STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315228	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT COURT HOUSE, LLC	144 MAGNOLIA DRIVE CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey 2/2/2023 Census: 98 Sample Size: 24+2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		3/9/23

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

Electronically Signed | 02/17/2023

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F 690	Continued From page 1 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure that an EX Order 26.4B1 is maintained off the floor in accordance with professional standards of practice and facility policy. This deficient practice was identified for 1 of 1 Resident reviewed for an EX Order 26.4B1 EX Order 26.4B1 (Resident # 75) and was evidenced by the following: During the initial tour of the unit on 1/25/2023 at 10:17 AM, Resident #75 was observed resting in bed with eyes closed and with an EX Order 26.4B1 . The EX Order 26.4B1 was observed resting on the floor. On 1/27/2023 at 8:54 AM Resident #75 was observed awake, alert and nonverbal resting in bed. Resident #75's EX Order 26.4B1 EX Order 2 was observed touching the floor. A review of the Admission Record revealed that Resident #75 was admitted with a diagnosis including but not limited to: EX Order 26.4B1 EX Order 26.4B1 . A review of the Order Summary Report of active orders as of EX Order 26.4B1, revealed a physician's	F 690	1. The EX Order 26.4B1 for resident #75 was replaced and placed in a dignity bag. The care plan has been reviewed and updated. The certified nursing assistant and nurse responsible for monitoring placement were both re-educated on proper EX Order 26.4 bag placement and dignity. 2. Currently, the center has 5 residents who may be affected by this practice. All 5 residents were monitored and observed to ensure EX Order 26 bags did not touch the floor. All were properly placed. All care plans were reviewed and updated. 3. All nursing staff will be re-educated to ensure EX Order 26 bags do not touch the floor and educated on infection control by the Director of Nursing (DON) and/or Infection Control Preventionist. The facility Director of Nursing or designee will monitor this process daily x 1 month then weekly x 2 months. 4. The DON and/or designee will be responsible to monitor and complete the audits. Results of the audits will be reviewed monthly at the monthly center QAPI committee meeting for three	

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F 690	Continued From page 2 order for EX Order 26.4B1 EX Order 26.4B1 for diagnosis EX Order 26.4B1). A review of the Care Plan with an initiated date of EX Order 26.4B1 and revised on EX Order 26.4B1 revealed the Focus area of Resident #75 requires EX Order 26.4B1 EX Order 26.4B1 due to EX Order 26.4B1. The Interventions included but were not limited to: Keep EX Order 26.4B1 off floor. During an interview with the Surveyor on 2/1/2023 at 9:17 AM, Nurse's Aide (NA #1) stated, "I usually hook it on the side of the bed," when asked where should the EX Order 26.4B1 be placed when a resident is in bed. NA #1 further stated that the EX Order 26.4B1 should never be on the floor. During an interview with the Surveyor on 2/1/2023 09:20 AM, Licensed Practical Nurse (LPN #1) replied, "it should be below the waist," when asked where should the EX Order 26.4B1 be placed when a resident is in bed. LPN #1 further stated that the EX Order 26.4B1 should be kept off the floor. During an interview with the Surveyor on 2/1/2023 at 11:17 AM, Registered Nurse/Unit Manager (RN/ UM #2) replied, "they hang on the bed, never touch the floor," when asked where should the EX Order 26.4B1 be placed when a resident is in bed. A review of a facility policy titled, Catheter Care, Urinary revealed, "Infection Control 2. Be sure the catheter tubing and drainage bag are kept off the floor."	F 690	months.	

