23 at 11:48 AM, a second interview with the CNA who provided care to Resident #28,

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revealed that the facility did not have a CNA care card. She further stated that nail care was not addressed on the ADL Worksheet and usually she will perform nail care and [redacted] on shower days.

On 05/31/23 at 11:51 AM, an interview with a random CNA regarding [redacted], confirmed that the CNAs do not have a care card to follow. In the morning she received report from the nurse regarding care. The nurses do not address [redacted]. The CNA further stated that [redacted] are part of grooming and should be done when [redacted] are [redacted] and the resident could be visibly seen in need of [redacted] When asked for the rationale for [redacted] not being done for some residents, she declined to comment.

On 05/31/23 at 11:20 AM, Resident #28 was observed in Physical Therapy, appearance was disheveled and [redacted] still had not been done.

On 06/02/23 at 2:15 PM, the facility was made aware of the above concerns.

On 06/05/23 at 8:35 AM, the Regional Administrator (RA#2) provided a folder with in-services only. No further information was provided.

A review of the facility provided, "Activities of Daily Living" policy reviewed 11/22/22, included a resident who cannot carry out ADLs will receive the necessary services to maintain grooming.

NJAC 8:39-27.1(a), 27.2(g)

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F 685	Continued From page 64	F 685		
F 685 SS=E	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of [redacted] or the office of a professional specializing in the provision of [redacted] devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to arrange for an [redacted] consult when a hearing impairment was identified. This deficient practice was identified for 1 of 31 residents (Resident #8) reviewed and was evidenced by the following: On 05/26/30 at 9:30 AM, the surveyor observed the Certified Nursing Assistant(CNA), while in in Resident #8's room repeat herself several times during a conversation she had with Resident #8, the resident responded "huh?" to several questions/comments from the CNA. Resident #8 stated "[redacted]." The CNA stated to the surveyor that Resident #8 had some [redacted] but she had not observed him/her wearing [redacted] The surveyor reviewed Resident #8's medical record. Resident #8 was admitted to the facility	F 685	ELEMENT ONE: CORRECTIVE ACTION: An [redacted] appointment was made for resident #8 ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by this practice. An audit was completed by unit managers on all residents with noted [redacted] to ascertain need for [redacted] appointment. ELEMENT THREE: SYSTEMIC CHANGES: Director of Nursing/ Designee in- serviced license nurses and unit clerk on making [redacted] appointments for residents, ensuring transportation arrangements have been made and following up on consultant recommendations. Unit Manager/designee will bring all [redacted] consult to clinical meeting to	6/23/23

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F 685	Continued From page 65 with diagnoses which included but were not limited to, The Annual Minimum Data Set (MDS) Assessment dated , revealed that Resident #8 was Resident #8 scored on the Brief Interview for Mental Status (BIMS). The resident required limited assistance of one staff for activities of daily living (ADLs). The resident had Resident #8 was assessed as having , usually e deficits, and The Comprehensive Care Plan (CP) dated , reflected a focus for communication due to . The Goal was for Resident #8 to communicate needs without frustration. The following interventions were to be implemented: of words or . Initiated On 05/26/23 at 10:14 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the Wing regarding Resident #8's . The LPN stated that for any resident with a consultation had to be initiated for an evaluation to see if the	F 685	ensure follow up is completed for recommendations. ELEMENT FOUR: QUALITY ASSURANCE: Social Worker/designee to audit 24-hour report and daily order listing report, during clinical meeting weekly x4 then monthly 2 then quarterly thereafter to track and identify any consults has been completed for all residents Audit Results to be reported monthly times 3 to Quality assurance performance improvement team then quarterly thereafter for review and revision as necessary.	

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resident had [redacted], and then the resident would be referred to the [redacted] at the [redacted]) clinic. The surveyor reviewed the clinical record and was unable to locate any follow-up that was done regarding what the LPN stated would be the protocol for a resident with a [redacted].

On 05/26/23 at 12:30 PM, during an interview with the Social Worker (SW), the SW stated that Resident #8's concerns with [redacted] had first been identified in [redacted]. However, the SW stated stated that she could not tell if Resident #8 ever had [redacted]. The SW further stated that the nursing department was responsible to follow up with any appointments. The SW declined to answer further questions regarding the above issue and deferred to nursing for follow-up.

On 05/30/23 at 10:43 AM, the SW provided a form titled, "Report of Consultation", dated [redacted]. Under report the following was documented:
Findings: [redacted]
Diagnosis: [redacted]
Recommendations: Continue [redacted] and go to [redacted].

On 05/30/23 at 11:05 AM, the surveyor returned to the [redacted] Wing and reviewed the clinical record again with the LPN to locate any documented follow-up for the [redacted] recommendations. The LPN was unable to locate any documentation regarding the follow-up.

On 05/30/23 at 11:15 AM, the above concern was presented to the Director of Nursing (DON). The DON stated that all consultation recommendations should be followed-up. The

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F 685	Continued From page 67 DON added that she was not aware of any consultation regarding the [redacted] concerns for Resident #8 and stated she was not working in the facility at that time. She could not comment on what had been done regarding the referral. On 05/31/23 at 9:32 AM, the surveyor conducted a follow up interview with the SW. During the interview, the SW stated that she obtained the request for the [redacted] consult from an old chart but could not verify if the follow up appointment was completed. The SW could not provide any information documented evidence regarding if the referral had been made for a [redacted] and was rejected by Medicare. A review of Resident #8's Personal Needs Allowance (PNA) provided by the SW dated [redacted] revealed that Resident #8 had over $ [redacted] dollars in the account. There was no documented evidence that Resident #8 was asked if he/she would consider paying for [redacted] [redacted] his/her quality of life. On 06/02/23 at 2:15 PM, the facility was again made aware of the above concern. No additional information was provided on the exit day for review. NJAC 8:39-27.5(a)	F 685		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/23/23

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F 689	Continued From page 68 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation it was determined the facility failed to: a.) ensure the facility policy for Falls Management was followed to appropriately assess a resident and determine the causal factor of a and implement appropriate interventions to prevent recurrent for a resident (Resident #23), who was identified as a , required with bed mobility, and had a history of with injury which included an unwitnessed at 18:40 (6:40 PM), resulting i required transfer to emergency room on with a diagnosis of an comminuted (a ildly displaced (a gap between the broken bones) . A subsequent unwitnessed occurred o and required 911 transport to the emergency room, and resulted in a measuring cm and a per a computerized , b.) ensure a complete " Assessment" was completed as required by a Registered Nurse prior to transferring Resident #23 to the bed, when reportedly Resident #23 was found on the floor on at 6:00 AM, c.) provide adequate supervision to prevent , and d.) ensure that existing interventions to preven were consistently implemented. This deficient practice occurred for 1 of 3	F 689	ELEMENT ONE: CORRECTIVE ACTION: Resident # 23 were investigated, Root Cause Analysis completed, and investigation updated. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents with unwitnessed are at risk. Director of Nursing/Designee completed an audit on all incidents and accidents for the last 3 months to ensure completion of investigation and proper documentation. Director of Nursing/Designee completed an audit on all discharges for the last 1 month to ensure proper investigation and documentation was completed if applicable. ELEMENT THREE: SYSTEMIC CHANGES: Director of Nursing /Designee re-educated nursing staff on falls management program including documentation required. Director of Nursing /Designee re-educated Interdisciplinary Care Plan Team/ committee on management program including resident assessment, completing investigations, root cause analysis identification and updating care plan with appropriate or new interventions and follow up as needed.	

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residents, Resident #23, reviewed for [redacted] with injury and was evidenced by the following:

On 05/22/23 at 10:40 AM, the surveyor observed Resident #23, positioned on the [redacted], in a bed that was against the wall and the resident was facing the wall. The surveyor observed a pad on the floor next to the bed. Resident #23 was unable to maintain a conversation with the surveyor and the resident also had a blanket covering the head.

On 05/24/23 at 8:16 AM, the surveyor observed Resident #23 in bed, and was again positioned in the same manner as observed by the surveyor two days prior. At that time, the Certified Nursing Assistant (CNA) was inside the room and attempted to assist Resident #23 with the breakfast meal. The CNA stated to the surveyor that Resident #23 had a poor appetite and exited the room shortly after the surveyor entered.

On 05/24/23 at 10:25 AM, (two hours later) Resident #23 was observed still in bed and was in the same position facing the wall. The [redacted] Wing Activities of Daily Living (ADLs) worksheet (a document that direct care staff documented the resident care that was provided), could not be located by the staff to verify any documented care that had been provided to Resident #23 regarding position change or being repositioned.

On 05/24/23 at 1:05 PM, the surveyor returned to the room and observed Resident #23 in bed, on his/her back with head elevated. At that time, the surveyor observed a [redacted] [redacted]) on Resident #23's [redacted]. A Licensed Practical Nurse (LPN), who later identified herself as the Infection

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Director of Nursing /Designee re-educated Social Worker and Unit Managers and nursing staff on discharge/transfer documentation.

ELEMENT FOUR: QUALITY ASSURANCE:
Regional Director of nursing /Designee will audit 24 hour report as well as incidents/accidents daily x 14 days, weekly x 4 weeks and monthly x 4 to ensure identified residents are assessed, investigations are completed, root cause analysis identified. and care plans are updated with appropriate interventions. Director of Nursing/designee will continue to audit 24 hour reports as well as incidents/accidents monthly thereafter to ensure identified residents are assessed, investigations are completed, root cause analysis identified and care plans are updated with appropriate interventions. Needed corrections will be addressed as they are discovered. All Audits Results to be reported monthly to Quality assurance performance improvement team for review and revision as necessary.

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Preventionist (LPN IP) was in the room and assisted Resident #23 with the lunch meal. Upon surveyor inquiry regarding the observed injury on Resident #23's [redacted], the LPN IP stated that the injury was from a [redacted] the resident sustained and she would not elaborate further on the observed injury.

On 05/24/23 at 1:25 PM, the surveyor reviewed Resident #23's electronic medical record and could not locate any documentation regarding the observed injury that the LPN IP confirmed Resident #23 sustained during a [redacted] at the facility. According to the Admission Face Sheet, Resident #23 was admitted to the facility with diagnoses which included but were not limited to; [redacted].

A review of the Significant Change Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care dated [redacted], revealed that Resident #23 was [redacted] Resident #23 scored 6/15 on the Brief Interview for Mental Status (BIMS).

Section G of the MDS, which referred to activities of daily living (ADLs), revealed that Resident #23 was totally dependent on staff for care and required an extensive assistance of [redacted]r, and [redacted] for care.

A review of the progress notes did not contain documentation regarding the fall that the LPN IP stated occurred on [redacted] for Resident #23, however a fall that occurred on [redacted] was documented. The following entry dated

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F 689	Continued From page 71 timed 19:42:31 [7:42 PM], Note Text: Notified by aide that resident was on the floor. I found resident laying on the floor on the right side. I observed no and resident said [his/her] head was fine. Resident expressed that [his/her] , and [he/she] was in . Called MD to make aware. Called for . in progress. Made supervisor aware. Will continue to monitor resident throughout the shift. VS [vital signs] [blood pressure] [pulse] [temperature] [respirations]. Another entry dated revealed the following: "Resident had increased MD was notified and [Resident #23] was sent out to the hospital. one. Resident found to have , without significant . The surveryor reviewed the current Comprehensive Care Plan (CP) initiated last revised (revised four days after the that occurred on) which included pages and had a "Focus" for ADL and functional mobility deficit related to: decreased strength, balance, endurance and coordination. "I require extensive assistance/Total Dependence with ADLs, transfers, functional mobility and safety awareness." The Goal for this Focus was for Resident #23 to improve ADL and functional mobility level by next review. Initiated and Revised , with a Target Date of , The CP interventions included:	F 689		

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F 689	Continued From page 72 Converse during care, Ensure that all assistive devices are in place, and Introduce yourself and explain all care. Date Initiated: [redacted], Date Revised: [redacted]. Resident #23 also had a CP Focus for "At Risk for [redacted] due to [redacted] [redacted]", Date Initiated: [redacted] The Goal was "Minimize risk for [redacted] through next review", Date Initiated: [redacted] The following interventions were documented: Provide assistance to transfer and ambulate as needed. Initiated [redacted]. Reinforce the need to call/ring for assistance. Initiated [redacted]. Reinforce wheelchair safety as needed such as locking brakes. Initiated [redacted] Therapy evaluation and treatment as ordered. Initiated [redacted]. On [redacted] Resident #23 was found lying on the floor in his/her room. The following interventions were added to the care plan: Assess for [redacted] and medicate if needed. Initiated [redacted] Assessment Completed, Date Initiated [redacted] Continue at risk for [redacted] intervention, Date Initiated [redacted] Monitor [redacted] every shift x 72 hours, Date initiated [redacted]. [redacted], Date initiated [redacted]3 Notify MD [Medical Doctor] of the incident and for any significant change, Date initiated [redacted] Epic evaluation of meds[medications], Date initiated [redacted]. Floor mat at bedside, Date initiated [redacted] Sent to Hospital for evaluation of [redacted]. Initiated [redacted] [redacted]. Initiated [redacted] Orthopedic appt [appointment] scheduled, Date	F 689		

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Initiated [redacted].
[redacted] management adjustment, Date Initiated 02/20/23.
A review of the [redacted] Risk Assessment dated [redacted] 13:30 [1:30 PM] revealed that Resident #23 was assessed as a [redacted] Risk, Resident #23 received a score of [redacted] indicative of a [redacted] risk.

On 05/24/23 at 11:00 AM, the surveyor requested all investigations for Resident #23.

On 05/24/23 at 12:10 PM, the surveyor, again reviewed the electronic medical record. There was no documentation regarding the [redacted] occurred on [redacted].

On 05/24/23 at 1:30 PM, the surveyor reviewed the [redacted] There was no revision made to the CP, including additional interventions added, after Resident #23 sustained a [redacted] on [redacted]

On 05/25/23 at 8:30 AM, the surveyor went to [redacted]-Wing and observed that Resident #23 was no longer in the room. The bed was stripped, and the mattress had been deflated.

On 05/25/23 at 9:10 AM, the LPN assigned to the [redacted]-Wing, informed the surveyor that Resident #23 was transferred on [redacted] to another facility that was owned by the same company. The LPN could not offer any details as to why Resident #23 was transferred the prior evening.

On 05/25/23 at 9:49 AM, the surveyor reviewed the electronic progress notes. There was no documentation in the medical record regarding Resident #23's transfer. When interviewed, the

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staff would not comment on who authorized or any reason for the transfer. There was no physician order for the transfer.

At that time, the surveyor attempted to contact Resident #23's physician and the responsible party. Messages were left for both, and neither returned the surveyor's phone calls.

The surveyor again, reviewed the electronic progress notes and noted the following entry dated [redacted] timed 21:37 [9:37 PM]:
"This note is a follow up to: [redacted] 7:39:00 Nursing Progress Note (Other) Focus: Effective Date: [redacted], 21:10:00 [9:00 PM] Department: Nursing, Position: registered nurse, Created Date: [redacted] 21:37:06 [9:37 PM], Note Text: On [redacted] at 7:39 AM, "CNA advised me that res [resident] [redacted] in [his/her] room. Upon arrival to res [resident] room, I observed res [resident] lying in bed. Res [resident] observed [redacted]. "[redacted] applied. Assessment and [redacted] assessment done to evaluate [redacted]) check complete. Res [resident] was [redacted], [redacted] Vital signs were taken (BP) blood pressure: [redacted] Pulse [redacted] Temp (temperature): 9[redacted] Respirations 1[redacted] Unable [redacted]) [redacted] "911 was called for immediate attention" and MD was notified. No family listed. EMTs (Emergency Medical Transport) transferred res [resident] to [hospital name redacted] for further observation of the resident. Onboarding nurse made aware.

On 05/25/23 at 10:15 AM, the surveyor again requested any investigations for Resident #23

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from the Director of Nursing (DON), including any statements that were obtained from staff that worked on [redacted] for the 11:00 PM-07:00 AM shift [when fall occurred]. The investigation, nor any supporting documentation was provided.

On 05/26/23 at 11:15 AM, the DON provided [redacted] documents dated, [redacted] respectively. There were no statements attached to either document or that had been requested by the surveyor.

There were no statements attached to the [redacted]" documents to inform the reader who had witnessed the [redacted] The causal factor/s were not identified. A note entered on the [redacted] document dated [redacted] days after the [redacted], indicated the following: "Resident was found on the floor. When asked as to what happened, he stated, "I was trying to leave." On assessment c/o[complain] of [redacted] MD [Medical Doctor] notified and ordered [redacted]. Resident was medicated for [redacted] and assessed every shift while waiting for the [redacted] to be done. [redacted] was placed at bedside. To continue current at-risk care plan. Resident #23 was transferred to the Emergency Department on [redacted] at 10:50 AM due to complaint [redacted] Resident #23 was diagnosed with a [redacted]

The [redacted] document dated [redacted]3 timed 18:40 PM [6:40 PM], did not provide information regarding when Resident #23 was last observed and cared for and by whom. The [redacted] document did not include, and documentation in the "Other" section including if the bed was in low or high position, if the resident was in bed or in a

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F 689	Continued From page 76 wheelchair when found on the floor, if the call light was activated, if the resident was [redacted] the presence of absence of any devices that would alert the staff of the fall. The Predisposing Situation Factors section had "History of [redacted] [redacted] as the only checked area. "Other. Alarm Sounded, Call Light on at Time, Reaching for Something, Wanderer, Attempted Self Toileting" was left blank. The [redacted] was unwitnessed. The revised care plan for [redacted] dated [redacted]3 failed to address the line of supervision required by Resident #23 to prevent recurrence. Another [redacted] document dated [redacted] timed 07:21 AM, revealed the following notes entered by the LPN (Licensed Practical Nurse) on duty that night: "CNA notified nurse that resident [redacted] while attempting to change [him/her]. Resident [redacted] his/her] [redacted] on the floor just missing the floor mat and was [redacted] The Registered Nurse (RN) who went to the room to assess the resident, documented the following on the "[redacted]" document: "CNA notified nurse that resident fell when attempting to change [him/her]. Resident [redacted] [his/her] [redacted] on the floor just missing the mat and was [redacted]sely." IDT Interdisciplinary Team discussed resident upon return from ER [emergency room] and [resident] will be treated with [redacted] per MD order, family also requested [redacted] services. On 05/25/23 at 11:00 AM, the surveyor reviewed the assignment sheet dated 05/21/23 provided by the 07:00-3:00 PM shift which revealed that a Hospitality Aide (HA) was assigned to the [redacted] Wing and cared for Resident #23 on the 11:00-PM-7:00 AM shift. The facility did not have a statement from the staff who cared for Resident #23 on the	F 689		

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F 689	Continued From page 77 11:00 PM-07:00 AM shift on [redacted] according to the assignment sheet provided. On 05/30/23 at 10:30 AM, the DON provided a witness statement dated [redacted] which was not attached to the [redacted] document dated 05/21/23. According to the CNA's statement, she was assigned to Resident #23 during the 11:00 PM-7:00 AM shift, not the HA per the original assignment sheet as provided to the surveyor. On 05/30/23 at 11:00 AM, the facility provided a copy of a revised CP that included [redacted] pages, with additional interventions added that were not included on the CP that was revised on [redacted], and documented the following: Focus: "[Resident #23] had a [redacted] was found lying on the floor in [his/her] room." [redacted] "Resident [redacted] during care when [he/she] was turned to the side of the bed, it happened so fast, staff unable to prevent fall", Date Revised: [redacted] The Goal was to "Risks for falls will be mitigated", Date Initiated: [redacted], Date Revised: [redacted] and Target Date: [redacted] The following interventions were documented: [redacted] assist during care, Date Initiated [redacted]. 911 Was called and sent to hospital for evaluation, Date Initiated [redacted] [redacted] Initiated, Date Initiated [redacted] [redacted], Date Initiated [redacted] Complete assessment with [redacted] [redacted], Date Initiated [redacted]. [redacted] check Initiated, Date Initiated [redacted]; [redacted] check x [redacted] hours, Date Initiated [redacted] [redacted] applied, Date Initiated [redacted] Primary physician made aware of the event, Date	F 689		

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F 689	Continued From page 78 Initiated [redacted] Resident returned to the facility with [redacted] dose and [redacted], Date Initiated [redacted]. On 05/30/23 at 11:30 AM, an interview with an additional CNA who worked the 07:00-3:00 PM shift on [redacted] on the [redacted]-wing and who was listed on the assignment sheet for the same day, confirmed that the CNA who documented the statement did not provide care for Resident #23 on [redacted] on the 11:00 PM-07:00 AM shift. The CNA confirmed that the HA provided care to Resident #23 when the incident occurred. On 06/01/23 at 09:35 AM, the surveyor conducted a telephone interview with the Registered Nurse who worked on the 11:00 PM-07:00 AM shift on [redacted]. The RN revealed that she was informed around 06:45 AM by the HA, that the resident sustained a [redacted]. She went to the room and observed the resident was in bed and was [redacted] from the [redacted], the resident reported [redacted] and was [redacted]. The RN stated she then applied a [redacted] dressing, assessed the resident, implemented a [redacted] [redacted], and called 911. Upon inquiry, the RN stated that the CNA who documented the statement was not assigned to Resident #23. In the presence of three other surveyors and the supervisor of the survey team, the RN stated that the HA was assigned to the resident. The RN further stated that when she questioned the HA regarding the mat that was to be in place to minimize injuries from [redacted], the HA changed his story several times. The RN also stated that she discussed the incident with the DON. The RN stated she did not know who transferred the resident back to bed after the resident was found on the floor. She further stated that she was	F 689		

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made aware "only two days ago" that the staff who cared for Resident #23 on [redacted] during the 11:00 PM-07:00 AM shift, was a HA and was not a Certified Nurse Aide (staff trained to assist with certain non-resident care tasks).

On 06/01/23 at 11:30 AM, the survey team informed the DON that the CNA who signed the witness statement, per interview and review of the timecard, was not assigned to the 11:00 PM shift on 05/21/23. The DON stated that she was told that the CNA reported that Resident #23 [redacted] during care, "she was not aware that Resident #23 was found on the floor by the Hospitality Aide." The DON was unable to explain why the HA was documented on the assignment sheets as having a resident assignment and was assigned to provide direct care to Resident #23.

On 06/01/23 at 12:25 PM, the surveyor in the presence of the survey team, interviewed the CNA who signed the witness statement dated [redacted]. The CNA stated that she was the CNA assigned to Resident #23 when the incident occurred, although her name was not listed on the schedule as being assigned to Resident #23 and contradicted the RN and LPN interviews. She stated during care Resident #23 [redacted] missed the mat and she yelled for help. The nurse then came into the room, assessed the resident on the floor and assisted her in transferring the resident to bed with a pulled sheet.

On 06/01/23 at 12:30 PM, a review of the CNA's timecard provided by the Staffing Coordinator, revealed that the CNA who signed the witness statement worked [redacted] hours on [redacted] and reported to work on [redacted] at 07:02 AM. The CNA was not at the facility when Resident #23

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sustained the [redacted]

On 06/01/23 at 12:41 PM, the surveyor interviewed the Director of Nursing regarding the HA job description and inquired about who was responsible to monitor the HA. The facility had [redacted] Hospitality Aides assigned to the facility. The DON replied that the HAs had been working at the facility before she accepted the position as a DON, and she was not too sure of who was responsible to supervise or monitor the HAs. The DON then stated the nurses were responsible to monitor the HAs

A review of the job description for the HA provided by the facility on 06/01/23 at 12:15 PM, revealed under "Duties"

Report all pertinent information concerning resident care as directed to the appropriate supervisor/ personnel.
Transport residents to activities, therapy, outside to smoke.
Make beds, distributes linen as needed, and transports dirty linen to the linen room using established standards precautions.
Distributes and sets up food trays for residents during meal times and collects empty trays from resident rooms and dining rooms. Monitor dining areas as assigned. Passes water pitchers
Complete assignments timely, completely, and accurately.
Conduct resident rounds as assigned.
Answer call lights and obtain assigned staff members if direct patient care is needed. Cannot do any clinical care.

On 06/02/23 at 09:53 AM, a telephone interview with the HA revealed that he worked the 11:00

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PM -07:00 AM shift on [redacted]. He stated that around 06:00 AM he went to the room to distribute linen and confirmed that he found Resident #23 on the [redacted] (not the CNA as documented on the statement) and then he informed the nurse. The HA stated that he discussed the incident briefly with the DON on [redacted] and was not asked to document a statement. The surveyor then inquired regarding his name being on the schedule with a full assignment, he could not provide the rationale why he had a resident assignment. He stated that his job was to assist with task not related to direct care such as passing water, make beds, distribute linen.

On 06/02/23 at 10:07 AM a telephone interview was conducted with the LPN who worked the 11:00 PM-07:00 AM shift. The LPN confirmed she worked on [redacted] and the HA was the person who reported the fall. The LPN continued and stated, that the RN went into Resident #23's room and assessed the resident after the [redacted] The LPN stated she did not go to the room, and she assisted with the paperwork for the emergent transfer. The LPN was unaware of who transferred the resident to bed. The LPN confirmed that the HA was the one assigned to and provided care for Resident #23 on the 11:00 PM-07:00 AM shift on [redacted].

On 06/02/23 at 10:16 AM, during a second telephone interview with the RN, she stated that the HA had a resident assignment that day, and he cared for Resident #23 and confirmed that he was the one that reported the [redacted]. The RN went on to state that when she entered the room, Resident #23 was already in bed and [redacted] [redacted] She did not ask who transferred the

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resident to bed. She was aware of the process to follow: Assessed while on the floor, ensure no [redacted], implement [redacted], alerted EMT (Emergency Medical Transport), notify the physician. She further stated that she discussed the fall with the DON.

The surveyor reviewed Resident #23's ADLs worksheet for the month of May, left blank and there was no staff initials documented to identify who cared for Resident #23 on [redacted] during any of the shifts.

On 06/02/23 at 11:15 AM, the DON was made aware of the discrepancy surrounding the [redacted] dated [redacted] The DON was made aware of the telephone conversations with the nurses and the HA who worked the 11:00 PM-07:00 AM shift on [redacted] The DON stated that she was told that Resident #23 [redacted] during care. The DON further stated since the resident was found on the floor, she considered the incident as a [redacted] and did not investigate any further. The DON was asked to provide any additional information along with any Interdisciplinary Team Notes regarding the [redacted] document dated [redacted] for review on the exit day.

On 06/05/23 at 11:34 AM, in the presence of the acting Administrator, the DON stated she "went along with the information that was provided to her" that Resident #23 [redacted] during care, and that "the [redacted] a witnessed [redacted] and she did not investigate."

The facility did not present any further information.

A review of a form titled, "Accidents and

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F 689	Continued From page 83 Incidents-Investigation and Reporting" dated 11/15/22, indicated the following: Policy Statement: 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of accidents or incidents as appropriate. 2. The following data, as applicable shall be included on the Report of Incident/Accident form: The date and the time the accident or incident took place. The nature of the injury /illness. The circumstances surrounding the accident/incident if known. Where the accident/incident took place if known. The name (s) of witnesses if any and their accounts of the incident or accident if known. The injured person's account of the accident/incident if able to communicate. Other pertinent data as necessary or required ... 3. The Nurse Supervisor/ Charge Nurse and /or the department director or supervisor shall complete a Report of Incident/Accident form and get witness statements if any at the time of the incident. This individual will submit completed documents to the Director of Nursing Services /designee and discuss the incident at the morning management meeting. Post Fall/ Injury Resident Management In the event a resident has [redacted] and/ or is found on the ground, a complete head to toe assessment must be performed prior to moving the resident unless life-threatening safety concerns are present (fire, highway etc.) Remain with the resident while calling for assistance. If able, ask the resident to explain what happened	F 689		

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and what they were attempting to do at the time of the [redacted] (helpful for root cause analysis later).
Upon arrival of the nurse, a quick head- to-toe scan will be performed without unnecessary movement, palpating and examining all areas for breaks in the skin and/or other abnormal findings.
[redacted]
1. Assess the resident/ patient and immediately implement appropriate measures to prevent injury.
Initiate and complete the Incident including pertinent witness statements. Review [redacted] Risk Assessment for any changes in [redacted] risk, reassess [redacted]

On 06/05/23 at 08:35 AM, the acting administrator provided a folder with in-services that were done regarding some of the concerns addressed with the facility on 06/02/23 during a pre-exit conference. Regarding the incident of [redacted] the acting administrator submitted a witness statement from a CNA that was not on the schedule. No statement from the nurses who worked that night were collected even when the facility was made aware of the discrepancy and the telephone interviews with staff that worked on 11:00 PM -07:00 AM shift.

The Acting Administrator also submitted an undated form titled, "[redacted] Risk Management". Under Policy Statement the following were entered:
Based on previous evaluations and current data, staff will identify interventions related to the resident's specific [redacted] risks and causes to try to prevent the resident from [redacted] and to try to minimize complications from [redacted]
Under procedure #7
"Falls are discussed at the clinical meeting in an

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F 689	Continued From page 85 attempt to determine the root cause(s). Review the fall, each morning and document in PCC (Point Click Care . However Resident 23 sustained a [redacted]. The facility did not submit the IDCP notes along with any root cause analysis that was done to identify the causal factor of the [redacted] and rule out abuse. (Resident #23 was transferred from the floor to the bed prior to the nurse arrival to the room. There was no facility information provided regarding the transfer that occurred on [redacted] when the resident was found in bed, [redacted] [redacted], and required 2 persons physical assist for transfer.) NJAC 8:39-27.1 (a)	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		6/23/23

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§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
This is a repeat deficiency from the Standard Survey Date: 03/31/22

Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to identify and consistently comprehensively assess, implement, and modify interventions, consistent with professional standards of practice a.) in response to an unplanned significant [redacted] of [redacted] in less than 6 months for (Resident #128), and b.) in response to a significant [redacted] of [redacted] pounds (lbs) in [redacted] days for (Resident #51). This deficient practice occurred for 2 of 5 residents reviewed for nutrition.

The deficient practice was evidenced by the following:

Reference: The Academy of Nutrition and Deititians, "Position of the Academy of Nutrition and Dietitianss: Individualized Nutrition Approaches for Older Adults: Long-Term Care, Post-Acute Care, and Other Settings", dated April 2018. Position Statement "It is the position of the Academy of Nutrition and Dietitians that the quality of life and nutritional status of older adults in long-term care, post-acute care, and other settings can be enhanced by individualized nutrition approaches. The Academy advocates that as part of the interprofessional team, registered Dietitian nutritionist assess, evaluate, and recommend appropriate nutrition

ELEMENT ONE: CORRECTIVE ACTION:
Resident # 128 was interviewed, and his menu options and choices were reviewed to residents satisfaction.
Resident #128 re-assessed for [redacted] [redacted] and adjusted weight plan as well as updated care plan.
Food Service Director completed an audit on all the thermometers and the foods' temperatures to ensure they are at the right temperature.

The Interdisciplinary Care Plan Team will meet weekly to review 20 charts and care plans for all residents in house to reflect all issues/concern/problems/likes or dislikes until all charts have been audited. Thereafter Interdisciplinary Care Plan Team, will maintain quarterly review and adjust /update care plans as necessary.
Resident #51 was re-assessed for [redacted] [redacted] interventions in place reassessed and adjusted as needed.
The Minimum Data set for resident #51 was corrected and resubmitted.
Physician for resident #51 was made aware of resident [redacted].
Care plan for resident # 51 was updated.

ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:
All residents have the potential to be affected.

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interventions according to each individual's medical condition, desires, and rights to make health care choices. Nutrition and dietetic technicians, registered assist registered Dietitian nutritionists in the implementation of individualized nutrition care."

a.) On 05/24/23 at 10:30 AM, Surveyor #1 observed Resident #128 as he/she attended the Resident Council Meeting (RCM). During the RCM, Resident #128 stated the food was "inedible" and that he/she had lost weight. Resident #128 stated that "everything is mushy because it was steamed like the vegetables. I've eaten very few veggies (vegetables), too overdone." Resident #128 stated that he/she had spoken to the Dietitian "twice" and provided food preferences and that the Dietitian informed him/her that the vegetables were frozen and steamed. Resident #128 stated he/she would be "happy with one piece of celery and a carrot, just fresh" and that also the fruit was all canned and served at room temperature, not cold. Resident #128 stated that he/she was also informed by the Dietitian that "whole grains never going to happen". Resident #128 further stated that the "protein is inedible".

All six residents who attended RCM acknowledged that they were not offered an alternative menu such as the Asian menu provided to the Asian population of residents.

A review of Resident #128's Admission Record (an admission summary), revealed the resident was admitted on [redacted] with diagnoses which included but were not limited to; [redacted],

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Director of Nursing/Designee completed a 3-month weight audit on all residents. On residents noted with a significant [redacted] [redacted] a Root cause analysis was completed, and issues were addressed if applicable.

ELEMENT THREE: SYSTEMIC CHANGES:
Food Service Director/Designee educated the kitchen staff/Cook on how to make the food more palatable and tastier.
Resident food committee was formed and meets monthly to discuss menu/likes/dislikes, and diversity of food.
Residents were re-educated about the alternate menu and choices available for every meal.
New thermometers were ordered for the kitchen.
Regional director of nursing in serviced Interdisciplinary Care Plan Team on chart auditing, quarterly assessments, and care planning/updating care plan.
The Interdisciplinary Care Plan Team will meet weekly to review 20 resident charts and care plans for all residents in house to reflect all issues/concern/problems/likes or dislikes until all charts have been audited.
Thereafter Interdisciplinary Care Team will maintain quarterly review and adjust /update care plans as necessary.
The Contracted qualified Register Dietician is assessing residents for likes and dislikes, ensuring /assisting in ensuring every reasonable attempt to get residents likes as a food option, assessing residents' dietary needs within 72 hours of

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A review of the facility provided, and Vitals Summary", dated , revealed the following dates :

01/31/23 0 lbs (pounds)
02/01/23 ht lbs
02/08/23 lbs
02/13/23 lbs " change [comparison t 01/31/23, lbs, - lbs]
02/20/23 weight lbs "- change [comparison weight 01/31/23, lbs, lbs]
02/22/23 weight lbs change [comparison 01/31/23, lbs, lbs]
03/06/23 lbs " change [comparison 02/01/23, lbs, , lbs]; change [comparison 01/31/23, lbs, - lbs]
04/08/23 weight lbs
04/17/23 weight lbs
04/24/23 weight lbs
05/01/23 weight lbs
05/08/23 weight lbs.

There were no further documented follow up or re- the electronic medical record (eMR).

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admission, documenting, and updating care plan as needed.
Director of Nursing/Designee educated certified nurse's aides on weighing residents.
The weight management policy was reviewed with staff and staff reeducated on same.
The Director of nursing , the contracted qualified register Dietician and Unit managers meet weekly to discuss and review all resident with significant weight changes with plans of care updated as needed.

ELEMENT FOUR: QUALITY ASSURANCE:
Social Services Director/Minimum data set Coordinator/Designee will complete an audit of 5 charts per unit to ensure care plans are updated and Interdisciplinary care plan team completing, weekly x4, monthly x4 then quarterly thereafter. The needed corrections will be addressed as they are discovered. Audit Results to be reported monthly times 4 then quarterly thereafter to Quality assurance performance improvement team for review and revision as necessary.

Administrator/Designee will check the temperatures of the food daily X14 days, twice weekly X 4 weeks, and then monthly thereafter.
In addition, the administrator/Designee will check the Quality/presentation of the food daily X14 days, twice weekly X 4 weeks, and then monthly thereafter.

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F 692	Continued From page 89 A review of the Assessment section in the eMR did not reveal any nutritional assessments. A review of the Progress Notes (PN) in the eMR ranging from revealed the following: Admission notes revealed weight lbs. , the Physician's history and physical revealed a weight of lbs. a Physician's note indicated a weight of lbs. days after admission, the first dietary note, indicated review of weights upon admission. The note included 'does not consume all vegetables in facility limiting intake of vitamins and minerals' 'resident educated ...possibility of MVI (multivitamin) with mineral supplement' 'resident request [name redacted - supplement drink]' The note indicated a different supplement drink was requested by Dietitian. "Food preferences reviewed and noted". There was no calculation of estimated protein or calorie needs, and determination of causal factor for the unplanned , a nursing note indicated the resident was seen by the and recommendations were made for periodonta . , a Physician's note indicated a weight of lbs. , a Physician's note indicated a weight of a Physician's note indicated a weight of lbs 5 (on admission weight lbs. "progressive from lbs to lbs-will sch (schedule) f/u (follow up) work to indicate over a	F 692	Administrator/Designee will check with 5 random residents per unit on how their food is, including presentation, taste and consistent with residents wishes, daily X14 days, twice weekly X 4 weeks, and then monthly thereafter Qualified register Dietician/designee will run a report monthly to continue monitoring of resident's t with follow-up actions as needed	

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month period), , monitor po (intake by mouth) intake, dietary eval (evaluation), consider dietary supplement and Remeron (medication used for appetite stimulation).

The Progress Notes did not contain any additional notes from the Dietitian, any assessment to determine the causal factor of the and interventions to prevent . The PN dated , by the Physician did not indicate that a plan was ordered.

A review of the facility provided, "Order Summary Report" (OSR), dated active orders as of , included but was not limited to; an order dated for (et regular texture, thin consistency, for diet), and an order dated for [name redacted] liquid supplement two times a day for supplement. An order dated with no end date for a ( ).

There were no active orders for the the follow up blood work, po intake monitoring, or dietary evaluation requested by the physician on . There were no active orders for a planned loss.

A review of the person-centered comprehensive Care Plan last review completed , with a print date of , revealed no focus area regarding Resident #128's significant no Goals regarding the , and no interventions regarding the .

A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool used to

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facilitate the management of care dated [redacted], included but was not limited to; a Brief Interview for Mental Status (BIMS) of [redacted]; which indicated the resident was [redacted]. [redacted] indicated a height of [redacted] and a weight of [redacted]s of 5% or more in the last month or loss of 10% or more in last 6 months" was inaccurately documented as "0" "NO".

On 05/30/23 at 12:17 PM, during an interview with the surveyors, the Licensed Nursing Home Administrator (LNHA) informed the survey team that the Dietitian was on vacation and unavailable for interview. The LNHA further stated she "would have to see who is covering" and that she was unable to locate the Dietitians credentials.

On 05/30/23 at 12:22 PM, the LNHA stated that the Dietitian was only gone for one week, so the facility did not need coverage. She also stated that the practice is the Dietitian would document in the eMR and that the Director of Nursing (DON) would confer with the Dietitian.

On 05/30/23 at 1:29 PM, during an interview with the surveyors, the DON stated she worked with the Dietitian and that every Monday weights and reweighs would be completed. On Thursday they would have a weekly weight meeting and discuss significant weight changes and interventions. She stated the Dietitian would make recommendations for the nurses to carry over. The DON stated, "we discuss what could have caused the weight change, any supplements that may be needed, review what might be appropriate, speak to dietary to see that orders were carried out, monitor weights, we assign a specific Certified Nursing Aide (CNA) to do the

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F 692	Continued From page 92 weights. We have to investigate what's wrong with the weights like maybe a different wheelchair was used, and we notify the doctor for orders." The DON stated that the Dietitian would ask about food preferences and that "some residents ask for organic food, but we can't accommodate organic for just one and we would have to tell resident." The DON stated that the weekly weights were documented in a log and the Dietitian would document them in the eMR as well. The surveyor inquired what would happen if a CNA obtains a resident weight and there was a ██ lbs difference, what would be the process. The DON stated that the CNA assigned should know to re-weigh the resident. The DON stated the Dietitian went on vacation ████ and was expected to return 6/8/23 (15 days later) and that the DON had only been with the facility for 3 months but the Dietitian was at the facility much longer. The DON stated she would provide the weight meeting information regarding Resident #128. On 05/31/23 at 12:11 PM, Surveyor #1 observed Resident #128 in his/her room with their lunch tray on top of the over bed table. Resident #128 showed the surveyor that he/she only ate a chicken thigh and not the mashed potatoes or carrots. Resident #128 stated he/she had talked to Dietitian about fresh versus canned vegetables. Resident #128 stated he/she usually only drinks the supplement drink once a day not twice. He/she further stated the Dietitian knew about the weight loss and that he/she wanted to lose some weight "but not because of (facility) food choices." Resident #128 stated "I just want better food choices." On 05/31/23 at 1:00 PM, the Regional	F 692		

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F 692	Continued From page 93 Administrator #2, the DON, and the Regional Vice President of clinical services (RVPCS) were made aware of the above concerns. On 06/02/23 at 9:00 AM, the DON provided four photocopied untitiled pages. The DON indicated the pages were the [redacted] Meeting notes. The pages included, but were not limited to Resident #128's name and the following information [redacted] weight [redacted] # (pounds); [redacted] weight [redacted] #; DO: (doctor order) [redacted] WW (weekly weights) x 4; and [redacted] WW x 3. Page 2 added [redacted] weight [redacted] #; [redacted] weight [redacted] #; and [redacted] WW x 2. Page 3 added [redacted] weight [redacted] #, [redacted] weight [redacted] [redacted] weight [redacted] #; [redacted] WW x 1, [redacted] 23 WW x 4 due to monthly weight loss, and [redacted] WW x 1 since weight stable. Page 4 added [redacted] weight [redacted] #; [redacted] weight [redacted] #; [redacted] weight [redacted] #; 5/8/23 weight [redacted] #; and [redacted] WW x 4; [redacted] WW x [redacted] WW x [redacted] WW x 1; and [redacted] monitor weights monthly. There was no documentation by the physician regarding a planned [redacted], any discussion of a [redacted] plan with the resident or interventions ordered. On 06/02/23 at 10:40 AM, the RVPCS stated that the [redacted] were "worksheets", and they can't go by those [redacted] She stated that on Sunday the Dietitian would review Thursday's weights, and Tuesday she would review Thursday weights. The RVPCS further stated the weights would be in the [redacted] meeting book and if a resident were being monitored for [redacted], that would also be in the eMR. She stated any interventions or orders would be implemented immediately.	F 692		

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F 692	Continued From page 94 A review of the weights revealed that on [redacted], the resident weighed [redacted] lbs. On [redacted], the resident weighed [redacted] pounds which was a -[redacted] loss in less than [redacted] months. The facility was unable to explain the discrepancies in the weights documented in the eMR versus the [redacted] meeting logs; to provide documented evidence that interventions were revised in response to the significant [redacted]; to provide any additional documentation of the [redacted] by the Dietitian; to provide a Dietitian assessments, food preference list; or any person-centered comprehensive care plan of focus area, goals, or interventions for Resident #128's significant [redacted] b.) On 05/22/23 at 10:25 AM, Surveyor #1 observed Resident #51 lying in bed with just a sheet on. Resident #51 appeared very thin, and the surveyor was able to observe [redacted] under areas of his/her [redacted]. On 05/23/23 at 12:36 PM, Surveyor #1 observed Resident #51 in a [redacted] wheelchair in the [redacted]-unit day room. The resident had a lunch tray with beef macaroni casserole and carrots. The resident was drinking his/her juice but not eating the casserole. On 05/23/23 at 12:45 PM, the Licensed Practical Nurse (LPN) was encouraging Resident #51 to eat but the resident refused. The LPN asked if the resident wanted a peanut butter and jelly sandwich, and the resident nodded his/her head yes. During an interview at that time, the LPN stated the resident likes peanut butter and jelly and would usually eat all of the breakfast meal. The	F 692		

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LPN stated that the facility Dietitian would be the one in charge of the resident's [redacted] if any.

A review of the facility provided, [redacted] and Vitals", dated [redacted], revealed the following:

[redacted] a weight of [redacted] lbs.
[redacted] a weight of [redacted] lbs. (recorded by the Dietitian); [redacted] change [comparison weight [redacted], [redacted] lbs., -[redacted] lbs.] and -[redacted] change [comparison weight [redacted] lbs., [redacted] lbs.]
[redacted] a weight of [redacted] lbs. (recorded by the Dietitian); -[redacted] change [comparison weight [redacted] lbs., [redacted] lbs.] and [redacted] change [comparison weight [redacted] lbs., [redacted] lbs.]

A review of Resident #51's Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted]

A review of the most recent Annual MDS dated [redacted], included but was not limited to a BIMS of [redacted], which indicated the resident was [redacted]. [redacted], Functional Status, revealed Resident #51 required limited assistance with a one-person physical assist for eating. [redacted], [redacted] Status, revealed the resident weight as [redacted] lbs. and a score of "0" "NO" for weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months.