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F 690	Continued From page 3	F 690		
F 693 SS=D	NJAC 8.39 19.4(a)(5) Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure nutritional formula connected to a EX Order 26.4B1 was accurately labeled for 1 of 1 resident (Resident #26) reviewed for EX Order 26.4B1.	F 693	1. The misdated EX Order 26.4B1 for resident #26, was removed and discarded. The LPN (licensed practical nurse) who misdated the bottle was re-educated to monitor bottle for proper dating. 2. Currently the center has 4 residents	3/9/23

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F 693	Continued From page 4 The deficient practice was evidenced by the following: On 1/30/2023 at 9:04 AM, the surveyor observed a bottle of nutritional formula hanging from a pole that was connected to a EX Order 26.4B1 that was attached to Resident #26's EX Order 26.4B1 while he/she was in bed. The EX Order 26.4B1 was operating. At that time, the surveyor observed that the date written on the bottle was "1/27", indicating that the nutritional formula was opened on January 27th. A review of Resident #26's Quarterly Minimum Data Set (an assessment tool) dated EX Order 26.4B1 revealed that he/she had a EX Order 26.4B1 while a resident in the facility. A review of Resident #26's physician orders located in the electronic medical record (EMR) revealed an order for EX Order 26.4B1 an hour via EX Order 26.4B1 through the EX Order 26.4B1 at 6:00 PM to infuse a total of EX Order 26.4B1 hours. On 1/30/2023 at 9:39 AM, during an interview with the surveyor, Licensed Practical Nurse (LPN #1) replied, "Absolutely not." when asked if the nutritional formula should have been running since January 27th. Further, LPN #1 replied, "No." when asked if there was any reason it was up for that long. A review of the Jevity 1.5 manufacturer instructions located on the bottle revealed, "Hang product up to 48 hours after initial connection when clean technique and only one new feeding	F 693	who may be affected by this practice. The enteral feeding bottles were audited by the Director of Nursing (DON) to ensure all were dated with the correct date. No concerns were noted. 3. All licensed staff will be re-educated to ensure they are monitoring and dating enteral feedings for proper date by the DON or designee. The center DON or designee will monitor this process through auditing 3 x weekly x 1 month then weekly for 2 months thereafter. 4. The DON and/or designee will be responsible to monitor and complete the audits. All findings from the audits will be reviewed monthly at the facility's QAPI committee for three months.	

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F 693	Continued From page 5 set are used. Otherwise, hang no longer than 24 hours." On 2/02/2023 at 1:29 PM, during an interview with the surveyor, the Director of Nursing stated, "I have a statement from the nurse stating she hung the bottle on the 28th. She dated it wrong." When asked if the other nurses on shifts are responsible to also look at the feeding bottle, the DON said yes. A review of the facility policy titled, "Enteral Tube Feeding via Continuous Pump" updated on 10/2019, revealed under "General Guidelines" number 5., "Refer to facility procedures for hang times and administration set changes." The facility was unable to provide facility procedures for hang times and administration set changes. NJAC 8:39-27.1(a)	F 693		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Resident #89 Based on observation, interview, record review and review of other pertinent facility records, it was determined that the facility failed to a.)	F 698	1. Resident #89 is now receiving a sandwich prior to [EX Order 26.4B1] and will receive an early lunch tray upon return to the center [EX Order 26.4B1]. The [EX Order 26.4B1] has been reviewed by her [EX Order 26.4B1].	3/17/23

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F 698	Continued From page 6 accurately implement a physician prescribed [NJ Exec. Order 26:4.b.1] for 1 of 2 resident's (Resident #89) reviewed for [EX Order 26.4B1], and b.) provide a meal or nourishment to a resident before or after completion of their [EX Order 26.4B1] treatment for 1 of 2 resident's (Resident #89) reviewed for [EX Order 26.4B1] This deficient practice was evidenced by the following: On 01/26/2023 at 12:16 PM the surveyor observed and interviewed Resident #89 in his/her room accompanied by resident's lifelong friend. Resident #89 stated that he/she was up at approximately 4 AM for a 4:30 AM pick-up time to go to [EX Order 26.4B1] Resident stated that he/she was provided an apple juice and a bag of Goldfish by nursing prior to leaving the facility, which he/she consumed. The surveyor questioned Resident #89 whether he/she received a breakfast meal on [EX Order 26.4B1] days. Resident #89 replied, "It's usually what I got today or nothing." The surveyor questioned if the facility saved a breakfast tray for him/her to consume upon return to the facility and the resident responded, "No." According to Resident #89's Admission Record, Resident #89 was admitted to the facility with diagnoses including but not limited to: [EX Order 26.4B1] According to the comprehensive Minimum Data Set (MDS), dated [EX Order 26.4B1], an assessment tool, Resident #89 had a Brief Interview for Mental Status score of [EX Order 26.4] indicating that	F 698	Based on her current intake, along with no s/s of [NJ Exec. Order 26:4.b.1], the MD has [NJ Exec. Order 26:4.b.1]. Her current intake, along with no signs/symptoms of [NJ Exec. Order 26:4.b.1] Her current [NJ Exec. Order 26:4.b.1] is [EX Order 26.4B1] provided by dietary ([EX Order] per meal) and [EX Order] provided by nursing in 24 hour period. A dietary communication form was delivered to and reviewed by the dietary director. Diet ticket updated to reflect [NJ Exec. Order] 2. All residents who require fluid restrictions may be affected. Currently the facility has three residents who may be affected by this practice. All 3 residents' [EX Order 26.4B1] orders and meal tickets were audited by the Registered Dietician (RD). These residents will be given a sandwich before leaving for [EX Order 26.4B1] and early/late lunch trays will be provided based on their individua[EX Order 26.4B1] schedules. Fluid restrictions were updated and reviewed with the dietician and the director of dietary. No concerns or discrepancies were noted. 3.The facilties's policies and procedures regarding [EX Order 26.4B1] meals and fluid restrictions have been reviewed. Meal tracker ticket system updated to reflect fluid restriction and amount of ml (milliliters)per day for any resident requiring fluid restrictions. All nursing and dietary staff will be re-educated regarding providing residents with a snack or meal	

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F 698	Continued From page 7 Resident #89 was EX Order 26.4B1. According to Section G of the MDS, Resident #89 required extensive assist with most activities of daily living and was able to eat and drink independently. The MDS also revealed that Resident #89 had an active diagnosis of EX Order 26.4B1 in Section I and received EX Order 26.4B1 according to Section O. A review of Resident #89's Order Summary Report with Active Orders As Of: 1/27/2023, Resident #89 had the following physician's orders: EX Order 26.4B1 per/day - EX Order 26.4B1 shift for NJ Exec. Order 26:4.b.1 EX Order 26.4B1 . and EX Order 26.4B1 Chair time. EX Order 26.4B1 According to Resident #89's comprehensive care plan, Resident #89 had a Focus of: [resident name] Nutrition Resident at NJ Exec. Order 26:4.b.1 r/t reliance on EX Order 26.4B1 , varied PO intake, EX Order 26.4B1 Date Initiated: EX Order 26.4B1 Revision on: EX Order 26.4B1 The following was revealed under Goal: o Resident meal intake will be NJ Exec. Order 26 Date Initiated: EX Order 26.4B1 Target Date: EX Order 26.4B1 o Resident will follow NJ Exec. Order 26:4 ordered. Interventions included: o EX Order 26.4B1 per/day Date Initiated: EX Order 26.4B1 Revision on: EX Order 26.4B1 and Provide diet as ordered Date Initiated: EX Order 26.4B1	F 698	prior to and upon return from EX Order 26.4B1, checking meal ticket for accuracy, as well as monitoring residents fluid restrictions during meals by the RD or designee. This process will be monitored 1 x weekly x 1 month, then bi-weekly x 2 months by the RD, Director of Nursing and/or designee. 4. The DON, Food Service Director and/or designee will be responsible for monitoring and completing audits. Results will be reviewed at the monthly at the QAPI committee for three months.	