A review of the PN for Resident #51 date range

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revealed a nursing entry on , that the resident's weight was lbs. The next entry was dated , by Social Services and did not address the resident's weight. The next entry was dated , by nursing and did not address the resident's weight. There were no progress notes to indicate the Dietitian evaluated the resident or that the physician was notified of the resident's t

A review of Resident #51's person-centered comprehensive care plan printed included but was not limited to a focus area of nutritional problem related to index (BMI) date initiated . Interventions date initiated , included monitor/record/report to MD (physician) PRN (as needed) signs / symptoms of lbs. in week,) in 1 month, in months, in months. There was no evidence in the eMR that the physician was notified of the of lbs. in

On 05/30/23 at 12:17 PM, during an interview with surveyors, the LNHA stated she would have to see who was covering for the Dietitian who was on vacation from 0 and to return on The facility Dietitian was unavailable for interview.

On 05/30/23 at 1:29 PM, during an interview with the surveyors, the DON stated the weekly weight documented in a log and the Dietitian would document the weights in the eMR. Surveyor #1 requested the meeting notes.

On 05/31/23 at 10:07 AM, the DON stated that

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she was still "looking for the [redacted] meeting information." The DON acknowledged she could not locate any documentation to immediately address the [redacted] lbs. [redacted] in [redacted] days and stated she did not know why Resident #51 was not reweighed.

On 05/31/23 at 11:10 AM, the DON provided an untitled paper and stated it was the [redacted] meeting notes with resident names. Resident #51's name was included. The paper included monthly weight difference [redacted] days [redacted] months; monthly weight [redacted] weight [redacted], [redacted] weight [redacted]#, [redacted] weight [redacted] Date weekly weight [redacted] weight [redacted] w/c (wheelchair), [redacted] weight [redacted]#, [redacted] weight [redacted]. Interventions included [redacted] [name redacted] supplement drink [redacted] times a day, [redacted] WW x [redacted] WW x 3, [redacted] WW x 2, [redacted] WW x 1, [redacted] monitor weights monthly. The interventions did not address the [redacted] in [redacted] days and the weights listed were either different or not documented in the eMR. There were no documented weights for [redacted] [redacted]

On 05/31/23 at 11:10 AM, the facility provided, "Nutritional Assessment-Quarterly", dated [redacted], which was reviewed and included but was not limited to; "current weight [redacted]. The assessment was signed by the Dietitian on [redacted]

The eMR did not include a documented weight of [redacted] lbs. The facility provided hand written, paper weight meeting notes which reflected a weight for [redacted] lbs.

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Surveyor #1 reviewed the weight logs on Resident #51's unit. An entry dated "weekly weights [redacted]" indicated Resident #51's weight was [redacted] lbs. An entry dated "[redacted] Monthly Weights" indicated Resident #51's weight as [redacted] lbs. An entry dated "Weekly weights [redacted]" indicated Resident #51's weight as [redacted] lbs. An entry dated "Weekly weights [redacted]" indicated Resident #51's weight as [redacted] lbs. An entry dated "Weekly weights [redacted]" indicated Resident #51's weight as [redacted] lbs. All of the entries were left blank in the area for staff to initial as having weighed the resident.

The [redacted] weight was not documented in the eMR. The [redacted] weight in the eMR was [redacted] lbs. and [redacted] lbs. The [redacted] weight was not documented in the eMR. The [redacted] weight was not documented in the eMR. The [redacted] weight in the logbook was [redacted] lbs. and the eMR had a documented weight of [redacted] lbs. indicating a [redacted] lb. discrepency.

On 06/01/23 at 10:05 AM, Surveyor #1 informed the facility of the weights which did not coincide with the eMR and Resident #51's [redacted] lbs. weight loss, and no documented reweigh or immediate interventions, as stated by the DON, upon discovery of a significant [redacted]. At that time, the facility was unable to provide additional information.

On 06/02/23 at 9:39 AM, during an interview with Surveyor #1, the LPN working on [redacted] Wing stated that if there was a large discrepancy in a resident's weight, the staff would first re-weigh the resident and then inform the DON and physician. Upon reviewing the weight on [redacted], the LPN stated that weight was entered by the Dietitian,

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and she would be the one responsible for comparing and reviewing the weights. The LPN further stated that if there was a re-weigh completed on [redacted], it would be located in the eMR. The LPN accessed the eMR in the presence of the surveyor and was unable to find a documented re-weigh for Resident #51.

On 06/02/23 at 10:40 PM, during an interview with the surveyor team, the RVPCS stated that the weight sheets were "worksheets" and you "can't go by those weights."

A review of the facility provided, "Dietitian" job description, reviewed 06/10/22, included but was not limited to; communicates with medical staff, nursing and other department personnel; must be able to relate information concerning a resident's condition; conduct nutrition assessments of patients referred by healthcare providers; maintains nutritional care plans, reviews medical records, documents findings; collects patient information and records patient information; effectively and efficiently completes all paperwork requirements for billing and medical records compliance; evaluates how patients respond to their diets; and works to ensure patient satisfaction.

A review of the facility provided, "Weight Assessment, Management and Intervention Procedure", undated, included but was not limited to Weight Assessment 1. The nursing staff will measure resident weight, weight will be placed in unit weight book for Dietitian review; 2. Any weight change of 3% or more since the last weight will be retaken for confirmation; 3. The Dietitian will respond within 24-72 hours of receipt of notification; 4. the threshold for significant

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F 692	Continued From page 100 unplanned and undesired weight loss will be based on: a. 1 month - 3% weight loss is significant; greater than 5% is severe; 6 months-10% weight loss is significant; greater than 10% is severe; 5. If the weight change is desirable, this will be documented. Analysis 1. The interdisciplinary team will identify conditions and medications that may be causing weight loss or increasing the risk of weight loss. 2. The Dietitian will discuss undesired weight gain with the resident and/or family; 3. A weight loss regimen should not be initiated for a cognitively capable resident without his/her approval and involvement. NJAC 8:39-17.1 (c); 17.2(d)	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure: (a) that a resident received supplemental [redacted] as prescribed by the physician, and (b) received the necessary [redacted] care and services for residents who received [redacted] treatment according to standards of practice for 2 of 3	F 695	ELEMENT ONE: CORRECTIVE ACTION: Resident #33 has [redacted] set per physician order. Medication variance report was initiated. Physician was notified of previous [redacted] [redacted] without new orders. The facility reinforced the procedure of	6/23/23

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residents reviewed (Resident #21 and Resident #33) for [redacted] care.

The deficient practice was evidenced by the following:

1.) On 05/22/23 at 11:00 AM, the surveyor observed Resident #33 in bed wearing a [redacted]. The surveyor observed that the [redacted] was connected to an [redacted] that was set to [redacted]. The resident stated that he/she was on [redacted] most of the time.

On 05/23/23 at 12:19 PM, the surveyor observed Resident #33 lying in bed with their eyes closed. The surveyor observed that the resident was wearing the [redacted] and that the [redacted] was set to [redacted]

On 5/24/23 at 8:41 AM, the surveyor observed Resident #33 lying in bed and was awake. The surveyor observed that the resident was wearing the [redacted] and that the [redacted] was set to [redacted] The resident stated that he/she was usually on [redacted]

According to the Admission Record, Resident #33 was admitted to the facility with diagnoses which included, but were not limited to, [redacted]

F 695

licensed nurses verifying resident respiratory equipment is set/administered per Physician orders at shift start. The facility also reinforced the procedure of licensed nurses verifying all administered [redacted] therapy is signed in Medication administration record /Treatment Administration Record as appropriate prior during administration.

ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:
All residents receiving [redacted] therapy have the potential to be affected.
An audit was performed 6/23/23 by the Director of nursing on all residents receiving [redacted] therapy to verify if [redacted] equipment was set per Physician orders. Residents not receiving [redacted] therapy per Physician orders were assessed with settings corrected to reflect Physician orders.
An audit was performed 6/23/23 by the Director of Nursing on all residents receiving [redacted] therapy to verify if their Medication administration record /Treatment Administration Record reflected administration of [redacted] per Physician orders. A medication variance was initiated including physician notification of any Medication administration record /Treatment Administration Record not reflecting oxygen administration per Physician orders.

ELEMENT THREE: SYSTEMIC CHANGES:
Director of Nursing/Designee re-educated

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F 695	Continued From page 102 Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated , indicated that Resident #33 had a Brief Interview for Mental Status score of , which indicated that the resident had . The MDS also revealed that Resident #33 had or when therapy, that they needed from two staff members to transfer (from the bed to a wheelchair) and did not walk in their room during the assessment window of the MDS. Review of the Physician's Order Form indicated that Resident #33 had an active physician order for) prn (as needed) for dated . Review of the Treatment Administration Record (TAR) and the Medication Administration Record (MAR) revealed that the nurses did not sign that n was administered to Resident #33 on , and During an interview with the surveyor on 05/24/23 at 8:57 AM, Resident #33's assigned Licensed Practical Nurse/Unit Manager (LPN UM #1), while reviewing Resident #33's physician orders, stated that the resident was supposed to be on The surveyor brought the LPN/UM #1 to Resident #33's room. The resident was wearing a that was connected to an . The surveyor asked the LPN/UM#1 what the resident's was set to? The LPN/UM#1 stated that the was set to	F 695	licensed nurses on the Therapy policy including ensuring residents equipment is set per Physician orders and ensuring the Medication administration record /Treatment Administration Record reflects administration of therapy. The facility adopted a procedure of ensuring each medication cart has an updated daily list of residents in that assignment who have physician orders for therapy. Each nurse is to verify that the is set per physician orders and that the residents Medication administration record /Treatment Administration Record reflects administration of therapy. ELEMENT FOUR: QUALITY ASSURANCE: The Director of Nursing/Designee will audit all residents receiving therapy weekly x 12 then quarterly thereafter to ensure equipment is set per physician's orders with immediate modifications as needed. The Director of Nursing/Designee will audit all residents receiving therapy weekly x 12 then quarterly thereafter to ensure resident's Medication administration record /Treatment Administration Record reflects reflect oxygen administration with medication variances initiated as needed. Audit results will be reported to the Quality assurance committee monthly x 3 then quarterly thereafter for review and recommendations	

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F 695	Continued From page 103 but should be set [redacted] as the physician ordered for [redacted]). The LPN/UM#1 added that when a resident was ordered [redacted] the nurse should check the physicians order and the TAR for the correct rate of [redacted], and during the nurse's rounds of the residents, the nurse should check that the [redacted] is set at the correct LPM as ordered. During an interview with the surveyor on 05/31/23 at 11:56 AM, in the presence of another surveyor and the facility's Vice President of Clinical Services (VPCS), the Director of Nursing (DON) stated that there should be a physician order for [redacted] and the nurses should follow the physician orders for [redacted]. When the nurses administer [redacted] whether prn (as needed) or [redacted], they should document in the resident's TAR. The VPCS added that sometimes the nurses would document that [redacted] was administered in the MAR. The DON further stated that the nurses should make sure that the correct [redacted] was set on the [redacted] when making their resident's rounds. The facility policy titled, [redacted] Therapy" with a reviewed date of 11/02/22, indicated "[redacted] is administered by licensed staff and with a physicians order." The Procedure section of the policy indicated to "Adjust the delivery device so that it is comfortable to the resident and the proper [redacted] is being administered." NJAC 8:39-27.1 (a)	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		6/23/23

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F 725	Continued From page 104 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to: a.) have a system in place to ensure that all nursing and related services were consistently provided for residents to maintain the highest practicable physical, mental, and psychosocial wellbeing for each resident, as determined by resident assessments, individual plans of care and in accordance with the facility assessment. This deficient practice	F 725	ELEMENT ONE: CORRECTIVE ACTION: Resident # 28 [redacted] were [redacted], and cleaned. Resident #35 was [redacted] and showered and nails cleaned and trim. Rooms [redacted] -wing- [redacted] and [redacted] were deep cleaned.	

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F 725	Continued From page 105 was observed on 1 of 3 nursing units and for 2 of 31 residents reviewed, (Resident #28, #35) for care. This deficient practice was evidenced by the following: Refer to F677 a) On 05/22/23 at 09:49 AM, Surveyor #2 toured the [redacted] Wing of the facility and observed Resident #28 lying in bed. Resident #28 appearred [redacted]. The [redacted] was rested on the blanket with [redacted] and [redacted] with a [redacted] the [redacted]. Resident #28 was [redacted]. At the surveyor's request, the resident was able to use the [redacted] to pull the cover and exposed the [redacted]. The [redacted] was [redacted], and the [redacted] were [redacted] with a [redacted] k [redacted] the [redacted] On 05/23/23 at 12:35 PM during a tour of the [redacted] Wing hallway, Surveyor #1 observed, in the presence of Surveyor #2, and while the lunch meals were being distributed, both surveyors smelled a [redacted] in the hallway outside of Room [redacted] Residents were observed eating meals in both Room [redacted] and the adjacent Room [redacted]. At that time, the Director of Nursing (DON) was in the hallway and Surveyor #1 asked the DON if she could smell anything and the DON stated she could not and walked away from the surveyors. On 05/23/23 at 12:36 PM, both surveyors interviewed the [redacted] Wing Registered Nurse (RN) if there were any noticeable odors. The RN stated yes "a little, like [redacted]". The RN stated, "it	F 725	Director of nursing/ Designee inservices and re educated certified nursing assistant on all units on grooming during Activities of daily living care and shower days. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected. Housekeeping Director/Designee completed facility wide audit of all rooms , and a facility wide deep cleaning, daily, weekly, monthly and as needed schedule and procedure were established. Director of Nursing/designee completed a facility wide review of resident s hygiene including appearance, [redacted], and residents wishes was completed. ELEMENT THREE: SYSTEMIC CHANGES: Director of Nursing/ Designee re-in-serviced Certified Nursing Assistant on assessing residents hygiene during care, including need for [redacted] [redacted]. Director of Nursing/ Designee re-in-serviced Certified Nursing Assistant on grooming during Activities of daily living care and shower days.	

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F 725	Continued From page 106 needs to be cleaned". On 05/23/23 12:42 PM, Surveyor #1 interviewed two unsampled residents who were eating at their bedside in Room [redacted] Both residents confirmed that the room was [redacted]. On 05/23/23 at 2:13 PM, Surveyor #2 observed Resident #28 in bed. Resident #28 was [redacted] were [redacted], and [redacted] with the [redacted] [redacted] the [redacted] On 05/24/23 at 10:27 AM, Surveyor #2 observed Resident #28 out of bed in the courtyard smoking. Resident #28 already received care and the [redacted] were in the same condition, long and jagged. When asked about the [redacted] and the [redacted] Resident #28 stated that he/she would like to be [redacted] Surveyor #2 reviewed Resident #28's Admission Face sheet which revealed that the resident was admitted to the facility with diagnoses which included but were not limited to, [redacted] Surveyor #2 reviewed the Quarterly Minimum Data Set (MDS) an assessment tool dated [redacted], which indicated that Resident #28 was totally dependent on staff for all activities of daily living (ADLs) and there was no rejection of care exhibited. Surveyor #2 reviewed the electronic progress notes from [redacted] through [redacted] and could not locate any documentation regarding personal care was offered and Resident #28 refused.	F 725	Housekeeping Director/designee inserviced staff on room cleaning schedules and procedures. ELEMENT FOUR: QUALITY ASSURANCE: Director of Nursing/designee will audit 3 residents per unit for hygiene 3 times per week for 2 weeks, then monthly thereafter Administrator/designee will conduct environmental rounds on each unit daily to ensure the units are clean and odorless. Administrator/designee will audit 5 residents random rooms on each unit daily x 14 days , twice weekly x 4 and monthly thereafter Needed corrections will be addressed as they are discovered. Audit Results to be reported monthly times x12 to Quality assurance performance improvement team for review and revision as necessary and quarterly thereafter.	

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Surveyor #2 reviewed the ADL worksheet (a form Certified Nursing Assistant's (CNAs) used to document the care provided) Resident #28 for the month of [redacted]. The document revealed that hygienic care was completed however, there was no specific entry for [redacted] and [redacted]

On 05/26/23 at 7:40 AM, Surveyor #2 observed Resident #28 in bed, [redacted] were [redacted] with [redacted] the [redacted].

During an interview with Surveyor #2 on 05/26/23 at 8:30 AM, the resident's assigned CNA acknowledged Resident #28 was dependent on staff for care. The CNA stated that she provided care to the resident this morning and she could not recall if the [redacted] needed to be [redacted]

During a second interview with Surveyor #2 on 05/31/23 at 11:48 AM, the same assigned CNA for Resident #28 revealed that the facility did not have a CNA care type card (a document specific to the individualized care that CNA's needed to provide residents). She further stated that [redacted] care was not listed on the ADL Worksheet and that she "usually" performed [redacted] and [redacted] on shower days.

During an interview with Surveyor #2 on 05/31/23 at 11:51 AM, another CNA confirmed that the CNAs do not have a care type card to follow for [redacted]. The CNA added that in the morning she received report from the nurse regarding resident care, and that the nurses did not address [redacted] care and shaving. The CNA further stated that [redacted] care were part of grooming and should be completed when

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were and it could be visibly observed that the resident needed . Surveyor #2 asked toe CNA what was the reason that care was not being completed for some residents and the CNA declined to comment.

Surveyor #2 reviewed the facility "Activities of Daily Living" policy, reviewed 11/22/22, revealed that a resident who cannot carry out ADLs will receive the necessary services to maintain grooming.

On 05/24/23 at 8:31 AM, Surveyor #3 observed Resident #35 in their room sitting in a wheelchair. Resident #35 reached towards Surveyor #1 and slightly the surveyor's . Surveyor #1 requested to see Resident #35's The surveyor observed that all on were of the had , and there was a .

On 05/25/23 at 8:53 AM, Surveyor #3 observed Resident #35 in the hallway in their wheelchair. The resident's s were still in the same condition. At that time, Resident #35 stated that he/she needed help to cut and clean his/her and would like his/her and cleaned.

On 05/25/23 at 9:10 AM, during an interview with Surveyor #3, the Certified Nursing Assistant (CNA) caring for Resident #35 stated that it was her responsibility to set up the resident to clean and wash him/herself. The surveyor asked about shaving and care. The CNA stated she "could not answer" that and that the resident "probably refused". When asked the process when a resident refuses care, the CNA stated she would

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let the nurse know. The CNA stated that there was only one place to document care and that was if a resident needed their cut and they had to call the Surveyor #3 and the CNA went to observe Resident #35's . The CNA stated, "to me yes they (the need to be done but only during shower days."

On 05/25/23 at 9:13 AM, during an interview with Surveyor #3, the Licensed Practical Nurse (LPN) caring for Resident #35 stated that if a resident refused care, the staff should wait and try to encourage the care later. She stated if the resident did not allow their to be cut, the staff should ask if they could file the resident's If the resident refuses, the staff need to let the nurse know so it could be documented. The nurse would let the doctor know. The LPN stated she was never informed that Resident #35 refused care.

Surveyor #3's review of Resident #35's Admission Record (an admission report) revealed that the resident had diagnoses which included but were not limited to .

Surveyor #3's review of Resident #35's most recent Quarterly Minimum Data Set (MDS) an assessment tool to facilitate care, dated included but was not limited to a Brief Interview for Mental Status (BIMS) of which indicated the resident had . Status indicated that the resident required supervision and set up help for personal hygiene.

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Surveyor #3"s review of the person-centered comprehensive care plan, printed on 05/30/23, included but was not limited to a focus area of ADL deficit, needing supervision/limited assistance with ADLs date initiated [redacted] and revised [redacted]. Interventions included bed bath daily and shower at least 2 x (times) a week.

Surveyor #3's review of the facility provided, "Order Summary Report", dated active orders as of [redacted] for Resident #35, included an order dated [redacted] for weekly skin checks on shower days Tuesdays and Fridays.

Surveyor #3's review of the facility provided, "IDCP (Interdisciplinary care plan) Team Care Conference", dated [redacted], included but was not limited to 2. B. Resident #35 requires [redacted] and direction with ADLs.

Surveyor #3's review of the facility provided Progress Notes (PN) ranging from [redacted] through [redacted], contained no documentation that Resident #35 had refused any ADL care.

Surveyor #3's review of the CNA Assignment for [redacted]-Wing dated [redacted]) and dated [redacted]), both indicated the same CNA on both days. The Assignment sheet further indicated [redacted] all residents, [redacted] [redacted] on shower days". The resident had not received [redacted] care during his/her shower on [redacted] [redacted] and there were no progress note to indicate any refusal of care.

A review of the New Jersey Department of Health (NJDOH) Certified Nurse Aide (CNA) Scope of Practice indicated that a Certified Nurse Aide

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F 725	Continued From page 111 shall provide care and assist residents with the following tasks related to the activities of daily living (ADL) only under the general supervision of a registered nurse. (a) Tasks associated with personal care included but were not limited to, Grooming, Shaving, and Caring for the nails. The facility provided, "Facility Assessment Tool", reviewed 10/2022, indicated to provide appropriate training/education and adequate staffing to meet its residents' daily needs, preferences, and routines to help each resident attain or maintain the highest practicable physical, mental, and social well-being. In the section titled, "Staffing Plan," 3.2. The overall number of qualified staff provided to meet each resident's needs does not fall below the minimum daily average required by state law for direct care and services per resident per day. NJAC 8:39-5.1 (a)	F 725		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review it was determined that the facility failed to ensure each resident was provided with meals that were palatable, met specific preferences related to their clinical condition and were offered alternate meal options, including options that the	F 800	Element One: Corrective Action: Resident # 49 was interviewed regarding their likes and dislikes of food and updates were made to resident s dietary tray ticket.	6/23/23

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facility only provided to a subset of the resident population. The deficient practice occurred for 6 of 6 residents who attended a resident council meeting, for 1 of 3 residents reviewed for food (Resident #49) and was evidenced by the following:

Refer to 692G

On 05/23/23 at 2:23 PM, a copy of a three week menu cycle was provided by the Licensed Nursing Home Administrator LNHA and signed by [Name] "Dietitian", and an unsigned two week [Asian] menu cycle.

On 05/24/23 at 10:30 AM, the surveyor conducted a resident council meeting with six residents. The residents were asked about the meals and residents stated to the surveyor the food "is inedible", "everything is mushy and the vegetables were over done", "you get whatever they offer you, and the only alternate is a grilled cheese". One resident stated the Dietitian informed him/her that "whole grains are never going to happen", and then stated mostly canned fruit instead of fresh and the canned fruit was not served cold. The residents were asked about the alternate [Asian] menu and 6/6 stated they were not offered those items. Six of six residents informed the surveyor that there was no food committee to discuss the menu or food concerns that were brought up by the resident council.

On 05/24/23 at 10:59 AM, the surveyor observed Resident #49 at the nurses cart outside of the resident's room. Resident #49 was using exploitive and telling the nurse about the poor quality of the food at the facility.

F 800

A monthly resident food committee was created to allow residents to have a voice in the menu planning and food service operations. It empowers them to provide input, make suggestions, and share their preferences, likes, and dislikes.

Element Two: Identification of at-Risk Residents:
All Residents have the potential to be affected.

All residents were audited/interviewed to identify their food likes, dislikes, and preferences. Updates were made to the residents tray tickets.

Element Three: Systemic Changes
The dietary department was educated on how to make the food more palatable and tastier.
Resident food committee was formed and meets monthly to discuss menu including adding more diverse items on menu

Residents were educated on the alternate menu and food choices available to them.

Element Four: Quality Assurance
To maintain and monitor ongoing compliance, the Administrator will check the Quality/Presentation of the food for fourteen days straight, weekly for four weeks, and then monthly thereafter.

In addition, the Administrator/Designee will audit five random residents per unit on how their food is, including presentation, taste and consistent with residents

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F 800	Continued From page 113 On 05/25/23 at 8:59 AM, the surveyor interviewed Resident #49, who stated, "I can't eat this [exploitive redacted]. Resident #49 stated he choked on freezer burned chicken and then went to the hospital and they found out that he/she had a tumor. Resident #49 stated he she used to be [redacted] pounds. Resident #49 stated again, "I cannot eat this [exploitive redacted]", and added "I would not give it (food served) to a pig." The resident stated that the facility food was so bad, and there were no options, that he/she would rather just drink a supplement than eat the horrible food. The surveyor reviewed Resident #49's medical record which revealed the following: The Admission record revealed, but was not limited to, a diagnosis of [redacted]. A Nursing Progress Note dated 05/05/23 at 17:30 revealed "Resident not happy with meal he received this PM. Resident is on mechanical soft diet and states he can eat regular food as long as its soft. this nurse explained we can only give what was recommended after swallow evaluation. This [nurse] will put in for another consultation with dietitian so dietary can be aware of what specific foods resident would like to eat. Resident is receiving [redacted] daily] will recommend for an increase in supplement. A 5/18/2023 18:01 Dietary Note revealed Resident #49's May weight is [redacted]. A desirable [redacted] in [redacted] days. [His/her] diet texture was upgraded to [redacted] last month but he expressed to DON he does not like meals and will prefer to drink more supplements. Writer visited resident and [he/she] confirmed	F 800	wishes, daily for fourteen days, twice a week for four weeks, and then monthly, thereafter. The Food Service Director/ Designee will report to the Quality assurance performance improvement team the suggestions/issues/concerns monthly x12 All Audits Findings are to be reported monthly to the Quality assurance performance improvement team	

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preference of commercial supplements to present texture of food ... Resident is on agreement to diet plan. Continue to provide trays for oral gratification rather than nutrition ...

The Care Plan for Resident #49 was reviewed which revealed a Focus of At risk for [redacted] secondary to [redacted] and increasingly [redacted] [redacted] I am also at risk because of my refusal to take my [redacted] [redacted], Date Initiated [redacted]. Goal: I will work with my dietician and medical team to understand my needs for diet adjustment including increase calories or change in food consistency. There were no interventions regarding specific preferences and concerns with dislike of food and there was no follow-up regarding preference updated or follow-up regarding concerns with food preparation or alternate options available.

On 05/24/23 At 12:06 PM, the cook identified as the special food cook for only the [redacted] menu per the FSD. The surveyor observed that he was cooking an item that looked very visually appealing and was in a large pan on the stove. The item also smelled very appetizing. When the the surveyor asked about the item the cook stated it was Garlic Shrimp, and Cabbage, the surveyor asked the FSD who was entitled to eat that item. The FSD stated "only [redacted] people get it" and then stated it is something that the [redacted]] people sign for upon admission and it is "never" on the regular menu. The FSD then stated "only" if there were leftovers could other residents have it.

The Administration informed the survey team that the Dietitian was unavailable for the duration of

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F 800	Continued From page 115 the survey. On 05/31/23 at 1:23 PM, the survey team informed the Vice President of Clinical Services (VPCS), Regional Administrator #2 (RA #2) and the Director of Nursing (DON) regarding the resident concerns regarding the food and the lack of choice. During a facility pre-exit conference held on 06/01/23 at 10:05 AM. The RA #2 acknowledged the facility residents were not able to choose menus or have an alternate menu available. Dietitian job Description, reviewed 06/10/2022 revealed: Responsibilities: Listens attentively to patient complaints and resolves or refers to appropriate individuals. NJAC 8:39-4.1(12); 17.4(1)	F 800		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified	F 801		6/23/23

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F 801	Continued From page 116 nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food	F 801		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 117 service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to ensure a Registered Dietitian provided resident care per the Facility Assessment and completed nutritional assessments, implemented and updated nutrition care plans and implemented and revised interventions. The deficient practice affected residents who resided on 3 of 3 resident care units and was evidenced by the following: Refer to 692G, 693D, 800F On 05/22/23 at 12:03 PM, the surveyor received the Facility Assessment, dated October, 2022,	F 801	801 ELEMENT ONE: CORRECTIVE ACTION: The facility has contracted with Nutra-Co to provide qualified registered dietician service on a consultant basis. R#49 was evaluated and interviewed to determine any needed medical interventions, and to discuss the resident s food preferences, and alternate choices available. Resident s care-plan was updated. A food committee was created to allow residents to have a voice in the menu planning and food service operations. It	

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F 801	Continued From page 118 from the Licenced Nursing Home Administrator (LNHA). The document revealed Part 1: Our Resident Profile, 1.3, The [Facility Name] typically accepts residents or continues to provide care for residents that may develop the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management. Each resident is assessed and reviewed on an individual basis... ; Part 2: Services and Care We Offer Based on our Residents' Needs... Nutrition, Specific Care and Practices- Individualized dietary requirements, liberal diets, specialized diets, IV hydration, tube feeding, cultural or ethnic dietary needs... ; Part 3: Facility Resources Needed to Provide "Competent" Support and Care for our Resident Poulation "Every day" and During Emergencies, Staff type, 1.1, The [Facility Name] has the following staff members, other health car professionals, consultants, and medical practioners to provide support and care for residents. This list includes but is not limited to: ... Food and Nutrition Services: Certified Dietary Manager, cooks, dietary aides, porters, "Registered Dietititian". On 05/23/23 at 2:23 PM, a copy of a three week menu cycle was provided by the Licensed Nursing Home Administrator LNHA and signed by [Name] "Dietitian", and an unsigned two week [Asian] menu cycle. On 05/30/23 at 12:17 PM, during an interview with the surveyors and upon requests made by the survey team to interview the Dietitian, the LNHA stated she would have to see who was covering for the dietitian. She stated the Dietitian was on vacation from Saturday 05/27/23 through 06/03/23.	F 801	empowers them to provide input, make suggestions, and share their preferences, likes, and dislikes. Facility food menus have been given to all residents. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected. The nursing administration team and NutraCo completed nutritional assessments on all residents to address residents' nutritional needs, prevent complications associated with malnutrition, and optimize their overall health outcomes and quality of life. . All residents were interviewed to discuss their dietary preferences. Resident care-plans and tray tickets were updated. ELEMENT THREE: SYSTEMIC CHANGES: The Administrator was educated on ensuring the facility had a dietician available on a full-time, part-time, or contracted basis. The Food Service Director was educated on providing residents with a nourishing, palatable, well-balanced diet that meets the residents daily nutritional and special dietary needs. Nutritional assessments were completed on all residents to address residents' nutritional needs, prevent complications associated with malnutrition, and optimize their overall health outcomes and quality of life. Resident care-plans were updated. The food committee will meet monthly to allow residents to have a voice in the	

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On 05/30/23 at 12:22 PM, the LNHA stated that since the Dietitian was only going to be gone one week, there would not be a dietitian covering. She stated that the Dietitian and the Director of Nursing (DON) would work together and that the dietitian would document in the electronic medical record (eMR). The surveyors requested the Dietitian's credentials.

On 05/30/23 at 1:29 PM, the survey team interviewed the DON about the function of the Dietitian. The DON stated the Dietitian would come to the facility on Monday and Thursday and look at weekly weights during her Monday visits. The Dietitian would meet with residents to discuss preferences and snacks. The DON confirmed the Dietitian was on vacation and she was unsure if "she was contracted with the facility or worked for herself."

On 05/31/23 at 1:23 PM, the survey team with the DON, the Vice President of Clinical Services (VPCS) and the Regional Administrator (RA #2). The VPCS stated that the RA #2 was trying to locate the credentials and certification file for the Dietitian.

On 06/01/23 at 10:14 AM, the RA #2 stated that he was aware that the Dietitian's certificate expired in 2016 and he can get a copy when she returns. At that time he provided the survey team with a copy of an [redacted] with the Dietitian's name on it and was for [redacted], Membership Number [redacted]. The survey team requested the contract with the Dieititan. The survey team reviewed the online [redacted] and

F 801

menu planning and food service operations. It empowers them to provide input, make suggestions, and share their preferences, likes, and dislikes.

ELEMENT FOUR: QUALITY ASSURANCE:
The Director of Nursing/Designee and qualified registered dietician will audit five random nutritional assessments per unit to identify any needed dietary interventions and ensure assessments are completed weekly for four weeks, then monthly, for two months then quarterly thereafter.
Social Worker/designee will randomly audit/interview five residents per unit to ensure the facility is meeting their dietary needs/preferences completed weekly for four weeks, then monthly, for two months then quarterly thereafter.

The Administrator/Designee will complete an audit of sample food trays to ensure the resident s meals are palatable and nourishing. Audits will be completed daily for fourteen days, weekly for four weeks, then monthly for two months and quarterly thereafter. All audits Results of the audits to be discussed at monthly Quality assurance performance improvement then monthly, for two months then quarterly thereafter.

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F 801	Continued From page 120 [redacted] system and entered the information provided by the facility for the Dietitian. The message received was "There are no individuals in the [redacted] database who are credentialed and match the information provided." On 06/05/23 at 8:40 AM, the RA #2 was unable to provide additional information to ensure the Dieitian was qualified to provide services at the facility, including a contract or any information regarding the a certification or credential for the Dietitian. The RA #2 stated the Dietitian was "still on vacation" and "anything we gave you on the Dietitian was all we have". NJAC 8:39-17.1 (a,d)	F 801		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to serve foods at an acceptable temperature for 1 of 6 residents interviewed during a resident council meeting and for 1 of 1 resident reviewed for [redacted] Care (Resident #86). The deficient practice was evidenced by the following:	F 804	Element One: Corrective Action: An interview was completed on resident #86. The resident confirmed that he did not like certain foods. He was offered other food options and updated food preferences. Social worker met with daughter who informed that her father	6/23/23

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On 05/24/23 at 8:37 AM, Resident #86 was observed in bed, a [redacted] meal tray was at the bedside. Resident #86 greeted the surveyor, and the surveyor observed that the meal appeared congealed and uneaten. When the surveyor asked the resident if he/she liked the food, the resident stated, "food, not so good."

On 05/24/23 at 11:11 AM, during the surveyor conducted resident council interview, 1 of 6 residents stated the food was "inedible", "vegetables are over done", and the food is "mushy."

On 05/24/23 at 11:15 AM, the surveyor observed that the posted menu for the lunch meal was barbeque chicken, steamed rice, oriental mixed vegetables, fruit cocktail, whole milk and coffee.

On 05/24/23 at 12:09 PM, the surveyor requested regular meal which consisted of barbeque chicken, mixed vegetable and rice and puree meal that consisted of puree chicken, mixed vegetables and mashed potato and a four ounce container of milk. The Food Service Director (FSD) accompanied the surveyor with what was identified as a calibrated thermometer and the meal trays arrived on the [redacted] Wing at 12:10 PM, and the final tray was passed on the unit at 12:16 PM. The surveyor asked the FSD what the temperature of the hot foods should be and she stated 165 degrees Fahrenheit (F). The facility Administrator (LNHA) was also present at that time and the temperature of the meals was checked which revealed:

Barbeque Chicken 165 F.
Rice 120 F. At that time the surveyor asked the

F 804

resident #86 has requested traditional [redacted] food and they have been bringing all his favorite foods and daily request.
It was confirmed that the temperatures during the survey on certain items needed to be in the proper temperature range.

Element Two: Identification of at-Risk Residents:

All Residents have the potential to be affected.

The Interdisciplinary care plan team will meet weekly to review a minimum of 20 charts and care plans for all residents in house, to reflect all issues/concern/problems/likes or dislikes until all charts have been audited and residents interviewed.
Thereafter Interdisciplinary care plan team will maintain quarterly review and adjust /update care plans as necessary during Interdisciplinary care plan meeting with resident/guardian.
Food Service Director/ designee completed an audit on all the thermometers and the foods' temperatures to ensure they are at the right temperature with modifications done as needed.

Element Three: Systemic Changes

The Administrator/ designee in serviced the kitchen staff/Cook on how to make the food more palatable and tastier.
Resident food committee was formed and

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F 804	Continued From page 122 FSD if the temperature of 120 F was acceptable and the FSD stated it was "not okay". Mixed Vegetable 129 F. Puree Chicken, 127 F. At that time the surveyor asked the FSD if the temperature of 120 F was acceptable and the FSD stated it was "no, it should be hotter". Puree Vegetable 127 F. Mashed Potato 118 F. Four ounces of milk, 58 F. At that time the surveyor asked the FSD if the temperature was acceptable and the FSD stated it was "no, it should be 30 F". At 12:29 PM, the surveyor entered the kitchen to review the final cooking temperatures with the Cook, and to review the temperature log. The Cook showed the surveyor the cooking temperatures, documented in the temperature log, for the Barbeque Chicken- 200F, Mixed Vegetable-200 F and the Starch (Rice) -197 F. The puree food temperatures were left blank. The Cook stated she did not write the temperatures in the temperature log, and was unable to provide the temperatures for the puree food to the surveyor. The Cook then stated "we had to reheat them" [puree food]. At 12:32 PM, the surveyor requested that the FSD calibrate the thermometer used for the test tray in the presence of the surveyor. The FSD stated the thermometer should be 32 F when calibrated and the surveyor observed the FSD place the thermometer in an ice bath which revealed 32 F. On 05/24/23 at 1:27 PM, the surveyor asked the LNHA and FSD for a policy related to when food temperatures should be taken and what the food	F 804	meets monthly to discuss menu/likes/dislikes The Food Service Director were re-educated the residents about the alternate menu and choices available for every meal Activities staff is completing selected menu with alert and oriented residents weekly to give all the residents choices as to what they want for lunch and dinner. New thermometers were ordered for the kitchen. Element Four: Quality Assurance To maintain and monitor ongoing compliance, the administrator/Designee will check the temperatures of the food daily X14 days, twice weekly X 4 weeks, and then monthly thereafter. In addition, the administrator/Designee will check the Quality/presentation of the food daily X14 days, twice weekly X 4 weeks, and then monthly thereafter. Administrator/Designee will review with the food service Director any food related concerns from resident council. In addition, the administrator/Designee will check with 5 random residents per unit on how their food is, including presentation, taste consistency and temperature with residents wishes, daily X14 days, twice weekly X 4 weeks, and then monthly thereafter. Needed corrections will be addressed as they are discovered. Findings to be reported monthly to Quality assurance performance improvement team for review and revision as	

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F 804	Continued From page 123 temperatures should be when the food was received by the residents. The LNHA stated the facility does not have a policy to determine what the food temperatures shoud be and when the staff should take the food temperatures. The survey team requested to speak with the facility Dietitian throughout the survey and the facility LNHA and Corporate Administration had informed the survey team that the Dietitian was unavailable for the duration of the survey and there was no coverage for the position. NJAC 8:39-17.4 (a)2	F 804	necessary. Audit Results to be reported monthly times x12 to Quality assurance performance improvement team for review and revision as necessary.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		6/23/23

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F 812	Continued From page 124 This is a repeat deficiency from the Standard Survey Date: 03/31/22. Based on observation, interview and document review it was determined the facility failed to maintain the kitchen environment, and all of the equipment, dishware and other items in a clean, intact and sanitary manner to limit the potential of food borne illness and potential injury. The deficient practice was evidenced by the following: On 05/22/23 from 9:49 AM through 10:47 AM, the surveyor completed an initial tour with the Food Service Director (FSD) and Regional Administrator (RA #1) and observed the following: 1. A large black floor fan was in the back area of the kitchen, facing the food preparation area. The fan was running and the grate was embedded with dust like debris throughout. The surveyor asked the FSD who was responsible for cleaning the fan and she stated, it "was just brought out." 2. The walk-in refrigerator had what appeared as rust through on the shelving which contained food items that included a glass jar of sliced pickles with hand-written date on metal lid 10-13 and the lid appeared visibly rusted in several areas. The pickles were discarded by the FSD. Underneath the shelves contained debris and the fan had dust like debris. A glass jar of maraschino cherries, had a white lid with a marker- type hand-written scribble on the top of the white lid which also had black spots on it and a date 1-6. The white label of the maraschino cherries had black mold-type markings throughout.	F 812	Element One: Corrective Action: The large black fan with dust was cleaned. New shelving was purchased to replace the walk-in refrigerator shelves. All equipment that had noted rust, black spots, or were dirty, and that was unfixable and/or uncleanable were discarded and replaced. The fan in the fridge was cleaned and free of dust The metal floor in the freezer was repaired All wet lids and plates were removed, new shelving was purchased to prevent the nesting of water. All chipped plates were discarded and replaced The vents were cleaned to ensure they were free from dust. The dry storage room s walls were fixed, cleaned, and painted. The dish machine was immediately cleaned. A new closed container for the ice machine scooper was purchased. Ceiling tiles that were noted to be dirty were replaced. A new blue can opener insert was installed. The metal hood grates were cleaned by staff and a licensed vendor. New wooden Pallet was place in the dry storage area Infection Preventionist inserviced Regional administrator on proper handwashing Element Two: Identification of at-Risk	

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The surveyor asked the FSD what the use by date/expiration date was for maraschino cherries and the FSD stated she cannot see the expiration date because of the black marker on the top of the lids. The jar was discarded by the FSD.

3. The walk-in freezer had a diamond plate metal floor which had a large separated, unsealed seam throughout the middle of the diamond plate metal floor. The open area created an uneven walking surface inside the freezer and exposed the undersurface of the diamond plate floor. The freezer fan was running and did not have a fan grate. The diamond plate floor was soiled underneath the shelving throughout the freezer.

The surveyor asked the FSD about the floor and she stated, "usually the black [rubber] mats are covering it." At that time, the RA #1 interjected and stated "that is going to be fixed."The surveyor requested, from the RA #1, that all documentation regarding the pending repair of the floor be provided, including any estimates, contracts, etc. The RA #1 stated "we are scheduled and there is no documentation."The RA #1further stated the maintenance person will fix the floor. At that time, the surveyor inquired to the FSD when the repair of the floor was scheduled and she stated she was unaware of the timeline for repair.

4. Two rolling racks near the tray line that contained insulated lids and bases identified as clean by the FSD. There were many lids and bases that were double and triple stacked in one of the slots of the rack, the edges of both racks had debris and did not appear clean. The surveyor asked the FSD to remove the wet lids to view. The FSD then washed her hands and proceeded to remove lids which revealed that 7 of

F 812

Residents:

All Residents have the potential to be affected.

The administrator and Food Service Director created and completed a kitchen audit that will ensure the kitchen remains clean, the equipment that is drying is free from water nesting, the proper procedure for dishwashing, and labeling food.

Element Three: Systemic Changes
The Food Service Director was educating on labeling/dating food items and storage, the cleaning schedule /process for kitchen.

The dietary department was educated on the new kitchen cleanliness/sanitation cleaning audit tool.

The Food service Director will audit the facility s plates to ensure they are free of any broken chips monthly for 3 months. Replacements will be ordered as necessary.

The dietary department was educated on the proper procedure for using the dishwasher, preventing water nesting with equipment that is drying, and the correct procedure for labeling/dating food items.
Maintenance Director/designee will review exterminator reports to verify treatment completion by Pest control company of any areas with pest sightings

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the lids and 6 of the bases on both racks were visibly wet inside. During that time, the RA #1, without first washing his hands proceeded to touch the clean lids on the racks. The surveyor asked if he had washed his hands and he stated before, which was not observed by the surveyor as the RA #1 was observed on his cell phone immediately prior to the observation.

5. There were two rectangular black wall vents located behind the rolling racks and both vents had visible dust like debris on the grates.

6. The surveyor observed the emergency food supply storage area with the FSD. The emergency food supply was stored on a visibly disintegrated wooden pallet that was on the visibly rusted interior floor of a walk-in refrigerator that was not in use. Two cases of diced beets and a case of dice peaches were observed.

On 05/24/23, from 9:04 to 10:03 AM, two surveyors observed the following in the presence of the FSD:

7. Multiple dishes soiled with food debris including eggs were stacked on a cart by the dish machine and the FSD confirmed that they were going to be cleaned. Many of the dishes had visible chips on the edges, including one dish that had a missing piece and a jagged edge. There were 25/43 dishes observed that were chipped and as was counted and confirmed with the FSD. The surveyor asked the FSD if the chipped dishes were okay for use and she stated "we try not to use" the chipped dishes. The surveyor asked the FSD if the chipped dishes were going to be used and she stated, "no, because you don't want anyone to get hurt". The FSD stated she was

F 812

Element Four: Quality Assurance

To maintain and monitor ongoing compliance, the Food service Director /designee will audit the cleanliness of the kitchen daily for 14 days straight, twice a week for four weeks, and then monthly thereafter
Maintenance Director/designee will ensure that the Pest management service the basement storage areas routinely.
In addition, the Administrator/Designee will audit the kitchen to ensure there is no water nesting for the items that are drying weekly for four weeks, then monthly thereafter

The Administrator/Designee will audit food items to ensure they are properly labeled and stored weekly for four weeks then monthly thereafter

Needed corrections will be addressed as they are discovered.