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F 698	Continued From page 8 The surveyor reviewed Resident #89's Friday 1/26/2023 Breakfast meal ticket. The meal ticket indicated that Resident #89 was to receive a [EX Order 26.4B1 or 26.4B1) EX Order 26.4B]." The meal ticket revealed that Resident #89 was to receive the following "Beverages" at the breakfast meal: Milk 8 Oz (ounces), Hot Coffee 6 Oz, and Special Requests Apple Juice 6 Oz. The total fluid provided at the breakfast meal was 20 Oz or equivalent to 600ML. The meal ticket did not indicate that Resident #89 had a [NJ Exec. Order 26:4.b.1]. On 1/27/2023 at 08:26 AM, the surveyor observed Resident #89 lying in bed after the breakfast meal. The surveyor observed Resident #89's breakfast tray on the over the bed table. Resident #89 consumed 100% of his/her breakfast meal. The surveyor observed a 6 oz coffee on the breakfast tray, an 8 oz 2% milk, a 6oz apple juice and a 16 oz water on the bedside table (total volume of fluid was 36 oz or 1,080ML). A review of the breakfast meal ticket revealed that [NJ Exec. Order 26:4.b.1] was listed on breakfast meal ticket for 1/27/2023. The ticket revealed a diet order for [EX Order 26.4B1] diet and the following beverages: Milk 8 Oz, Hot Coffee 6 Oz, and Special Request Apple Juice 6 Oz. On interview Resident #89 said "I've always been on a [EX Order 26.4B1]; I was on one in another state. I do ok." Resident #89 further stated, "I only drank some of the milk because I know I need to watch my fluids." On 1/27/2023 at 10:10 AM the surveyor interviewed the nurse on Resident #89's floor regarding the process for ordering a [NJ Exec. Or NJ Exec. Order 26:4.b.1]. The nurse stated, "Nursing, speech	F 698		

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F 698	Continued From page 9 therapy or the registered dietitian will provide a change in diet slip to the Director of Dining (DOD) for any diet changes. There is a box located at each unit to put the diet change recommendations in and dietary staff collect them and bring them to the DOD. The DOD then makes the changes in the Matrix meal tracker (a computerized meal ticket system) according to the diet recommendation form and it will reflect the diet change for particular resident." The surveyor asked if the nursing staff was required to keep a copy of the diet recommendation forms. The nurse stated, "Physical ticket forms are saved by the DOD for records and a copy is kept in the resident's physical medical record. Communication is not electronic but completed via paper." On 1/27/2023 at 12:30 PM, the surveyor reviewed Resident #89's paper medical record. The surveyor observed (3) separate "DIET REQUISITION FORMS" in the medical record under the dietary tab. . One form indicated that resident #89 was a [redacted] and was to receive a [redacted] diet, the form was undated. The second DIET REQUISITIO FORM, date unreadable (12/?/2022 under comments revealed "[redacted] a day 300 cc (cubic centimeters, a measure of volume) nursing." A third DIET REQUISITION FORM, dated 12/20/2022, revealed a [redacted] for [redacted] ml with a Dietary Total of [redacted] ml and a Nursing Total of [redacted] ml. On 1/27/2023 at 1:12 PM, the surveyor observed Resident #89 seated in his/her room eating the lunch meal. Resident #89 had consumed 6 oz of iced tea and had received an 8 oz 2% milk on his/her tray. Resident #89 did not drink the milk.	F 698		

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F 698	Continued From page 10 Resident #89 stated, "I'm trying not to drink too much fluid. I'm watching it myself." On 1/30/2023 at 8:27 AM, the surveyor observed Resident #89 lying in bed with his/her breakfast tray on the over the bed table. The surveyor observed an 8 oz 2 % milk (4 oz consumed), 6 oz coffee, (not consumed), and 6 oz apple juice (100% consumed). Resident #89 stated to the surveyor, "My [NJ Exec. Order 26:4.b.1] isn't on my ticket. I've been on a [NJ Exec. Order 26:4.b.1] since I came here." Resident #89 further stated, "Last night the CNA (certified nursing assistant) asked me if I was on a [NJ Exec. Order 26:4.b.1] because he/she shouldn't be giving me water between meals. The CNA stated that I should let her know that I was on a [NJ Exec. Order] I think they (staff) should know I'm on a [NJ Exec. Order 26:4.b.1]." On 1/30/2023 at 1:04 PM, the surveyor made another meal observation with Resident #89 at the lunch meal. The surveyor observed an 8 oz 2% milk and a 6oz cup of lemonade on the resident's tray. The milk was 50% consumed and the lemonade was still full. Review of Resident #89's lunch meal ticket did not identify that Resident #89 was on a [NJ Exec. Order 26:4.b.1]. On 1/30/2023 at 1:07 PM the surveyor conducted an interview with the Licensed Practical Nurse (LPN #3) assigned to Resident #89 on that shift. The surveyor questioned LPN #3 regarding Resident #89's [EX Order 26.4B1]. LPN #3 replied, "We (nursing) are allowed to provide [EX Order] ml of fluid per shift. Generally, we just give it to swallow medications. The additional amount comes from dietary, whatever is on the tray." LPN #3 further stated, "Nursing and the CNAs	F 698		

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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 698	Continued From page 11	F 698		

are trained to monitor the tray to ensure they don't get what they are not supposed too. He/she (Resident #89) gets a milk and a glass full of juice, usually. Dietary should monitor for their own quantity of fluid provided."