All audit findings will be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.

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F 812	Continued From page 127 going to discard the chipped dishes. 8. The surveyor observed a staff member at the end of the tray line, a stack of dishes included visibly chipped dishes were placed in a plate warmer adjacent to the tray line. At 9:15 AM, the Licence Nursing Home Administrator (LNHA) and the RA #1 joined the tour. The FSD was alerted of the observation by the surveyor and stated the dishes in the plate warmer were clean, and proceeded to remove the stack of dishes from the plate warmer. The FSD removed the dishes which revalued 15 plates were chipped, 1 plate had food stuck to it and 9 were wet. The surveyor asked the FSD if the plates were clean and she stated yes, and then asked if it was okay for wet dishes to be in the plate warmer. The FSD stated that "they can air dry in the well when it is plugged in". The surveyor asked the FSD to provide the surveyor with the specifications for the plate warmer and the RA #1 interjected and stated, "If I can get it, it is a pretty old machine" (the specifications were not not provided by the RA #1 throughout the course of the survey). 9. A separate pile of dishes was observed at the end of the dish machine. There were 20/41 dishes were chipped. 10. The top of the dish machine was observed being used and dust and debris were pervasive on the top of the machine. 11. The ice machine scoop was left uncovered and stored next to the ice machine.	F 812		

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12. Multiple ceiling tiles over the ice machine, blender area and can opener were soiled with splattered dark debris.

13. The blue can opener insert was embedded with a dark substance and was unable to be removed by the FSD.

14. The metal hood grates that were over the entire cooking battery were soiled with a shiny grease like substance throughout and grease like drips.

15. A food service worker was observed putting dishes in the dirty side of the machine and then removing from the clean side without first performing hand hygiene.

9. The basement dried storage area had two large dead [redacted] type bugs. At that time the RA #1 looked at the dead bug and stated "means the execrator is working" and the surveyor requested all of the exterminator records. The concrete block area by the bottom of food storage shelves that contained food items such as a case of white vinegar had visible debris throughout.

The surveyor requested policies related to cleaning the kitchen and eqipment and sanitation and requested to interview the facility Dietitian. There was no additional information provided and facility managment informed the survey team that the Dietitian was not available for interview for the duration of the survey and there was no covering dietitian available for interview.

On 05/24/23 at 12:10 PM three surveyors observed the lunch tray line in progress. The RA

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F 812	Continued From page 129 #1 was also present in the kitchen at that time. Dietary staff was observed placing plates with food on wet bases and the wet lids over food. The surveyor observed a dripping lid that dripped fluid onto a meal tray that proceeded to be placed on the meal cart. During the surveyor inquiry at that time, the RA #1 interjected with a loud voice and stated "you are not stopping the tray line, don't stop the tray line, residents need to be fed". The FSD proceeded to hurriedly go through the bases and lids that were on the tray line and separated the wet lids and one lid was noted with food debris. The food Receiving and Storage Policy, Dated 01/05/23 revealed: Foods shall be received and stored in a manner that complies with safe food handling practices, 1. Food Services, or other designated staff, will maintain clean food storage areas at all times, 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date). Labeling and Dating Procedure in the Dietary Department, Reviewed 11/26/22 revealed: Procedure: 1. Food items, as appropriate, will be labeled and dated by dietary staff using the facility labeling system, and the Food Service Director/designee will oversee labeling and dating, Label System Process: 3. Opened Date, a. Food items will be labeled with an open date once the individual item is opened for use, including but not limited to: iii) Refrigerated salad dressings, mayonnaise, cherries, horseradish, etc. NJAC 8:39-17.2(g)	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly	F 814		6/23/23

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F 814	Continued From page 130 CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that garbage was maintianed in a manner to prevent potential contamination as evidenced by the following: On 05/22/23 at approximately 10:00 AM, the surveyor began a tour of the dietary department with the Food Service Director and observed the Dumpster area with 1/2 uncovered dumpsters. A Regional Administrator (RA #1) joined the tour. The area next to the dumpsters contained a large field of debris that included gloves, cups, papers and various other debris. There were two dumpsters observed and 1/2 dumpsters did not have a lid in place. When asked who was responsible for keeping the area clean the FSD stated she did not know and the RA #1 immediately interjected and failed to provide information pertinent to the surveyor inquiry. On 06/02/23 at 2:05 PM, the Regional Administrator (RA #2) and Director of Nursing (DON) were informed of concerns regarding the debris. No additional information regarding the debris was provided. NJAC 8:39-19.7(b)	F 814	ELEMENT ONE: CORRECTIVE ACTION: The housekeeping department cleaned the dumpster area to ensure there was no remaining debris. has ensured that all dumpsters have a functionable dumpster lid that will remain closed. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by this deficient practice All parameters on the outside of the facility have the potential to have an accumulation of debris. Housekeeping Director/ designee completed audit to identify all outside areas of the facility that have the potential for an accumulation of debris with clean up as needed ELEMENT THREE: SYSTEMIC CHANGES: The facility has created an Outside Rounds program to prevent the accumulation of debris on the parameters of the facility. This tool will be an ongoing, weekly task to prevent the accumulation of debris outside of the facility. Regional Administrator inservice The Housekeeping Director on maintaining the outside parameters of the facility to prevent the buildup of debris.	

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F 814	Continued From page 131	F 814	ELEMENT FOUR: QUALITY ASSURANCE: The Housekeeping Director/Designee will audit the outside dumpster area and the other areas outside of the facility that are noted to have the potential for a buildup of debris weekly for four weeks, then monthly thereafter to ensure there is no buildup of debris and that the dumpster lids remain closed. Results to be reported monthly to Quality assurance performance improvement team.	
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure all residents received the care and services needed to enhance their quality of life related by failing to ensure: a) a safe, sanitary, and home-like resident environment on 3 of 3 Resident Wings (Wing [redacted]), b) a thorough investigation of an injury of unknown origin was completed for 1 of 31 residents (Resident #23) reviewed, c) mandatory reporting to the New Jersey Department of Health (NJDOH) for a reportable event of an injury of unknown origin (Resident	F 835	Element One - Corrective Action: Administrator/designee initiated multiple environmental repairs including but not limited to wallpaper repair, closets repair, fixing ceiling, repair and replacement of hand rails, bathroom and floor repairs, overbed table and bed based repairs, window blinds and curtains replacement, replacement of air conditioner units, replacement of over bed lights, tile replacement, call bell unit repairs and pest control to treat dry storage room R23 s injury of unknown origin was investigated and reported to the New	6/23/23

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F 835	Continued From page 132 #23) for 1 of 31 residents reviewed, d) the facility Dietitian was a credentialed Registered Dietitian (RD) per the Facility Assessment, e) there was a process in place to respond to issues and concerns presented by residents during the Resident Council Meeting (RCM), and f) the LNHA provided oversight for the Quality Assurance Performance Improvement (QAPI) to ensure the facility consistently self-identified concerns. The deficient practice affected residents who resided on 3 of 3 Wings and resulted in Substandard Quality of Care in the area of Resident Rights (F565 and F584) and was evidenced by the following: Refer to F584, F924, F610, F609, F801, F812, F867, and F565 a.) On 05/23/23 and 05/24/23, the survey team conducted environmental rounds on [redacted] and [redacted] Wings. The LNHA and other facility staff were present with different surveyors on different Wings. There were multiple observations in the resident rooms, hallways, common areas and shower rooms. The surveyors observations included but were not limited to: ripped wallpaper, broken closets, missing closet drawers, holes in the ceilings and walls, loose handrails, broken dressers; visibly soiled: walls, floors, bathrooms, overbed tables, bed bases, window blinds, window curtains, and air conditioner units; air conditioner units with missing knobs, broken covers, and areas open to the outside; soap dispensers pulled from the wall, toilet paper holder pulled from the wall and leaving a hole, cracks in walls, cobwebs, a light over a residents head of their bed leaning towards the resident's bed unsecured, multiple wires hanging from ceilings in resident rooms, fall mats that were	F 835	Jersey Department of Health to rule out abuse. The facility is now contracted with NutraCo to provide qualify register dietitian. Grievance process has been reinforced to respond to issues and concern presented by resident during the monthly resident council meeting. Director of Nursing/designee Inservice the staff on responding to abuse allegations. Regional administrator in serviced administrator on the facility quality assurance performance improvement policy Element Two -Identification of at Risk Residents: All residents have the potential to be affected by this practice. Element Three Systemic Change: The Regional administrator educated the facility administrator on 1 providing a safe, sanitary, and home-like environment for units [redacted] AND [redacted]. 2. On the requirement of registered dietitian, 3. Resident Council The Regional administrator also re-in serviced the Administrator and Director of nursing on abuse and thorough investigation of incidents of unknown origin following the facilities policy: . the mandatory reporting requirements to the New Jersey Department of Health The Regional administrator inserviced administrator and the interdisciplinary care	

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ripped and visibly soiled, missing tiles in rooms and shower rooms, and emergency call bell units ripped from walls; varied types of insects in resident rooms, hallways and large cock roach type insects in the dry food storage room.

On 05/23/23 at 12:54 PM, during the environmental rounds, the LNHA stated she would make rounds every morning with the maintenance and housekeeping directors. The LNHA acknowledged such things as rooms with ripped wallpaper, missing drawers on closets, damaged or missing furniture, holes in the walls, and loose or damaged handrails and stated that she had not been aware of all of the identified concerns.

On 05/23/23 at 1:14 PM, the LNHA stated that the "whole floor does for themselves." When the surveyor inquired about her morning rounds, the LNHA stated to the surveyor, "you do realize the whole building is behavioral?" Upon inquiry by the surveyor regarding the process for identifying and addressing environmental issues, the LNHA was unable to provide a system that ensured items were repaired. The LNHA stated that maintenance would verbally inform her if items had not been fixed. No additional information was provided by the LNHA.

A review of the facility provided, "Admission Agreement", undated, included but was not limited to Resident Rights: ...Physical and Personal Environment ...To live in a safe, clean, comfortable, and home-like environment ...

b.) On 05/24/23 at 9:30 AM, a surveyor observed Resident #23 in bed and noticed the resident had a [redacted]. At that time, there

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team on quality assurance performance improvement

Prohibition of Resident Abuse & Neglect which included:

1. The definition of abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.
2. Types of abuse-Physical, verbal, sexual, mental/emotional/psychological, involuntary seclusion, neglect, exploitation, and misappropriation of resident property.
3. Prevention which includes employee and volunteer screening, training, which is completed upon hire, and minimally quarterly to employees. Re-education is also completed when/if there is an allegation of abuse.
4. Reporting abuse- Abuse must be reported to immediately to supervisor. The supervisor will then report to the Abuse Coordinator. If the abuse coordinator is unavailable the next highest administrative position is made aware Director of nursing
5. Protection-Immediately remove the resident(s) from the situation, assess and treat, accused employees (if applicable) will be suspended immediately pending further investigation.
6. Investigation: a full investigation is completed with a comprehensive review

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was a Licensed Practical Nurse (LPN) in the room who informed the surveyor that the hematoma was from a fall. The resident had a Brief Interview of Mental Status (BIMS) of [redacted] out of [redacted] which indicated he/she was [redacted] [redacted].

On 05/26/23, the Director of Nursing (DON) provided the fall investigation. A review of the facility provided fall investigation revealed there were no statements from staff that worked the shift when the resident allegedly [redacted] to determine if it was witnessed or unwitnessed. The DON stated that she had been "told" Resident #23 fell during care and that she "did not investigate further." The DON acknowledged that a resident found on the floor bleeding would be considered an injury of unknown origin and that resident abuse would need to be ruled out.

c.) On 05/26/23, during an interview with surveyors regarding Resident #23's injury of unknown origin, the DON stated that the facility would always investigate and report to all agencies required. She stated, "I am sorry, I was told that the resident fell during care."

The facility had not obtained statements from the staff who had worked that shift and there was no investigation to rule out possible abuse. The facility had not reported the reportable event to the NJDOH.

A review of the facility provided Prohibition of Resident Abuse and Neglect policy, undated, included but was not limited to .... Injuries of unknown source .... Must be reported immediately to the employee's supervisor. The supervisor must immediately notify the LNHA

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of the situation, interviews with staff, residents, and any witnesses to the event and statements are recorded, statement review, environmental review, and medical record review.

7. New hires are trained upon hire during facility orientation, quarterly and prn.

the interdisciplinary care team completes environmental rounds weekly with the findings and required follow up reported timely to the appropriate Department head.
Director of Nursing/designee reviews 24 hour report and all incident and accident reports daily for completion of assessment investigation and mandatory reporting of any injury of unknown origin.
Nutrico employee are qualified register dietician
Social Worker/Designee will initiate individual grievance forms from concerns identified at the monthly resident council meeting a forward to the appropriate department head and monitor or track for prompt resolution.
Administrator/Designee schedule the quality assurance monthly meetings including the development and monitoring , discussion of performance improvement plans by department heads
Element Four - Quality Assurance:
Abuse Coordinator/designee to conduct random audits of residents ensure they feel safeguarded against abuse weekly x4, monthly thereafter
Abuse Coordinator/designee to conduct random audits of staff to ensure staff

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F 835	Continued From page 135 and/ or the DON. ... injuries of unknown source will be reported to the appropriate authorities including not limited to local law enforcement agencies, NJDOH, and Ombudsman .... The investigation shall consist of: a comprehensive of the event ... interview with the person (s) reporting the incident, interview with any witness, interview with the resident if possible, interview with staff members (on all shift as appropriate) having contact with the resident during the period of the alleged incident. ... The abuse coordinator / designee completes the investigation file to include .... Documents appropriate to the investigation. Quality Assurance: "the official file is forwarded to the Administrator ..." "the abuse coordinator/designee will consult with the Administrator concerning the progress of the investigation." On 06/02/23 at 1:29 PM, the DON stated that she would talk to the LNHA every morning and that they would review any nurse's notes about any falls and the written incident reports. The DON stated, "it must have been missed" when asked about the review of Resident #23's conflicting progress notes regarding the injury of unknown origin. The LNHA was unavailable for interview. The facility policy was not followed, the incident was not thoroughly investigated or reported to NJDOH. d.) On 05/22/23, the survey team entered the facility and requested entrance documents. A review of the facility provided Facility Assessment, dated 10/2022, included but was not limited to Part 2: Services and Care We Offer	F 835	aware of how to recognize and respond to abuse. Regional Administrator/Regional Nurse to review incident reports weekly x 4, then monthly thereafter to ensure any allegations of abuse are being properly identified and reported. Regional Administrator/Regional Director of Nursing will have oversite on these audits. Administrator/designee will review monthly resident council minutes to ensure resolution of reported concerns. Monthly x3 then quarterly thereafter Needed corrections will be addressed as they are discovered Audit Results to be reported monthly thereafter 2 to Quality assurance performance improvement team for review and revision as necessary. Maintenance Director/ designee and Housekeeping/Director/Designee will conduct environmental rounds on 5 room weekly Administrator/designee will ensure that Nutrico Dietician have the proper credentials as qualify register dietician	

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based on our Residents' Needs ... Nutrition, individualized dietary requirements, liberal diets, specialized diets, IV (intravenous) hydration, tube feeding, cultural or ethnic dietary needs. Part 3: Facility Resources Needed to Provide "Competent" Support and Care for our Resident Population .... 1.1 staff type, ...Food and Nutrition Services: .... Registered Dietitian.

On 05/30/23 at 12:17 PM, the surveyors requested to speak to the dietitian. The LNHA stated that she was on vacation from [redacted] through [redacted]. The LNHA further stated that there was no dietitian to cover because the facility dietitian was only going to be gone one week. The surveyors requested the dietitians certification and contract. The surveyors were informed the Dietitian had worked at the facility for 20 years.

On 05/30/23 at 12:22 PM, the LNHA informed the surveyors that she could not find a certification for the Dietitian and was still looking for a contract with the dietitian.

On 06/01/23 at 10:14 AM, the Regional LNHA #2 had provided a copy of a membership card (for a professional organization) with the Dietitian's name on it and an expiration of May 31, 2016 which also included a membership number. The survey team attempted to find the certification through the [redacted] ([redacted] but received a response that "there are no individuals in the [redacted] database who are credentialed and match the information provided."

On 06/05/23 at 8:40 AM, the Regional LNHA #2 stated the LNHA was wrong, and that the Dietitian was on vacation until [redacted] He further stated

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that "anything we gave you on the Dietitian is all we have." The facility failed to provide any credentialing document to prove the Dietitian was a currently credentialed Registered Dietitian. No service contract was provided and the LNHA #2 was unaware the [redacted] membership had expired in [redacted]

e.) The survey team entered the facility on 05/22/23 and requested documents which included the last three months of Resident Council Meeting Minutes.

The surveyor reviewed the Resident Council Meeting Minutes for dates 02/22/23, 03/24/23, and 04/19/23. The minutes provided failed to include any documented follow up information from prior months Resident Council Meeting Minutes.

On 05/25/23 at 8:20 AM, during an interview with the surveyors, the LNHA and Social Worker (SW) were asked about the follow up documentation to the resident council concerns. The LNHA stated there was no documentation or "follow-ups". When asked about a specific concern over container bins, the LNHA stated she had looked at the minutes and did not see "any need to address the bins". The LNHA stated that if there were a concern by an individual resident, it would be addressed through a grievance form.

The LNHA was unable to provide any policy or process to address the concerns expressed during Resident Council Meetings.

f.) On 05/22/23, the survey team entered the facility and requested documentation. The surveyor was provided with the facility Quality

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Assurance & Plan Improvement (QAPI) Plan for [facility name redacted], undated, and the QAPI Plan, undated.

A review of the QAPI Plan, undated, included but was not limited to Governance and Leadership: "the governing body and/or administration of the nursing home will develop a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts." ...governing body is ultimately responsible for overseeing the QAPI committee. Responsibility and Accountability: "The administrator and/or QAPI coordinator has responsibility and is accountable to the governing body for ensuring that QAPI is implemented throughout our organization. ... The administrator, or designee, is responsible for assuring that all QAPI activities and required documentation is completed and/or up to date."

During the course of the survey ranging from 05/22/23 through 06/05/23, the survey team identified concerns with the environment and with resident falls.

On 06/01/23 at 10:05 AM, the Regional LNHA #2 stated that the LNHA had [redacted personal problems] and "as you can see from QAPI that since April things were not completed such as audits were not done". The Regional LNHA #2 further stated that the LNHA "did not have the support." The Regional LNHA #2 did not elaborate on the lack of support supplied to the LNHA.

On 06/02/23 from 10:53 AM to 11:00, during an

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F 835	Continued From page 139 interview with the surveyors, the Regional LNHA #2 stated he was asked by the Regional LNHA #1 to come for support and confirmed that the Regional LNHA #1 would be responsible for checking on the facility. He further stated that other facility staff "should have" identified the issues. The LNHA #2 did not offer a process that included either the Regional LNHA #2, or the Regional LNHA #1 (who the Regional LNHA #2 had identified as being ultimately responsible for the facility), providing oversight of the LNHA who he confirmed stopped completing facility audits approximately two months prior. Although the Regional LNHA #1 was identified as oversight of the facility, he did not provide responses to the surveyors. On 06/05/23 at 9:40 AM, during an interview with the surveyors, the Regional LNHA #2 was unable to locate any follow up documentation for environmental concerns which began in QAPI in November 2022, or any follow up documentation for the QAPI Plan Goal 2 regarding the reduction of quality measure rate for falls with major injury. A review of the facility provided, "Administrator" job description, reviewed 07/20/22, included but was not limited to "The Administrator establishes, directs and is responsible for the overall operation of the facility's internal and external activities and works to ensure regulatory and corporate compliance, quality assurance, and the fiscal viability of the facility." General Tasks included but were not limited to responsible for the overall organization and management of the facility; directs, coordinates, and monitors the day to day operation and provision of resident services; acts as compliance officer; maintains a fundamental knowledge and awareness of the status of all	F 835		

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F 835	Continued From page 140 residents; ensures that all services and documentation are in accordance with the NJDOH rules and regulations governing a SNF (skilled nursing facility); ensures compliance with all pertinent standards, regulations, and requirements; ensures proper resident care services; provides for the identification, analysis, and development of new systems and programs; ensures accurate documentation, implementation and compliance of all issues; represents facility dealings with outside agencies; and completes all other inherent and logical tasks. NJAC 8:39-4.1 (a) (11, 29) NJAC 8:39-9.2 (a) NJAC 8:39-9.4 (f) NJAC 8:39-17.1 (a,d) NJAC 8:39-27.1 (a) NJAC 8:39-31.2 (e) NJAC 8:39-33.1 (a,c,d,e) NJAC 33.32 (b,d)	F 835		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867		6/23/23

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are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

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(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

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F 867	Continued From page 143 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility Quality Assurance Performance Improvement (QAPI) failed to make good faith attempts to correct and maintain identified issues to address conditions that adversely affected the resident population and were identified during Resident Council Meeting and the condition of the facility environment. The deficient practice was evidenced as follows: Refer to F584 and F565 On 05/22/23, the survey team entered the facility. The Licensed Nursing Home Administrator (LNHA) was asked to provide the entrance documents which included the QAPI plan. During the survey ranging from 05/22/23 through 06/05/23, the survey team made multiple	F 867	Element One - Corrective Action: The Regional Administrator educated The Administrator and the interdisciplinary care team on establishing a formidable Quality assurance performance improvement plan and process to identify areas of concern and/or inefficient systems of operations that need to be addressed, monitored, and revised as needed. A new Quality assurance performance improvement process/plan has been created. All residents of the facility were given residents rights and grievance forms.. Element Two -Identification of at Risk Residents: All the residents has the potential to be affected by this deficient practice	

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observations on [redacted] Wing ([redacted] which included but were not limited to, resident rooms with broken, missing, or damaged furniture; visibly soiled walls, floors, furniture, toilets, air conditioner units, curtains, privacy curtains, window blinds; dead insects; exposed wires hanging from the ceiling; missing call bells from the wall in the bathroom; embedded stains on the base of multiple over bed tables and bed bases; cobwebs; holes in walls and ceiling; sprinkler rusted with pieces missing; damaged floor in the kitchen; unit shower rooms with missing tiles, visibly soiled shower handles, call bell pulled from the wall.

On 05/23/23 at 12:54 PM, the LNHA was made aware of the conditions and was asked to accompany two surveyors during the inspection of the resident rooms. When questioned about broken closets that were missing the drawers, the LNHA stated the resident "pulls things out" and she further acknowledged that it was not acceptable for the doors of the closet to be left like that. The LNHA stated that she would make round every morning with maintenance and housekeeping directors.

On 05/23/23 at 1:14 PM, the LNHA stated that the "whole floor does for themselves." When the surveyor inquired about her morning rounds, the LNHA stated to the surveyor, "you do realize the whole building is behavioral?" The LNHA was unable to provide a process that ensured a list that she stated she provided to maintenance to fix was actually confirmed as fixed. She stated that maintenance would "let her know if things were not fixed."

On 05/23/23 at 1:18 PM, the LNHA stated she

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Element Three Systemic Change:

The facility has created a new Quality assurance performance improvement process/plan that will now meet monthly that will correct and maintain identified issues to address conditions that adversely affect the resident population. The regional administrator inservice the Administrator and the interdisciplinary care team on the Quality assurance performance improvement plan and process to identify areas of concern and/or inefficient systems of operations that need to be addressed, monitored, and revised as needed.

Element Four - Quality Assurance:

Administrator/designee will audit performance improvement plans for updates and resolutions of identified areas of concern

Assistant administrator/designee will audit The effectiveness of the Quality assurance performance improvement monthly with results reported to Regional Administrator. Audit Results to be reported monthly thereafter to the Quality assurance performance improvement team for review and revision as necessary.

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was "not aware of the condition of the rooms" or the condition of the furniture in the rooms.

On 05/25/23 at 8:20 AM, during an interview with the surveyor, the LNHA stated that there was no documentation, or "follow ups" to ensure any concerns from the Resident Council meetings had been addressed.

On 06/02/23 at 10:53 AM, during an interview with the surveyors, the Regional LNHA #2 stated that he took every concern "personally" and called on sister facilities to come help with the environmental concerns that were identified during the survey. He stated, "when you look at the building and clients, it doesn't take long for everything to go to [exploitive redacted]."

On 06/05/23 at 9:40 AM, during an interview with the surveyors regarding QAPI, the Regional LNHA #2 stated that the QAPI committee meets on a quarterly basis and the members included the Medical Director, Director of Nursing, LNHA, Human Resources, Admissions, Medical Records, Maintenance, Housekeeping, Dietary, Therapy, Activities, the Social Worker, Pharmacy and sometimes the unit managers. He stated that each department does its own QAPI, will identify issues and goals, and would report them to QAPI during the meeting. When asked about input from the residents, the Regional LNHA #2 stated they obtain that input from Resident Council meetings. The surveyor asked about the follow up to Resident Council meetings and the Regional LNHA #2 had no information to provide.

A review of the facility provided QAPI Plan, undated, included but was not limited to Plan: the QAPI plan will guide performance improvement

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efforts. This is a living document that you (facility) will continue to refine and revisit. Goal 2: will reduce the quality measure for falls with major injury.

During the 06/05/23 interview, the Regional LNHA #2 was asked about the follow up for Goal 2 regarding the reduction of the quality measure for falls with major injury. The Regional LNHA #2 reviewed the facility QAPI book and replied there was no [documented] follow up.

A review of the facility provided QAPI book revealed a QAPI Topic: Foot Boards & Headboards", dated 01/18/23. The topic included but was not limited to an audit was being conducted and it was noted some were in need of repair. Causal factors included 1. Footboards and headboards have a lot of wear and tear due to resident population. 3. Time is needed to paint / replace parts and this repair is not considered an emergency. 4. Not always enough staff in the maintenance department to complete non-emergency repairs. 5. Need to schedule time and supplies to complete the repair. Goal: the facility will be 95% in compliance with headboards and footboards to be in appropriate condition within the facility. There was a worksheet included which indicated that this project had begun 11/18/22 and the end date was "ongoing". A summary note included "what we'll do in the future to sustain improvement: continue to audit / review, hire more maintenance staff." There were "Rounds" for [redacted] units attached and dated 1/12/23. The rounds included repairs that were needed in [redacted] resident rooms and the shower room on [redacted] unit.

A review of the facility provided QAPI book

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revealed, "Maintenance Issues 4/11/23" which included but were not limited to resident rooms which needed "attention right away" included room [redacted] bathroom needs to be spackled, wardrobe (closet) door is missing. The identified concerns included but were not limited to hole in the wall (room [redacted] ceiling tiles need replacing, ceiling tiles moldy, air conditioner covers broken (room [redacted]), need new blinds, wardrobe missing drawers, wallpaper falling down, and no emergency pull station in bathroom.

The surveyor was provided with "Monthly Room Checks", dated April 2023, March 2023, February 2023, and January 2023. The room checks were conducted per wing and included either a check mark, "ok", or "fix". When asked for the follow up on the room checks, the Regional LNHA #2 looked at the Monthly Room Checks document and stated there was "no way" to determine if the "checks and x's meant good or something was bad." He stated the audits were "common area audits with only some resident rooms." He further stated after the findings, there should have been a repair and the concern should have went back to QAPI committee. The Regional LNHA #2 stated the concerns should have been documented in QAPI that it was completed.

A review of the facility provided, QAPI plan for the [name redacted] facility, undated, included but was not limited to Purpose: to take a proactive approach to continually improve the way we (facility) cares for and engages our residents ... To do this, all employees will participate in ongoing quality assurance and performance improvement efforts ... to provide quality services in a caring environment where individuals can attain their highest level of functioning. Guiding Principles: #1

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F 867	Continued From page 148 our organization uses quality assurance and performance improvement to make decisions and guide day-to-day operations. #2 the outcome of QAPI is to improve the quality of care and quality of life of our residents. #6 our organization sets goals for performance and measures progress toward those goals. Scope: the QAPI program encompasses all segments or care and services ...The [name redacted] facility that impact clinical care, quality of life, resident choice, and care transitions with participation from all departments. The Scope Segment of Care included but was not limited to: Maintenance and Housekeeping - provide and ensure that all health, sanitation, and OSHA (Occupation Safety and Health Administration requirements are met through regular cleaning, disinfection, and sanitation of all aspects of the building. A review of the facility provided, "QAPI Plan", undated, included but was not limited to documentation of performance improvement project activities: ongoing monitoring to be documented, outcomes, and lessons learned. Assuring sustained improvement: used to measure outcomes to assure continued improvement to identify any adjustments or corrective actions to achieve the established goals. To ensure the interventions are implemented and effective in making and sustaining improvements, indicators/measures are selected that tie directly to the new action and established threshold and outcomes are reviewed. The facility failed to follow their QAPI plan and were unable to provide any follow up information or ongoing adjustments to address projects that had been started six months prior.	F 867		

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F 867	Continued From page 149 NJAC 8:39-33.1 (a)(c)(d)(e); 33.2 (b)(d)	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(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;	F 880		6/23/23

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F 880	Continued From page 150 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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: This is a repeat deficiency from the Standard Survey Date: 03/31/22. Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to a.) maintain proper isolation procedures for a resident	F 880	ELEMENT ONE: CORRECTIVE ACTION: The garbage pail for resident # 509 was immediately placed inside the room. infection preventionist/ Designee re educated Certified Nursing assistant. #2	

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identified as a Person Under Investigation (PUI) for [redacted] for 1 of 1 resident (Resident #509) reviewed for Transmission Based Precautions (TBP), b.) perform hand hygiene during the passing out of the lunch meal trays on 1 of 3 units (Unit [redacted].) ensure the cleanliness of [redacted] equipment for 1 of 3 residents (Resident #83) reviewed for [redacted] care. This deficient practice occurred on 2 of 3 Wings (Wing [redacted]) was evidenced by the following:

a.) During a tour of Wing [redacted] on 05/23/23 at 11:53 AM, Surveyor #4 observed a three- tier white plastic bin which contained Personal Protective Equipment (PPE), two red paper signage attached to the doorway, indicating how to don (put on) and doff (take off) PPE and a red trash can located in the hallway outside Resident #509's room. The surveyor observed rolled up blue plastic isolation gowns inside the red trash can. At that time, the surveyor interviewed Resident #509 who stated he/she was on isolation because he/she did not receive all the [redacted] vaccinations required.

On 05/23/23 at 12:51 PM, Surveyor #4 observed the red trash can in the hallway outside Resident #509's room.

During an interview with Surveyor #4 on 05/23/23 at 12:02 PM, CNA #1 stated that when a resident was on PUI isolation, the staff were to remove all PPE prior to exiting the room and place the contaminated PPE in the designated trash can located in the hallway right outside the isolation room.

During an interview with Surveyor #4 on 05/23/23 at 12:52 PM, the Licensed Practical Nurse Unit

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on proper hand hygiene including while passing out trays.
Resident #83 [redacted] was changed, dated and bagged, and [redacted] [redacted] was removed and replaced.
Infection preventionist/ Designee re educated License practical Nurse #2 on [redacted] and [redacted] ensuring both are dated, placing [redacted] in [redacted] and ensuring [redacted] is clean and alerting Housekeeping of dirty equipment.

infection preventionist/ Designee re-in-serviced Unit manager in training on personal protective equipment usage, handwashing, and infection control.
Infection preventionist/ Designee Staff re-in serviced on residents washing hands prior to eating.
Infection preventionist/ Designee Staff re-in serviced on removing linen that falls to the floor.

ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:

All residents have the potential to be affected.

Infection preventionist/ Designee conducted an audit on all residents requiring [redacted] to ensure [redacted] dated, placed in bag when not in use and concentrator is clean including filter.

ELEMENT THREE: SYSTEMIC CHANGEs:

Infection preventionist/ Designee re in

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Manager (LPN UM#1) stated that when a resident was on PUI isolation, the staff were to remove all PPE prior to exiting the isolation room and dispose of the PPE in the red trash bin located inside the room. LPN UM #1 further stated that it was important to dispose of the PPE in the trash can located inside the isolation room prior to exiting the room so you don't cross contaminate the infection and put other residents or staff at risk for spread of the infection.

At that time, Surveyor #4 accompanied LPN UM #1 to Resident #509's room and the LPN UM #1 confirmed the isolation red trash can was in the hallway outside the isolation room. The LPN UM #1 stated the isolation trash can should be located inside Resident #509's room.

During an interview with Surveyor #4 on 05/23/23 at 1:31 PM, the Infection Preventionist (IP) stated that the contaminated PPE trash bin should be located inside the room, by the door, before you exit the isolation room. The IP stated it was important to dispose of the contaminated PPE in the trash can inside the isolation room, so you don't spread infection. The IP further stated that when a new admission was not fully vaccinated for [redacted], the resident will be placed under PUI isolation for 10 days and it was important to use proper infection control procedures.

During an interview with Surveyor #4 on 05/24/23 at 8:56 AM, the Director of Nursing (DON) confirmed that the contaminated PPE should be placed in the trash can located inside the PUI room.

During an interview with Surveyor #4 on 06/02/23 at 9:03 AM, the Vice President of Clinical

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serviced staff on infection control including personal protective equipment donning and doffing and ensuring garbage pail inside room when doffing, hand hygiene while passing out trays, dating, changing, and ensuring [redacted] is placed inside a bag when not in use, removing linen that is contaminated and residents washing hands prior to eating.

ELEMENT FOUR: QUALITY ASSURANCE:

Director of Nursing/Infection preventionist/designee to randomly audit each unit daily x 7 days, weekly x 4 and monthly x2 during meals to ensure residents are offered handwashing prior to meals, and staff washes hands while serving trays.
Director of Nursing/Infection preventionist/designee will audit Person under investigation rooms (if applicable) daily x 7 days, weekly x 4 and monthly x2 to ensure staff is donning and doffing personal protective equipment appropriately and garbage bin is placed inside the room.
All residents on oxygen will be audited daily x 7 days, weekly x4 and monthly x 2 to ensure oxygen tubing is dated, placed in bag when not in use, and equipment is clean.
Needed corrections will be addressed as they are discovered. . Audit Results to be reported monthly times 3 to Quality assurance performance improvement team for review and revision as necessary.

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Services stated the facility did not have a policy that included to keep the isolation trash can inside the isolation room but that the facility followed CDC (Centers for Disease Control and Prevention), CMS (Centers for Medicare & Medicaid Services), and DOH (Department of Health) regulations that required the isolation trash cans be located inside the isolation room.

A review of the facility's, "[redacted] Outbreak Response Plan", dated 02/08/23, reflected that the facility follows all CMS, CDC, Federal, State and Local DOH regulations regarding isolation and cohorting infected and at-risk residents from a communicable disease including [redacted]

A review of the CDC recommendations titled, "Transmission-Based Precautions", dated January 7, 2016, revealed that Transmission Based precautions are the second tier of basic infection control and are to be used in addition to Standard precautions for patients who may be infected or colonized with certain infectious agents. The recommendations also indicated to use PPE appropriately, donning PPE upon entry, and properly discarding before exiting the patient room was done to contain pathogens.

b.) On 05/22/23 at 12:15 PM, during the observation of the lunch meal tray distribution on Unit [redacted] Surveyor #2 observed CNA #2 deliver lunch trays between 12:15 PM and 12:24 PM, without performing hand hygiene prior to or after delivery of the trays.

The trays were delivered to the following rooms. One tray to room [redacted]; one tray to room [redacted]; one tray to room [redacted] one tray to room [redacted]; one tray to room [redacted]; one tray to room [redacted]; one tray to room

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; a second tray to room ; one tray to room ; one tray into room ; one tray into room ; a second tray to room ; one tray to room ; a second tray to room two trays into the unit day room.

On 05/22/23 at 12:29 PM, during an interview with Surveyor #2, CNA #2 stated the meal tray delivery process was for the nurses to check the trays, make sure all residents in the day room were eating together, clean the residents hands, and after every third tray delivery, the staff would clean their hands. When asked why she had not performed any hand hygiene between the delivery of the 16 meal trays, CNA #2 stated she was "just trying to get it done."

On 05/22/23 at 12:34 PM, during an interview with Surveyor #2, LPN #2 stated the process was for the nurses to check the trays for the correct diets, hand the trays to the CNAs, clean residents hands, and after three resident trays were passed out, the staff would clean their hands. LPN #2 stated this was "so don't pass on contamination."

On 05/23/23 at 1:31 PM, the LPN IP stated that during meal pass, residents would be provided hand hygiene and that the staff were to perform hand hygiene between each resident to prevent the spread of infection.

A review of the facility provided, "Job Description: CNA", reviewed 11/20/22, included 4. Follows infection control procedures (i.e. hand washing).

A review of the facility provided, "Hand Hygiene Competency Validation", "Soap & Water Alcohol Based Hand Rub (ABHR)", revealed that CNA #2 had been deemed competent on 02/15/23, and

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03/26/23.

A review of the facility provided, "Handwashing/Hand Hygiene" policy, dated 11/22/22, included 2. Follow the handwashing/hand hygiene procedures to help prevent the spread of infections; When to wash hands: 5. F. before and after eating or handling food (hand washing with soap and water), G. before and after assisting a resident with meals.

c.) On 05/22/23 at 10:06 AM, Surveyor #2 observed Resident #83 in his/her bed and there was an next to the resident. The of the was lying on the floor. Resident #83 stated that the staff "doesn't care if it's dirty".

On 05/24/23 at 8:23 AM, Surveyor #2 observed Resident #83 lying in bed and his/her was partially suspended in an open drawer with the hanging within inches of a Surveyor #2 observed the with substance splattered on it.

On 05/24/23 at 8:52 AM, Surveyor #2 observed LPN #2 had been in Resident #83's room administering medications. Surveyor #2 looked into the resident's room and observed that the and were still in the same position next to the e.

On 05/24/23 at 9:24 AM, during an interview with Surveyor #2, LPN #2 stated that was changed every Wednesday by the 11 PM to 7 AM staff. She stated her responsibility would be to ensure the was set at the prescribed liters per minute, if a resident used "off

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and on", to ensure the [redacted] is kept in a bag. Surveyor #2 went with LPN #2 to Resident #83's room where we both observed the [redacted] exposed to the environment, not in a bag and in close proximity to the [redacted] in it. LPN #2 acknowledged there was no bag in the room. At that time, Surveyor #2 also requested the LPN inspect the [redacted] LPN #2 acknowledged the [redacted] was visibly soiled. LPN #2 stated the [redacted] and [redacted] could cause cross contamination and it should be kept clean for infection control. LPN #2 stated she checked the [redacted] when she was in the room and thought there was a bag.

A review of the Admission Record revealed that Resident #83 had been admitted to the facility with diagnoses which included but were not limited to [redacted].

A review of the "Order Summary Report", active orders as of [redacted] included an order dated [redacted] to change and date [redacted] and [redacted] weekly.

A review of the most recent Annual Minimum Data Set (MDS) an assessment tool to facilitate care, dated [redacted] included but was not limited to a Brief Interview for Mental Status (BIMS) of [redacted] out of [redacted] which indicated the resident was [redacted] [redacted] which indicated the resident received [redacted] therapy while a resident at the facility.

A review of the facility provided person-centered

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comprehensive care plan printed on [redacted], included focus: [redacted] and use [redacted] frequently with an intervention to assess [redacted] status q (every) shift and apply [redacted] as needed; and focus: at risk for infection due to a history of [redacted] with an intervention to monitor for changes in [redacted] status.

On 05/31/23 at 1 PM, the Regional Administrator #2, the Regional Vice President of clinical services, and DON were made aware.

At 1:25 PM, the Regional Vice President of clinical services stated the [redacted] supplies should be cleaned weekly and "PRN (as needed)."

On 06/01/23 at 10:05 AM, the facility acknowledged that the [redacted] should have been cleaned but was not.

A review of the facility provided, "Job Description: LPN", reviewed 11/20/22, included 8. Practices standard precautions and adheres to infection prevention strategies.

A review of the facility provided, "[redacted] Therapy" policy, reviewed 11/20/22, included 1. [redacted] therapy is administered by way of a [redacted]; 11. When not in use, the [redacted] will be placed in a plastic bag labeled with the resident's name and dated.

A review of the facility provided, "Cleaning and Disinfection of Resident-Care Items and Equipment", reviewed 11/22/22, included resident-care equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention)

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F 880	Continued From page 158 recommendations and OSHA (Occupational Safety and Health Administration) bloodborne pathogens standard. 1. The following categories are used to distinguish the level of disinfection necessary. 1. D. reusable items are cleaned and disinfected (durable medical equipment). c.) On 05/22/23 at 12:23 PM, the surveyor went to the [redacted]-Wing to observed the lunch meal. The surveyor observed a Certified Nursing Assistant (CNA) delivered a lunch tray to a resident. While placing the tray on the bedside table, the linen that was on the bed fell on the floor. The CNA picked up the linen and placed it directly on the resident's bed. The surveyor followed the CNA to the hallway and inquired about the linen that was on the floor which he returned to the resident's bed. The CNA stated that he should not have placed the soiled linen on the resident bed. When asked for the rationale, the CNA stated, "for transmission of disease." On 05/23/23 at 12:05 PM, the surveyor returned to the B-Wing to observe the lunch meal. The surveyor observed CNAs and nurses delivered trays from Rooms [redacted] The staff did not provide hand sanitizer or sanitizing wipes for the residents to sanitize their hands prior to the lunch meal. On 05/23/23 at 12:40 PM, the surveyor interviewed the RN, who confirmed that the residents on the [redacted]-Wing high side, were not provided with the opportunity to sanitize their hands because the staff who went to get the sanitizing wipes had not returned to the [redacted] Wing yet. Shortly after, the surveyor observed the Unit Manager in training arrived on the [redacted]-Wing with two containers of sanitizing wipes and proceeded	F 880		

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F 880	Continued From page 159 to assist residents on the [redacted]-Wing [redacted] side with sanitizing their hands prior to the lunch meal. Upon inquiry regarding the above observation, the RN stated that she was not too sure of the facility's protocol for residents to sanitize their hands prior to receive their meals, she would inquire. On 05/23/23 at 1:00 PM, the RN informed the surveyor that she spoke with the Infection Preventionist, and was informed that all residents should be provided with opportunities for hand hygiene prior to receive their meals. On 05/26/23 at 8:30 AM, in the presence of the administrator, the surveyor observed an RN entered an isolation room to deliver the breakfast meal without wearing the proper (PPE) Personal Protective Equipment. The surveyor observed the RN with a surgical mask only. An isolation bin with PPE gowns, gloves and N-95 masks was observed in the hallway by the resident's room. Signage was posted at the door to inform staff and visitor of the proper PPE to wear prior to enter the room. Other staff who were assisted with the meal delivery attempted to alert the RN not to enter the room without the proper PPE. The RN handed the breakfast tray to the resident that was standing half way in the room. The administrator had a conversation with the RN and the RN went and washed her hands. On 05/26/23 at 8:45 AM, the surveyor interviewed the RN in the presence of the Administrator. The RN stated, "I should have donned PPE prior to enter the isolation's room." The facility was made aware of the above concerns with infection control on 06/02/23 at	F 880		

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F 880	Continued From page 160 2:15 PM. On 06/05/23 at 8:35 AM, the Regional LNHA #2 provide a folder with some in-services education that were done. No additional information was provided. NJAC 8:39-19.4 (a)(b)(c)(k)(m)(n)	F 880		
F 917 SS=F	Resident Room Bed/Furniture/Closet CFR(s): 483.10(i)(4), 483.90(e)(2)(3) §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv) §483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced	F 917		6/23/23

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F 917	Continued From page 161 by: Based on observation, interview and record review, it was determined that the facility failed to provide: a) a comfortable chair for each resident in his or her room for use by the resident or the resident's visitor for 66 of 157 residents, (b) a bed table with drawers for 3 of 157 residents, and c) individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident for 2 of 157 residents. This deficient practice was observed on resident Wings (Wing and was evidenced by the following: 1.On 05/30/23 at 8:47 AM, Surveyor #3 conducted resident room rounds on Unit A and observed the following: Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room housed 3 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and one chair Room 8 housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 3 residents and two chairs On 05/30/23 at 8:48 AM, Surveyor #2 conducted resident rooms rounds on Unit and observed the following: Room # housed 2 residents and one chair	F 917	Element One - Corrective Action: Rooms , and were provided chairs to ensure each resident had their own. Rooms and were provided bedside tables to ensure each resident had their own. Room was provided closet space to ensure each resident had their own. Element Two -Identification of at Risk Residents: All resident rooms have the potential to be affected by this. Administrator/designee completed a house-wide audit of all resident rooms to identify any rooms that were missing the required pieces of furniture. Element Three Systemic Change: Administrator/designee completed audit of resident rooms to ensure that each resident within the room has the appropriate piece of furniture available to them. The administrator was educated on ensuring that each resident has a chair, bedside table, and closet space available to them. A house-wide education was completed on staff identifying missing pieces of furniture in resident rooms, and the proper protocol for notifying the administrator to replace the furniture. Element Four - Quality Assurance: A random audit of 5 resident rooms per unit, will be completed to ensure each	

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F 917	Continued From page 162 Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 1 resident and no chairs Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room housed 2 residents and one chair Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room housed 2 residents and no chairs Room #34 housed 2 residents and no chairs On 05/30/23 at 8:53AM Surveyor #4 conducted resident room rounds on Unit observed the following: Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and no chairs Room housed 2 residents and one chair Room 6 housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 2 residents and one chair Room housed 3 residents and no chairs Room housed 3 residents and two chair On 05/30/23 at 8:54 AM Surveyor #5 conducted resident room rounds on Unit and observed the following: Room housed 2 residents and one chair Room housed 2 residents and one chair Room # housed 2 residents and one chair	F 917	resident has a chair, bedside table, and closet space available to them. Administrator/designee will complete Audit weekly x4, monthly x2. Needed corrections will be addressed as they are discovered. Audit Results to be reported monthly times 3 to Quality assurance performance improvement team for review and revision as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING ______ B. WING ______	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

(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 917	Continued From page 163	F 917		

Room # housed 2 residents and one chair
Room # housed 2 residents and one chair
Room # housed 1 resident and no chair

2. On 05/30/23 at 8:47 AM, Surveyor # 3 and #4 conducted resident room rounds on Unit and observed the following:

Room # housed 2 residents and one bedside table with drawers
Room # housed 2 residents and one bedside table with drawers
Room housed 3 residents and two bedside table with drawers

3.On 05/30/23 at 8:54 AM, Surveyor #5 conducted resident room rounds on Unit and observed the following:

Room housed 2 residents and there was no closet for each resident.