On 1/30/2023 at 1:34 PM, the surveyor conducted an interview with the nursing assistant (NA #2) assigned to Resident #89 for that shift. The surveyor questioned NA #2 how she determines if a resident is on a fluid restriction. NA #2 responded, "Usually I look at the residents ticket. And we have what is called handoff at report where we communicate prior to the start of our shift." NA #2 also stated, "The ticket (meal ticket) should say what fluids the resident is to receive. I am familiar with fluid restrictions. If I notice a tray with too much fluid, I immediately report it to the nurse."

On 1/30/2023 at 1:52 PM, the surveyor conducted an interview with the facility DOD. The surveyor asked the DOD to explain the process for a resident prescribed a fluid restriction. The DOD explained, "The dietitian provides a copy of the order. The dietitian then tells me what to give at each meal. It is written on the ticket that the resident is on a fluid restriction and how many milliliters the restriction is. That allows the people on tray-line to know what to put on the tray fluid wise." The DOD further stated, "The last person on the tray-line is to ensure the accuracy of the meal and food prior to putting the tray on the meal cart." The surveyor then presented a copy of Resident #89's meal ticket to the DOD and asked her if the ticket revealed that Resident #89 was on a fluid restriction. The DOD stated that the ticket should have fluid restriction on the top

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F 698	Continued From page 12 of the meal ticket/card. The DOD went on to say I agree that this ticket does not indicate that this resident is on a fluid restriction. The DOD said, "I'm going to have to check into that. Staff wouldn't be able to determine what fluids are on the tray because there is no indication of a fluid restriction." On 2/1/2023 at 10:50 AM, the surveyor conducted an interview with the facility Director of Nursing (DON) concerning Resident #89's EX Order 26:4B1 NJ Exec. Order 26:4.b.1 and why it was not on the resident's meal ticket. The DON explained, "We reviewed the NJ Exec. Order 26:4.b.1. Nursing was aware because they (NJ Exec. Order 26:4.b.1) show up on the MAR (medication administration record). There is a physical diet slip order that gets sent from nursing to the kitchen. The DOD is responsible to get the NJ Exec. Order 26:4.b.1 on the meal ticket. In absence of the director, any other trained kitchen personnel should be able to transfer the order (new) to the meal ticket. There should have been a NJ Exec. Order 26:4.b.1 on the meal ticket." On a follow up interview on 2/2/2023 at 11:39 AM, the facility DON admitted, "Dietary tickets were not completed to reflect the NJ Exec. Or [redacted] b.) On 2/1/2023 at 10:18 AM, the surveyor interviewed Resident #89 concerning his/her complaint of not getting something to eat prior to or after attending EX Order 26:4B1. Resident #89 explained, "If I don't have something in the room already before EX Order 26:4B1 I don't get anything. Sometimes they have snacks. Yesterday (1/30/2023) I had a cookie before EX Order 26:4B1. I had the cookie from the night before. My friend had brought me some oatmeal cookies and I had one	F 698		

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F 698	Continued From page 13 left." The surveyor asked Resident # 89 if she received a breakfast meal upon return to the facility at 10:45 AM. Resident #89 stated, "I had no food, and they did not save my breakfast tray. They did not offer me a snack upon return. I did not ask for anything either because yesterday my bones were aching." The surveyor asked the resident if he/she is hungry upon return to the facility from EX Order 26.4B1 Resident #89 responded, "Not really." I would prefer that they provide me with something to eat before I leave." On 2/1/2023 at 10:33 AM, the surveyor interviewed LPN #4, who was assigned to Resident #89 on that shift. The surveyor asked LPN #4 if they provide Resident #89 a meal prior to or after EX Order 26.4B1. LPN #4 responded, "The resident leaves at 4:30 AM. The EX Order 26.4B1 center does not allow residents to eat at the facility. We call for a fresh breakfast tray when they return to the facility." 02/01/23 10:44 AM, the surveyor interviewed the facility Registered Dietitian/Nutritionist regarding how the facility provides missed meals for EX Order 26.4B1 residents. The RDN replied, "Either we send them with a bagged sandwich, or we send an early tray and upon return to the center we will provide a tray. She further explained, "It depends on the resident and what they prefer. Resident #89 should have a tray when he/she returns to the facility post EX Order 26.4B1 Nursing is responsible for calling the kitchen and getting a tray for the resident upon return to the facility." On 2/1/2023 at 11:00 AM, the surveyor asked the facility DON if the facility had a policy for providing food prior to or upon return to the	F 698		

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F 698	Continued From page 14 facility after [redacted] treatment. The DON stated, "We don't have a specific policy for that. Our facility practice is that nursing will call the kitchen upon the resident's return to the facility and get the resident something to eat. We don't save meal trays due to temperature concerns and [redacted] centers do not allow residents to eat at the [redacted] facility anymore." The surveyor reviewed the facility policy titled [facility name] Encouraging and Restricting Fluids Level II, updated 10/2022. The policy revealed the following under the heading Purpose: "The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids." The following was observed under the heading General Guidelines: 1. "Follow specific instructions concerning fluid intake or restrictions."	F 698		
F 812 SS=F	N.J.A.C. 8:39-27.1 (a) 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.	F 812		3/17/23

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F 812	Continued From page 15 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 1/25/2023 from 9:47 to 10:43 AM, the surveyors, accompanied by the Director of Dining (DOD) observed the following in the kitchen: 1. Upon entry to the kitchen the surveyors observed a dietary aide (DA) in the cook's area. The female DA had a hair net that only partially covered their hair and the forehead to the middle of the head area was uncovered and exposed. On interview the DOD stated, "The hair should be fully enclosed in the hair net." 2. On a lower shelf in the dry storage area, a previously opened bag of egg noodles had no open or use by dates. When interviewed, the DOD responded, "It should be labeled with an open date and use by date. Pasta goes 30 days after being opened. I'm throwing it out."	F 812	1. 1.25.23- Dietary Aides were instructed on use of hair nets and type of hair net to be worn to eliminate hair exposure. Education provided for staff on proper use of hair nets. Open bag of egg noodles was discarded immediately and staff in-serviced on proper label and dating. Grated cheese exposed to air due to lid not being completely sealed was immediately discarded and staff in-serviced on proper techniques of sealing food. Kielbasa located in freezer without use by date was immediately discarded. Staff in-serviced on proper label and dating. The three-quarter pans found to be wet nesting were removed, washed, sanitized and air dried immediately. Staff in-serviced on proper ware washing procedures. 1.30.23-Vanilla health shakes found in nourishment room without use by or manufacturer date were immediately discarded. Director of Food Services was educated regarding labeling of health shakes that are supplied to residents on	

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F 812	Continued From page 16 3. In the walk-in refrigerator on an upper shelf a white plastic container contained grated parmesan cheese. The container was dated received on "1/12" and open on "1/18", according to the DOD. The lid was not completely sealed, and the cheese was exposed to the air. 4. In the walk-in freezer on an upper shelf a package of previously opened Kielbasa was wrapped in plastic wrap and dated "1/21." The Kielbasa had no identifiable open or use by date. 5. On a middle shelf of the pot/pan storage rack, a stack of (3) quarter pans were stacked on top of each other. The surveyor removed the top pan on the stack and observed a wet, watery substance on the base of the pan below. The surveyor touched the pan base, and it was determined to be wet to the touch. the surveyor then removed another pan and observed the pan base below to be wet with a watery substance and wet to the touch. The DOD observed the same quarter pans and stated, "They're wet. I'm going to re-wash them." On 1/30/2023 from 12:14 to 12:21 PM, the surveyor, accompanied by the Licensed Practical Nurse (LPN #3), observed the following in the 3rd floor Nourishment room: 1. On a middle shelf of the nourishment room refrigerator, (2) 4 fluid ounce vanilla shakes had no use by date and no manufacturer use by date. On interview, the LPN stated, "I will get rid of these immediately. The kitchen usually dates these and labels them. I'm throwing these away." On a follow up interview on with the facility DOD	F 812	the units. 2.1.23-The three uncooked cheese sandwiches were immediately discarded. Staff in-serviced on cook time and temperature control, as well as food handling. All Dietary Employees and Director of Food Service instructed regarding proper use of hair nets and type of hair net to be worn to eliminate hair exposure. The cake piece used to temp was discarded and staff in-serviced on time and temperature control. 2. All residents have the potential to be affected. 3. Education for all dietary staff members will be conducted by the Administrator/Registered Dietician and/or their designee on the following policy and procedures: Food Storage, Time/Temperature Control for Safety, Food Handling, and dating, ware washing, proper use of hair nets, and storge of non-perishable foods and supplies. Director of Food Service and/or her designee will complete weekly audits for three months which will include the following: food safety inspections, service ware storage, hair restraints, and food storage units. The Registered Dietician and/or designee will use the CMS Critical Element Pathway titled Kitchen Observation 1 x monthly x 3 months to ensure compliance with F812. The Director of Food Service and/or designee will audit nourishment pantries daily x 4 weeks, and 1 x weekly thereafter for three	

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F 812	Continued From page 17 on 2/1/2023 "House shakes are dated when pulled from the freezer. I go 7 days from the freezer pull date. All house shakes should be labeled with a use by date 7 days from the freezer pull date." On 2/1/2023 from 11;37 AM to 12:14 PM, the surveyors, accompanied by the DOD and Account Manager (AM), observed the following in the kitchen: 1. Upon entering the steam table area the surveyor observed three uncooked cheese sandwiches on white bread sitting on the steam table ledge. The sandwiches were uncovered and exposed. The surveyor questioned why the sandwiches were sitting on the steam table ledge and were left uncovered. The DOD stated that the PM cook had set them there and was going to make grilled cheese sandwiches for the lunch meal service. The PM cook removed the sandwiches and threw them in the trash. 2. The AM assisted the DOD with the food temperature monitoring process during the lunch meal observation. The AM had a solid bonnet style hair covering over top of a hair net. The AM had lengthy hair. The hair net only partially covered the back of their hair and the hair extended down to the shoulder area and was exposed. In addition, the DOD also had donned a hair net. The hair net only partially covered the hair on top of the head. The DOD had hair extending down to the shoulder area on the back of the head that was exposed while taking temperatures of the food to be served to facility residents at the lunch meal. When made aware that her hair was not fully enclosed in her hair	F 812	months. In addition, the Director of Food Service or designee will audit all food pantries within the facility for proper dating and labeling for three months. 4. The Food Service Director and Registered Dietician and/or designee will provide all daily, weekly, and monthly audits to the QAPI committee monthly for three months to ensure compliance.	

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F 812	Continued From page 18 net, the AM responded, "I'll shave my hair then." 3. During the observation of the lunch meal food temperature monitoring the surveyor asked the DOD to take the internal temperature of the dessert to be served for the lunch meal. The dessert was identified as a chocolate marble cake with vanilla frosting, made in house and did not contain eggs. The DOD wiped the thermometer probe with an alcohol wipe and then placed the thermometer probe in the middle of the cake. The DOD obtained a temperature of 42 F. The DA then took the cake from the DOD and placed the cake back on the dessert cart with the rest of the desserts to be served at the lunch meal. The surveyor asked the DOD if the DA had placed the cake that was used to measure temperature back on the cart to be served during the lunch meal. The DA responded, "It's here (pointed to an upper rack of a multi-tiered cart.) Do you wanna throw it away?" The DOD instructed the DA to throw the cake that had been used to measure temperature in the trash. A review of a facility policy titled [company name] Policy 019 Food Storage: Cold Foods with revised date of 4/2018, revealed under the heading Policy Statement: All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA (Food and Drug Administration) Food Code. In addition, the following was revealed under the Procedures heading:	F 812		

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F 812	Continued From page 19 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A review of a the facility policy titled [company name] Policy 022 Warewashing with a revised date of 9/2017, revealed under the Procedures heading: 4. All dishware will be air dried and properly stored. A review of a facility policy titled [company name] Policy 024 with revised date of 9/2017, under Policy Statement revealed, "All employees wear approved attire for the performance of their duties." In addition, under the heading Procedures it was revealed that 1. "All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained." A review of a facility policy titled [company name] Policy 017 Receiving with revised date of 9/2017 under the the Policy Statement revealed: "Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all foods." The following was revealed under the heading Procedures: 5. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. 7. All non-perishable foods and supplies will be stored appropriately.	F 812		

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F 812	Continued From page 20 NJAC 8:39-17.2 (g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: FACILITY Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to have a cover over the opening of 1 of 1 garbage dumpsters. This deficient practice was evidenced by the following: On 1/25/2023 at approximately 10:30 AM, the surveyors, accompanied by the Director of Dining Services (DODS) and the Senior Maintenance Director (SMD), observed the following in the facility designated garbage area: Two green dumpsters were behind a chain link fence with a gate. The dumpster closest to the building and designated as a garbage dumpster by the DODS and SMD was observed to have 1 of 2 black hinged lids opened and the bagged garbage was exposed. On interview the DOD stated that doors should be closed at all times to prevent access to rodents. When asked why it is important to keep the lids to the garbage closed the SMD also agreed doors are to be kept shut due to "birds and the smell. " A review of a facility policy titled Dispose of Garbage and Refuse [company name] Policy 030	F 814	1. Garbage dumpster cover was immediately closed. Dietary and Housekeeping staff received education on disposal of garbage and refuse. 2 . All residents who reside in the facility have the potential to be affected, as well as any visitors to the facility, and the surrounding community. 3. All staff who utilize the dumpster area will receive training on disposing of trash and insuring dumpster lids remain closed by the Maintenace Director, Food Service Director or designee. The Director of Maintenance has added camera coverage on the dumpster area that is monitored by the front desk personnel during business hours, 8:00 am to 8:00 pm, to assist with surveillance. Daily rounds to observe dumpster area to be completed and audited for the next 90 days by the Maintenance Director, Director of Food Service, and/or their designee. 4. Daily rounds/audit results will be provided to QAPI committee monthly for the next three months by the Director of Maintenance/Director of Food Service	3/17/23

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F 814	Continued From page 21 dated Original 8/2017, revealed under the heading Policy Statement: "All garbage and refuse will be collected and disposed of in a safe and efficient manner." NJAC 8:39-19.3(c)	F 814	and/or designee to ensure compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and 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	F 880		3/9/23

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F 880	Continued From page 22 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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:	F 880		

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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 880	Continued From page 23 Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed a) to ensure proper use of personal protective equipment (PPE) for staff on 1 of 2 units (unit 2), a COVID-19 designated unit, in accordance with the Centers for Disease Control and Prevention guidelines for infection control and b). failed to implement infection control measures by maintaining the EX Order 26.4B1 the floor to prevent the spread of infection. This deficient practice was evidenced by the following: On 1/25/2023, during the entrance conference, the facility Assistant Director of Nursing (ADON) provided the surveyors a copy of the facility floor plan. The ADON coded rooms EX Order 26.4B1 yellow on the floor plan and stated that these are our EX Order 26.4B1 rooms. On 1/26/2023 at 9:11 AM, the surveyor observed the following while touring the facility's EX Order 26 floor unit. A Registered Nurse (RN#1) was observed to enter room EX Order 26. RN#1 was observed to don a face shield and N95 mask while in the room. RN#1 did not don a gown or gloves prior to entering room EX Order. The surveyor observed RN#1 speak to Resident #196 from their position outside the door in the hallway. RN #1 had no physical contact with Resident #196 who was lying on the bed. After approximately 10-15 seconds RN #1 exited the room. Upon exiting room EX Order 2 the surveyor questioned RN #1 if she should have donned a gown and gloves to enter Room EX