On 05/23/23 at 1:18 PM, Surveyor #2 accompanied by the Licensed Nursing Home Administrator (LNHA) completed environmental rounds on Unit The LNHA stated that she was not aware of the conditions of the rooms. She further stated that she made daily rounds on the units.

On 06/02/23 at 10:53 AM, in the presence of the survey team, and in response to the environmental rounds that were completed by the survey team and shared with the Administration, the Regional Administrator (RA #2) addressed the survey team. The RA #2 stated that every concern that was provided to the facility, he took "personally" and called on sister facilities to

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	315263	A. BUILDING ______ B. WING ______	C 06/05/2023

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PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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F 917	Continued From page 164 provide assistance. The RA #2 further stated that "when you look at the building and the clients it doesn't take long for everything to go to [exploitive redacted]". The RA #2 further sated he was called into the facility for support as the RA #1 was responsible for checking on the facility. The Admission Agreement, undated, and was provided to the survey team during the entrance conference on 05/22/23 at 12:02 PM revealed the following: Exhibit 5, Resident Rights: ... Physical and Personal Environment ... To live in a safe, clean comfortable and home-like environment ... NJAC 8:39-31.8(c)(1-4)(10)	F 917		
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation, it was determined that the facility failed to ensure corridors were equipped with intact, firmly secured handrails. The deficient practice occurred on 3 of 3 units and was evidenced by the following: On 05/23/23 at 1:02 PM, on [redacted] Wing, two surveyors were observing the facility environment. In the hallway outside of room [redacted] the surveyors observed a broken handrail with sharp edges. On 05/23/23 at 1:14 PM, during an interview with	F 924	F924 Element One - Corrective Action: The handrails outside of room(s) [redacted] [redacted], the [redacted]-side of [redacted] wing, and in the hallway of [redacted]-Wing, were all repaired to ensure the handrails were intact and securely firm. Element Two -Identification of at Risk Residents: All the residents has the potential to be affected by this deficient pratice All corridors were audited to ensure the handrails within them were intact and	6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING ______ B. WING ______	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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F 924 Continued From page 165

the two surveyors, the Licensed Nursing Home Administrator (LNHA) stated that she made rounds in the mornings. She stated that most of the whole floor Wing) "does for themselves". She further stated, "you do realize the whole building is behavioral."

On 05/23/23 at 1:16 PM, the two surveyors escorted the LNHA to the broken handrail. The LNHA stated, "I didn't see it.". The surveyors and LNHA observed a loose handrail in the hallway outside of room A Certified Nursing Assistant (CNA) was present and stated a maintenance staff member had been "pulling at it yesterday". The LNHA stated she was unaware yesterday of the handrail being loose.

On 05/23/23 at 1:22 PM, the LNHA showed the two surveyors the Wing maintenance book. She stated when you "see something broke, I put it in here. They come in here every morning and look at the book and fix it." The last entry in the Wing maintenance book was dated 05/08/23.

On 05/23/23 at 1:38 PM, during an interview with the surveyors, the LNHA stated that maintenance had two pieces to fix handrails. She stated until the handrails were fixed, the staff would have to watch the residents, so they don't go there. The surveyors and LNHA observed there were no staff at the nursing desk.

On 05/24/23 at 8:26 AM, on Wing outside of room 9, Surveyor #1 observed the lower handrail was broken. The LNHA and Director of Nursing (DON) were at the nursing station. The LNHA stated she had looked at handrails that morning and that she was letting maintenance know.

F 924

firmly secured.

Element Three Systemic Change:
The Maintenance department was educated on ensuring corridors were equipped with intact, firmly, secured handrails. A house-wide education is being completed on staff utilizing the daily rounds work log that addresses any broken equipment on the resident care floors for the maintenance staff to address. In addition, a house-wide education was completed on staff identifying handrails that are not intact and/or securely firm, and the proper protocol to address the situation.

Element Four - Quality Assurance:
The Maintenance Department will complete a random corridors to ensure the handrails are firm, intact, and secured weekly, for four weeks, and monthly for 2 months. Results to be reported monthly to QAPI for 3 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING ______ B. WING ______	C 06/05/2023

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PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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F 924	Continued From page 166	F 924		

On 05/24/23 at 8:37 AM, on [redacted] Wing [redacted] side, Surveyor #3 observed a section of handrail leading to the resident [redacted] area. The handrail was visibly pulled away from the wall at the corners of the handrail. Survey #3 touched the handrail and it loose and able to be moved up and down.

On 05/24/23 at 9:08 AM, the LNHA was present, and Surveyor #3 asked where to find the maintenance department. The LNHA was shown the handrail and stated that the maintenance staff "was out and he will return shortly".

On 05/24/23 at 9:11 AM, the Maintenance Director arrived on [redacted]-Wing and Surveyor #3 showed him the unsecured, loose handrail. The Maintenance Director stated he checks the handrails "as needed" and that it was important for the handrails to be secure so "residents don't fall".

On 05/24/23 at 8:46 AM, on C-Wing, two surveyors observed a broken lower handrail on the corner with the corner cap missing. This was observed directly across from the nursing station with residents ambulating freely in the area.

A review of the facility provided, "Admission Agreement", undated, included but was not limited to Resident Rights ...Physical and Personal Environment ...to live in a safe, clean comfortable and home-like environment ....

A review of the facility provided, "Facility Assessment Tool", dated 10/2022, included but was not limited to 3.8 The [name redacted] facility "ensures equipment is maintained and monitored to protect and promote the health and safety of

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	315263	A. BUILDING ______ B. WING ______	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

(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 924	Continued From page 167 our residents. The facility's maintenance department has a preventative maintenance program in place to maintain the physical plant and equipment in a safe manner." NJAC 8:39-27.1 (a); 32.1 (a); 32.3 (a)	F 924		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060307	A. BUILDING: ______ B. WING ______	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD MAPLE SHADE, NJ 08052**

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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5750	8:43E-13.4(b) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to accurately complete the New Jersey Universal Transfer Form (UTF) for one resident. This deficient practice was identified for 1 of 3 residents (Resident #23) reviewed for falls with injury and was evidenced by the following: According to the Admission Record, Closed Record Resident #23 was admitted with diagnoses which included but were not limited to, unspecified dementia, acute kidney failure, blindness left eye, acquired absence of right leg above the knee. Review of the Significant Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care, dated 02/28/23, revealed that Resident #23 had severe cognitive impairment. Section G of the MDS, which referred to Activities	H5750	ELEMENT ONE: CORRECTIVE ACTION: Director of Nursing unable to modify Universal Transfer Form for Resident #23 is no longer at facility and the record is closed and cannot modified The Director of nursing educated the licensed nurses on how to properly filled a Universal transfer form. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS all resident has the potential to be affected by this deficient practice Residents who have been transferred out of the facility have the potential to be affected by this practice. Director of Nursing/Designee performed an audit on 6/23/23 of residents who were transferred x last 30 days to verify if all sections of the New Jersey Universal Transfer Form were completed.	6/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060307	A. BUILDING: ____ B. WING ____	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H5750	Continued From page 1 of Daily Living (ADL's) revealed that Resident #23 was totally dependent on staff for care and required extensive assistance of two person physical assist for transfer, and one person physical assist for care. Review of a progress note documented by a Registered Nurse in the Electronic medical Record (EMR) noted the following entry dated 05/24/23 timed 21:37 PM: "This note is a follow up to: 5/21/2023 07:39:00 Nursing Progress Note (Other)" Effective Date: 5/24/2023 21:10:00 Department: Nursing Position: Registered Nurse Created Date: 5/24/2023 21:37:06 The Note text revealed ... On 5/21/23 at 7:39 AM CNA advised me that res [resident] fell in his room ... 911 was called for immediate attention and MD was notified. No family listed. EMTs transferred resident to [hospital name redacted] for further observation of the resident. Onboarding nurse made aware ... Review of the UTF, dated 05/21/23 revealed the following: Reason for Transfer: fell out of bed, bleeding profusely from head. -The vital signs were recorded as (blood pressure) BP 192/52, Pulse 86, and Temperature 96.4; Bottom of the page the vital signs handwritten on the page as BP 123/65,Temperature 97.3 HR (hear rate) 83, 100% [oxygen concentration]. -The following sections on the UTR were left blank: Time of Transfer, Code Status, Secondary Diagnosis, Restraints, Respiratory Needs, Isolation/Precaution, Sensory, Skin Condition, Diet, IV Access, Personal Items Sent with Patient,	H5750	ELEMENT THREE: SYSTEMIC CHANGES: Director of Nursing/Designee continue to in services licensed nurses on ensuring accurate completion of all sections of the New Jersey Universal Transfer Form for resident transfers. Residents who are transferred will be reviewed in Clinical Meeting to ensure all sections of the New Jersey Universal Transfer Form have been accurately completed. Director of Nursing/Designee inserviced Nursing shift supervisor on ensuring that the forms are accurately and completely filed out ELEMENT FOUR: QUALITY ASSURANCE: Director of Nursing/Designee will audit all residents transferred weekly x 4 then monthly x 2 to verify the accurate completion of the New Jersey Universal Transfer Form. Audit results will be reported to Quality assurance performance improvement team monthly x 3 for review and revision as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060307	A. BUILDING: ______ B. WING ______	C 06/05/2023

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PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD MAPLE SHADE, NJ 08052**

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H5750	Continued From page 2 Bowel, Bladder and Attached Documents. -The following additional sections were also left blank: Sending Facility Contact Unit and phone number and the signature of section titled:Form Completed By (Name, Title, Unit and Phone). During an interview with the surveyor on 06/02/23 at 1:06 PM, the Director of Nursing stated that the nurse or supervisor completed the UTF which would include vital signs, resident's name, allergies, diet, wounds, ADL's (activities of daily living), awake alert and oriented status, date and time of the transfer and the reason for the transfer. Sometimes the nurses would miss it [the UTF] because 911 was called and 911 would tell the nurses they don't need a transfer form. No additional information was provided by the facility. N.J.A.C. 8:43E-13.4(b)	H5750		
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and	S 560		6/23/23

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	060307	A. BUILDING: ____ B. WING ____	C 06/05/2023

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PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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S 560	Continued From page 3 regulations. This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from the Standard Survey of 03/31/22. Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in CNA staffing for 2 of 14-day shifts reviewed. Findings include: 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 Aide (CNA) 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and	S 560	The facility leadership team has met on an on-going basis and will continue to identify staffing challenges and areas of improvement for certified nursing assistants (C.N.A.). ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: The facility has implemented a significant above market rate for certified nursing assistants. Recruitment continues to be a focus and interviews are conducted in a timely manner and contingency offers are made the same day as the interview. The facility adopted a new recruiting platform that has been effective in garnering new hires. Our onboarding process is being expedited with the Human Resources department team. Additional agencies have been explored and added to continue to support open positions. Weekly staffing meetings to discuss recruitment and retention in addition Certified nursing assistance opening, applications and position filled Regional director of Nursing inserviced	

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	060307	A. BUILDING: ___ B. WING ___	C 06/05/2023

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S 560	Continued From page 4 One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the 2 weeks from 05/07/2023 to 05/20/2023 revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -05/13/23 had 19 CNAs for 158 residents on the day shift, required 20 CNAs. -05/14/23 had 19 CNAs for 158 residents on the day shift, required 20 CNAs. During an interview with the surveyor on 05/24/23 at 10:17 AM, the Staffing Coordinator (SC) stated that she had been employed at the facility since 1996. Since the pandemic her position was full-time Staffing Coordinator and Business Office Manager and that her job description was to complete the daily nurse and CNA staffing schedule for all 3 shifts. The SC revealed that she also assists with hiring of CNAs by performing the second interview of a possible candidate for employment. The SC acknowledged the new minimum staffing requirements for nursing homes and feels that she was meeting those ratios. The SC added that the weekends are more challenging, but the facility staff would work as a team to chip in and help. Many nurses are doing doubles and filling in as needed. The SC stated that the facility does use two nursing agencies to fill the staffing needs of CNAs and sometimes nurses. Monetary incentives and bonuses are	S 560	Administrator/Human Resources coordinator regarding staffing ratios ELEMENT FOUR: QUALITY ASSURANCE: The Director of Nursing (DON) and/or Assistant Director of Nursing reviews staffing schedule weekly and coordinates with the staffing coordinator/ Human Resources the needs of the center. The Human Resources director/designee will audit call outs and staffing ratios weekly related to certified nursing assistants staff members and summarize for the Administrator. The Human Resources director will summarize all applicants and positions filled weekly until positions are filled and report to administrator weekly The results of these audits will be submitted to Quality Assurance and Performance Improvement (QAPI) monthly for further review and revision.	

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S 560	Continued From page 5 given to the facility staff for overtime, which does not have to be approved by administration. The SC revealed that when staff are calling out, they need to notify the SC or the nursing supervisor. The nursing supervisor can call the SC or a nursing agency to fill any staff vacancies. The SC added that the nursing department handles the orientation for agency staff, and the nursing agencies are responsible to provide and send to the facility the CNA's or nurse's credentials, such as their license, education, or CNA certification. The SC revealed that a Registered Nurse (RN) was always assigned daily on each shift and if an RN called out, the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) would work. The SC stated that she communicates daily with the Licensed Nursing Home Administrator (LNHA) and the DON regarding staffing. NJAC 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060307	A. Building B. Wing	7/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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 06/23/2023	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	
6/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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)
315263	A. Building B. Wing	7/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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 Reg. # 483.10(a)(1)(2)(b)(1)(2) LSC	Correction Completed 06/23/2023	ID Prefix F0565 Reg. # 483.10(f)(5)(i)-(iv)(6)(7) LSC	Correction Completed 06/23/2023	ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 06/23/2023
ID Prefix F0636 Reg. # 483.20(b)(1)(2)(i)(iii) LSC	Correction Completed 06/23/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 06/23/2023	ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 06/23/2023
ID Prefix F0685 Reg. # 483.25(a)(1)(2) LSC	Correction Completed 06/23/2023	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 06/23/2023	ID Prefix F0692 Reg. # 483.25(g)(1)-(3) LSC	Correction Completed 06/23/2023
ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 06/23/2023	ID Prefix F0725 Reg. # 483.35(a)(1)(2) LSC	Correction Completed 06/23/2023	ID Prefix F0800 Reg. # 483.60 LSC	Correction Completed 06/23/2023
ID Prefix F0801 Reg. # 483.60(a)(1)(2) LSC	Correction Completed 06/23/2023	ID Prefix F0804 Reg. # 483.60(d)(1)(2) LSC	Correction Completed 06/23/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 06/23/2023

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

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)
315263	A. Building B. Wing	8/8/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 08/08/2023	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 08/08/2023	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

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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)
315263	A. Building B. Wing	7/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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 F0814 Reg. # 483.60(i)(4) LSC	Correction Completed 06/23/2023	ID Prefix F0835 Reg. # 483.70 LSC	Correction Completed 06/23/2023	ID Prefix F0867 Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii) LSC	Correction Completed 06/23/2023
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 06/23/2023	ID Prefix F0917 Reg. # 483.10(i)(4), 483.90(e)(2)(3) LSC	Correction Completed 06/23/2023	ID Prefix F0924 Reg. # 483.90(i)(3) LSC	Correction Completed 06/23/2023

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
6/5/2023

☐ 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
	315263	A. BUILDING **01** B. WING ______	**06/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

(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 000	INITIAL COMMENTS LIFE SAFETY CODE 101:2012 THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R. The nursing home building construction was stated to be 1980s with no current major renovations or noted additions. It is a two story building Type V (111) construction and is fully sprinklered and has 7-smoke zones. The building has a partial basement under the A-wing. There is supervised smoke detection located in the corridors, spaces open to the corridors and battery operated in resident rooms. The interior natural gas generator is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The generator does approximately 30% of the building. The partial 2nd story 50' x 30' contains office space, supply room, HR office (2-staff members), conference room, medical records office, various closets. The 2nd floor has only one acceptable exit (K-241). The facility has a completion date of 12/7/23 to install a second exit/egres on the floor 2. The facility has 165 certified beds. At the time of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/27/2023

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
	315263	A. BUILDING 01 B. WING	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

(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 000	Continued From page 1 the survey the census was 157.	K 000		
K 241 SS=F	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/26/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that two acceptable exits, remote from each other, were provided for each floor/story of the building. This deficient practice was evidenced for 1 of 1 areas of the facility by the following: During the survey entrance conference held at 8:50 AM, the surveyor asked the MD, if the facility had any waivers. The MD stated to the surveyor that the facility had a Fire Safety Evaluation Systems (FSES) for the [redacted]) floor for having one acceptable exit from the 2nd floor. The surveyor toured the [redacted] floor and observed one acceptable exit from the [redacted] floor. This exit consisted of a single stairway to the main floor. At that time, the surveyor further observed (2) two facility staff members that were occupying the	K 241	K241 Element 1: This deficiency will be corrected before the waiver ends on 12/7/2023. If we are unable to complete the project, the facility will request an extension on the waiver. A quote is being prepared to install a second egress path from the second floor. Element 2: No residents are affected by this deficiency, as it is in a non-patient care area with coded locks to enter. Element 3: A quote is being obtained to install a second egress path from the second floor. An audit of the egress paths will be conducted to ensure they are working properly. Element 4: The newly installed second egress path will be audited weekly x4 by the Maintenance Director or designee, then monthly x2. The results of the audits will be reported to the QAPI meetings.	6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING **01** B. WING	**06/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

(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 241	Continued From page 2 2nd floor offices. When interviewed, the MD and RPOD, stated that residents were not permitted in this section of the building and that only authorized personnel had the code to unlock the stairway door. In addition, the [redacted] floor was used for the business and medical records offices and were for staff use only. Also, the [redacted] floor and exit stairway were protected by the fire alarm system and an automatic fire sprinkler system. The MD and RPOD further stated that staff would be in-serviced on the hazard of having only one exit from the [redacted] floor at orientation and annually thereafter, and that the facility would conduct at least one fire drill on the [redacted] floor each year. The MD and RPOD, indicated that the waiver to construct a [redacted] exit/egress was not expired, and good until 12/07/23. The surveyor informed the MD and RPOD of the waiver project expiration date of 12/07/23 at the Life Safety Code survey exit on 5/30/23. NJAC 8:39-31.1(c), 31.2(e)	K 241		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by:	K 281		6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING **01** B. WING ______	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

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K 281	Continued From page 3 Based on observation and interviews conducted on 5/30/23 in the presence of facility Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 2 of 5 occupied access areas observed and was evidenced by the following: 1). At 09:48 AM, the surveyor in the presence of the MD and RPOD observed in the resident occupied [redacted] day room, that 2-wall switches shut-off all 14 light fixtures. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. 2). At 11:53 AM, the surveyor in the presence of the MD and RPOD observed in the resident occupied [redacted] day room, that 3-wall switches shut-off all 14 light fixtures. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The MD and RPOD both confirmed the finding's at the time of observations. The MD and RPOD were informed of these findings at the Life Safety Code survey exit conference on 5/30/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	Element 1: This deficiency was corrected by creating emergency illumination that will operate automatically along the means of egress in accordance with National Fire Protection Association 101, 2012 edition, section 19.2.8 and 7.8. This emergency lighting will be installed in the A-wing day room and the C-wing day room. Element 2: All residents have the potential to be affected by this deficiency. An audit of all day rooms was completed to ensure emergency illumination was in place. Element 3: The maintenance department was educated on ensuring emergency illumination is present along the means of egress. Two automatic emergency lighting units were created in the A-wing day room and the C-wing day room. Additionally, an audit of the lighting units will be conducted to ensure the units are working properly. Element 4: The Nursing Home Administrator/Designee will audit the automatic emergency lighting units weekly x4, monthly x2. The results of the audits will be reported to the monthly Quality Assurance Performance Improvement meetings x3 months.	
K 321 SS=D	Hazardous Areas - Enclosure	K 321		7/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING 01 B. WING ___	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

(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 321	Continued From page 4 CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 5/30/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), A), it was determined that the facility failed to provide a fire barrier with one hour fire resistance rating in	K 321	Element 1 o The Administrator has revised and resubmitted the Time Limited Waiver for an extension to finish replacing the smoke doors in the following areas: basement generator room, basement personal	

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	315263	A. BUILDING 01 B. WING ______	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

(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 321	Continued From page 5 accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice was evidenced for 1 of 5 hazardous areas observed. B), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. A), At 11:34 AM, the surveyor observed in the generator room that an approximately 2' x 1' opening in the wallboard was observed in the ceiling. exposing combustible wood above the ceiling. The area was not fully protected in fire-rated material. The MD and RPOD both confirmed the finding in the generator room. B-1), At 11:42 AM, the surveyor observed in the basement that the smoke door was observed to have gaps approximately 1/4" at the top and bottom of the door to frame assembly. B-2), At 11:51 AM, the surveyor observed in the basement that the black personal clothes room door, did not have any fire resistant rating label, did not latch and the door frame was observed to be loose. B-3), At 11:57 AM, the surveyor observed in the basement storage room, right of the fire alarm annunciator panel, that the black door did not have a fire resistant rating label. B-4), At 11:59 AM, the surveyor observed in the basement that the black door to the chute room	K 321	clothing room, basement chute room, basement end unit storage room, across from the boiler room. " Element 2 o All residents have the potential to be affected by this deficient practice. " Element 3 o The maintenance department was educated on ensuring all smoke doors properly latch, with the proper sealing. The Administrator/Designee will audit all smoke doors to ensure they positively latch with the proper sealing. " Element 4 o The Administrator/Designee will complete a random audit of 5 smoke doors weekly x4, monthly x2 to ensure they positively latch, with the proper sealing. Results of the audits will be discussed at monthly QAPI x2. Anticipated date of completion will be on or before 9/1/2023	

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	315263	A. BUILDING **01** B. WING	**06/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

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K 321	Continued From page 6 did not have a fire resistant rating label. B-5), At 12:05 PM, the surveyor observed in the end unit storage room across from the boiler room, that the door did not have a fire resistant rating label. B-6), At 12:41 PM, the surveyor observed in the medical records office, that the door did not have an auto-closing device. The room was storing 40 plus filled combustible cardboard boxes and the room was greater than 50 square feet in size. The MD and RPOD confirmed the findings during the basement building tour on 5/26/23. The MD and RPOD were informed of the findings at the Life Safety Code exit conference on 5/30/23. NJAC 8:39-31.2(e)	K 321		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited 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	K 324		6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING **01** B. WING ___	**06/05/2023**

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PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

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K 324	Continued From page 7 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review on 5/30/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility: A) failed to ensure that 1 of 1 exhaust hood systems were maintained in optimal condition at all times in the facility as per NFPA 96, and B) it was determined that the facility failed to ensure facility vendor report deficiencies were repaired as per NFPA 96. This deficient practice was evidenced by the following: A) At 12:25 PM, the surveyor observed the kitchen hood cleaning inspection report dated 4/13/22. The system is required to be inspected semi-annually. The MD indicated they were getting a new kitchen hood cleaning vendor and this maybe why the semi-annual inspection was missed. The semi-annual report of the hood cleaning inspection was almost 8-months overdue. B) A proposal and service agreement from the facility vendor dated 4/5/22 indicated:	K 324	Element 1: This deficiency was corrected by repairing the hood as indicated in that proposal dated 4/5/2022, including: upgrading the control head, remounting the new control head on the wall near the existing cylinder (move existing link line, gas line, pull station conduit and re-cable), and replacing the 4-nozzles that have seized. The new hood cleaning vendor was contacted to complete inspection. Element 2: All residents have the potential to be affected by this deficiency. Element 3: The hood repair was installed which included: upgrading the control head, remounting the new control head on the wall near the existing cylinder (move existing link line, gas line, pull station conduit and re-cable), and replacing the 4-nozzles that have seized. The new hood cleaning vendor was contacted to complete the inspection. Additionally, an audit of the hood will be conducted to ensure the unit is working properly. Element 4: The Nursing Home Administrator/Designee will audit the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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K 324	Continued From page 8 Existing control head is out of date and in need of upgrade. Remount new control head on the wall near the existing cylinder (move existing link line, gas line, pull station conduit and re-cable). Replace 4-nozzles that have seized and unable to remove. Document review on 1/19/23 indicated that the (NEW) kitchen suppression vendor documented deficiencies to the current system as: Cylinder missing labeling and is not UL compliant Control head is not UL compliant Improper nozzle protection over appliances The MD during document review indicated that the facility new vendor performed the initial semi-annual kitchen inspection and reported the system to be no longer UL compliant and the facility new appliances are not properly protected; Technician advised customer that the system would require an overhaul, including a new control head, new cylinder, and re-piping of appliance nozzles to make system compliant. No further information was provided. The MD and RPOD were notified of the finding at the life safety code exit conference on 5/30/23. Reference: NFPA 96 19.3.2.5.3* (10) Procedures for the use, Inspection, Testing, and Maintenance of the cooking equipment are in accordance with Chapter 11 of NFPA 96 and the Manufacturers instructions and are followed. NJAC 8:39-31.2(e)	K 324	kitchen hood weekly x4, monthly x2 to ensure it is clean and properly functioning. Any findings will be corrected as found. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement x3.	

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K 324	Continued From page 9 NFPA 96, 19.3.2.5.3*(10)	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 5/26/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD) it was determined: A) that the facility failed to ensure smoke detection sensitivity testing was completed for the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. for 2 of 2 inspection documents provided, and B) it was determined that the facility failed to provide complete testing inspection documentation for resident room installed battery operated smoke detectors for 3 of 3 resident wings in the facility. A) At 11:10 AM, the surveyor reviewed all related fire alarm documentation provided by the MD from the fire alarm vendor to determine if the sensitivity test was performed. The fire alarm vendor inspection reports were dated: 1/20/23 and 7/22/22 and both reports failed to indicate when the last fire smoke detector sensitivity report had been conducted.	K 345	Element 1: This deficiency was corrected by immediately conducting a smoke detection sensitivity test for the facility smoke detectors, as well as a sensitivity test for the resident room battery operated smoke detectors on all 3 wings in accordance with National Fire Protection Association 72 (2010 edition) section 14.4.5.3.2. Element 2: All residents have the potential to be affected by this deficiency An audit of all smoke detectors was conducted to ensure the units are working/functioning properly. Element 3: The maintenance department was educated on completing monthly smoke detector inspections. Element 4: The maintenance director/designee will complete a random smoke detector test to ensure they are functioning properly. Audits will be conducted weekly x4, monthly x2. The results of the audits to the monthly Quality	6/23/23

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K 345	Continued From page 10 An interview was conducted with the MD during document review who indicated he was not sure if the required sensitivity test for the facility smoke detectors had been performed. The MD indicated he would contact the facility fire alarm vendor to see if sensitivity testing was performed. No further documentation was provided. B) At 12:00 PM, the MD provided a resident room smoke detector test log for the battery operated devices. The log only indicated a monthly check of resident wings: [redacted] wing and did not provide any information for each resident room that the battery operated devices were installed in. The log did not indicate monthly testing in resident rooms of each device, including device type, type of battery and individual installation date. The MD and RPOD were informed of the findings at the Life Safety Code Exit conference on 5/30/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	Assurance Performance Improvement meetings x3 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.	K 353		6/23/23

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K 353	Continued From page 11 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 surveyor observation on 5/30/23 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. This deficient practice was evidenced by the following: At 10:33 AM, the surveyor observed 4 of 14 sprinkler heads in the facility's kitchen with a green coating of oxidation/corrosion in the following areas: 2-fire sprinkler heads with a coating of green oxidation and/or corrosion over the 2-refrigerators 2-fire sprinkler heads with a coating of green oxidation and/or corrosion in the dish cleaning section of the kitchen. The Maintenance Director and Regional Plant Operations Director confirmed the findings during the kitchen observations. The MD and RPOD were informed of the findings	K 353	Element 1: The facility is working with a vendor to install four new sprinkler heads in the following locations: 2-fire sprinkler heads with a coating of green oxidation and/or corrosion over two refrigerators, as well as 2-fire sprinkler heads with a coating of green oxidation and/or corrosion in the dish cleaning section of the kitchen. Element 2: All residents have the potential to be affected by this deficiency. Element 3: The facility is working with a vendor to install the four new sprinkler heads in accordance with NFPA 25 □ Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Additionally, an audit of all sprinkler heads will be conducted to ensure they are working properly and are free from oxidation and/or corrosion. Element 4: A random sprinkler head will be audited weekly x4, monthly x2. The results of the audits will be discussed at QAPI meetings monnthly.	

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K 353	Continued From page 12 at the Life Safety Code exit conference on 5/30/23. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or 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	K 363		6/23/23

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K 363	Continued From page 13 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 5/30/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), 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 room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in 18 of 48 resident room (RR) doors observed and was evidenced by the following: During the building tour on 5/30/23 from 9:15 AM to 1:45 PM, the surveyor in the presence of the MD and RPOD toured the facility and observed the following compromised RR doors: RR # 1 top of door 1/4" to 1/2" gap RR # 4 door does not fully close into frame, loose latch RR # door will not latch into frame RR # latch on frame loose RR # top door has open gap RR # door does not latch into frame RR # door does not latch into frame RR # door does not latch into frame	K 363	Element 1: This deficiency was corrected by correcting all issues stated in the deficiency of resident rooms including: RR closed gap, RR tightened latch to allow the door to fully close into frame, RR door now latches into frame, RR latch on frame tightened, RR closed gap, RR door now latches into frame, RR door now latches into frame, RR door now latches into frame, RR # latch added to door and no longer rubs into frame, RR tightened hardware, RR tightened door knob and no longer rubs into frame, RR closed gap, RR 1 door no longer rubs into frame, RR # door no longer rubs into frame, RR tightened hardware, RR #55 door no longer rubs on floor, RR tightened hardware, and RR door no longer rubs into frame. Element 2: All residents in identified resident rooms are affected by this deficiency An audit of all resident doors was completed to ensure they were properly latching. Element 3: The maintenance department was educated on ensuring all resident room doors properly latch into their frame. Additionally, all stated issues with resident	

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K 363	Continued From page 14 RR # door missing latch and rubs into frame RR # loose hardware RR # loose door knob and rubs into frame RR # door has an approximately 3/4" top gap RR # door rubs into frame RR # door rubs into frame RR # loose hardware RR # door rubs on floor RR # loose hardware RR # door rubs into frame At the time of observations, the surveyor interviewed the MD who confirmed the above findings. The MD and RPOD was informed of the findings at the Life Safety Code exit conference on 5/30/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	room doors have been corrected to allow proper closing of all doors. Element 4: The maintenance department/designee will complete random audit of resident room doors weekly x4, monthly x2 to ensure they are properly latching. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement meeting, monthly x3.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal	K 374		6/23/23

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K 374	Continued From page 15 doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/30/23, in the presence of the Maintenance Director (MD), Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame, or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was observed for 2 of 6 sets of double smoke door sets observed and tested for closure and was evidenced by the following: 1) At 11:51 AM, the surveyor observed that the set of smoke doors by [redacted]-wing resident rooms [redacted] and [redacted] when closed from the electro-magnetic door closing device, the set of wooden doors closed, 1 of 2 doors were warped and a 3/4" gap remained at the astragal of the closed door. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire compromising the integrity of the smoke zones. 2) At 11:51 AM, the surveyor observed that the set of smoke doors by [redacted]-wing resident rooms 69 and 70 when closed from the electro-magnetic door closing device, the set of wooden doors closed, 1 of 2 doors were warped and a 1/4" to 1/2" gap remained at the astragal of the closed door. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke	K 374	Element 1: The facility purchased new smoke barrier doors for [redacted]-wing resident rooms [redacted] and [redacted], as well as C-wing resident rooms [redacted] and [redacted] that are resistant to fire for a minimum of twenty minutes. Element 2: All residents in [redacted]-wing are affected by this deficiency. An audit was completed of all smoke barrier doors to ensure they properly latch. Element 3: The Maintenance department was educated on ensuring all smoke barrier doors positively latch. Element 4: The Maintenance department/designee will complete an audit of smoke barrier doors to ensure they are properly latching weekly x4, monthly x2. The results of the audits will be reported to the monthly Quality Assurance Performance Improvement meeting x3 months.	

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K 374	Continued From page 16 compartment to another in the event of a fire compromising the integrity of the smoke zones. The MD and RPOD all confirmed the finding's during the smoke-door observations. The MD and RPOD were informed of the findings at the Life Safety Code exit conference on 5/30/23. NJAC 8:39-31.2(e)	K 374		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/30/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure resident room portable window air conditioner (AC) units were adequately maintained and operating in optimal condition, in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was identified for 4 of 43 observations and was evidenced by the following:	K 521	Element 1: This deficiency was corrected by immediately cleaning RR [redacted] and RR #15 units, RR #[redacted] had their right air-vent repaired, and a filter was added to AC unit in [redacted]-wing dining room. Element 2: All residents in [redacted]-wing are potentially affected by this deficiency. The Maintenance Department/Designee will complete an audit of all AC units to ensure they are clean and working properly. Element 3: The Maintenance and Housekeeping department were educated	6/23/23

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K 521	Continued From page 17 While touring the facility with the MD and RPOD from 09:15 AM, to 1:30 PM, the following observations were identified in resident room: RR [redacted] AC unit dirty RR [redacted] AC unit dirty fins under the filter RR [redacted] AC unit missing right air-vent exposing the interior of the fan [redacted]-wing dining room AC unit missing filter An interview was conducted with the MD during the observations, and he confirmed the findings, the facility did not have an AC inspection log to provide. The MD and RPOD were informed of the findings at the Life Safety Code exit conference on 5/30/23. NFPA 90 A Standard for the installation of ventilating systems NFPA 101-2012 -19.5.2.1 section 9.2.1 and 9.2.2 NJAC 8:39-31.2(e)	K 521	on ensuring AC units are clean, working properly, and maintained. Element 4: The Maintenance Department/Designee will complete a random resident room audit weekly x4, monthly x2 to ensure they are clean and properly functioning, Results of the audits to be discussed at monthly Quality Assurance Performance Improvement meetings x3 months	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all	K 741		6/23/23

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PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

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K 741	Continued From page 18 major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/30/23, in the presence of the Surveyor, Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. The practice of dumping cigarette butts and ash into trash cans with other combustibles, increases the risk of fire to facility occupants. This deficient practice was evidenced for 1 of 1 smoking areas observed and was evidenced by the following: At 1:14 PM, the surveyor, MD and RPOD observed in the occupied smoking courtyard between the [redacted] hall that a combustible garbage can was observed to have cigarettes, along with combustible paper and cardboard cups. The area was observed to have four oasis style ashtrays. The smoking supervisor indicated in an interview,	K 741	Element 1: This deficiency was corrected by purchasing Ashtrays with approved self-closing covered metal containers and replacing the Oasis style ashtrays. Element 2: All residents who are smokers have the potential to be affected. To ensure residents are protected from the risk of fire, the Nursing Home Administrator/designee will audit all smoke breaks to ensure resident cigarettes are safely disposed for 72 hours. Element 3: The smoking aides were educated on the procedure for proper disposal of resident cigarettes. Element 4: To ensure residents are protected from the risk of fire, the Nursing Home Administrator/Designee will complete an audit of all smoke breaks within the day weekly x4, monthly x2. Results of the audits to be reported to monthly Quality Assurance Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING **01** B. WING ______	**06/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

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K 741	Continued From page 19 that the oasis style ashtrays and combustible trash can were emptied into a plastic trash bag when they were full. The smoking area was not provided with an approved self-closing covered metal container's for the disposal of cigarette butts and ashes in the area. The finding's were verified by the RPOD and MD, at the time of the observations. The RPOD and MD were informed of the finding's at the Life Safety Code exit conference on 5/30/23. NJAC 8:39-31.2(e)	K 741	Improvement meeting x3 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 5/30/2023, in the presence of the Maintenance Director (MD), Regional Plant Operations Director (RPOD), 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 2 of 2 generator's. This deficient practice was evidenced for 1 of 1	K 911	Element 1: This deficiency was corrected by obtaining a Reliability Letter from the natural gas provider for the interior natural gas generator. Element 2: All residents are potentially affected by this deficiency. Element 3: A Reliability Letter was obtained from the natural gas provider. Additionally, the Administrator was in-serviced regarding the need to obtain	6/23/23

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	315263	A. BUILDING **01** B. WING ______	**06/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

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K 911	Continued From page 20 natural gas generators by the following: At 12:05 PM, the surveyor and MD reviewed all the facility's generator documentation. The facility currently has (1) one interior natural gas generator. The MD 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 confirmed there was no reliability letter available from the natural gas provider for the interior natural gas generator for the facility to present to the surveyor. No additional information was received. The MD and RPOD was informed of the findings at the Life Safety Code exit conference on 5/30/2023. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911	the Reliability Letter on an annual basis. Additionally, the Administrator will audit the Life Safety records, quarterly to ensure a Reliability Letter is obtained on an annual basis. Element 4: The Administrator will audit the Maintenance Department's LS binder on a quarterly, for three quarters, to ensure a Reliability Letter is obtained on an annual basis. Results of the audit will be reported to the monthly QAPI meeting monthly x3.	
K 918 SS=E	Electrical Systems - Essential Electric Syste	K 918		6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING 01 B. WING ___	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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K 918	Continued From page 21 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of	K 918	Element 1: This deficiency was corrected	

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	315263	A. BUILDING **01** B. WING ______	**06/05/2023**

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PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

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K 918	Continued From page 22	K 918		

facility documents on 5/26/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was identified for 3 of 12 monthly load test transfer times on the provided generator log and evidence was as follows:

At 10:25 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds for only 3 of 12 times on the provided generator log. Currently, the Maintenance Director was performing monthly generator load testing, but did not indicate the required transfer times on the provided log dates: 1/31/23, 12/27/22, 11/29/22, 10/25/22, 9/27/22, 8/30/22, 7/24/22, 6/28/22 and 5/31/22.

An interview was conducted with the MD, during document review and he stated that currently he just started installing the transfer time on the log for the most recent dates of: 4/25/23, 3/28/23 and 2/28/23.

The MD and RPOD were informed of the findings at the Life Safety Code exit conference on 5/30/23.

NJAC 8:39-31.2(e), 31.2(g)
NFPA 99
NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.
NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power

by in servicing the Maintenance Department on the proper procedures associated with certifying the time needed by the generator to transfer power to the building within the required 10 second time frame.
Element 2: All residents are potentially affected by this deficiency.
Element 3: The Maintenance Department was in-serviced on the proper procedures associated with certifying the time needed by the generator to transfer power to the building within the required 10 second time frame.
Element 4: The Maintenance Director/Designee will audit the generator load tests monthly x3, results of the inspection will be discussed at monthly Quality Assurance Performance Improvement x3 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING 01 B. WING	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 23 Systems	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, 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 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations on 5/30/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to meet the requirements of NFPA 99 by failing to maintain electrical equipment in accordance with NFPA 70, National Electrical Code. This deficient practice was evidenced for 2 of 6 appliance cords observed by the following: At 10:33 AM, the surveyor observed in the facility kitchen, that the electric plate warmer and electric pellet warmer, were observed to have exposed electrical wires. The (2) wires were pulled from the protective sheathing exposing single coated wires where the black cords entered the equipment. The MD stated and confirmed the findings during the kitchen observations. The MD and RPOD were informed of the findings at the Life Safety Code exit conference on	K 919	Element 1: This deficiency was corrected by purchasing a new plate and pellet warmer. Element 2: All residents are potentially affected by this deficiency. An audit of the all the plate and pellet warmers was completed to ensure they were functioning properly. Element 3: The dietary department was educated on ensuring that the plate and pellet warmer were functioning and in proper use for resident meals. Element 4: Additionally, the Nursing Home Administrator/Designee will complete an audit of the plate and pellet warmer to ensure they are properly functioning. Audits will be completed weekly x4, monthly x2. Results of the audit to be discussed at monthly Quality Assurance Performance Improvement x3.	6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING 01 B. WING ______	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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K 919	Continued From page 24 5/30/23. NJAC 8:39-31.2(e) NFPA 70, 99	K 919		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/30/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to prohibit the use of extension cords and power cords,	K 920	Element 1: This deficiency was corrected by immediately removing the power strips from the Housekeeping Director's office, as well as in-servicing all staff that power-strips are prohibited.	6/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING **01** B. WING ______	**06/05/2023**

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K 920	Continued From page 25 beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was identified for three 1 of 7 offices, observed and was evidenced by the following: At 11:12 AM, the surveyor and MD, observed in the housekeeping office that a microwave was plugged into a multi-outlet power strip that was plugged into another multi-outlet power strip then plugged into a duplex wall outlet. This was cited on the 5/17/23 report by the uniform fire code inspector ID # 0532. The findings were verified by the MD at the time of the observations, where he stated and confirmed that multi-outlet power strips cannot be plugged into each other (Daisy Chaining) and cannot be plugged into high draw appliances in the facility. The MD and RPOD were informed of the finding at the Life Safety Code Exit Conference on 5/30/23. NJAC 8:39-31.2(e)	K 920	Element 2: All residents are potentially affected by this deficiency. An audit of all administrative offices was completed to ensure extension cords were not in use. Element 3: The identified power strip was removed from the Housekeeping Director's office, and all staff were in-serviced regarding the prohibition of extension cords. Additionally, an audit will be conducted by the Maintenance Director/designee to ensure extension cords are not in use in administrative offices. Element 4: The Maintenance Director/designee will complete a random audit weekly x4, monthly x2 to ensure no power-strips are in use in the administrative offices. Results of the audit will be discussed at monthly Quality Assurance Performance Improvement meeting x3 months.	

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)
315263	A. Building 01 - MAIN BUILDING 01 B. Wing	7/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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 K0241	Correction Completed 06/23/2023	ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 06/23/2023	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 06/23/2023
ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 06/23/2023	ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 06/23/2023	ID Prefix Reg. # NFPA 101 LSC K0741	Correction Completed 06/23/2023
ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 06/23/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 06/23/2023	ID Prefix Reg. # NFPA 101 LSC K0919	Correction Completed 06/23/2023
ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 06/23/2023	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

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? ☐ YES ☐ NO
6/5/2023	

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)
315263	A. Building 01 - MAIN BUILDING 01 B. Wing	8/24/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	315 WEST MILL ROAD MAPLE SHADE, NJ 08052

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 K0321	Correction Completed 08/08/2023	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 08/08/2023	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 08/08/2023
ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 08/08/2023	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

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO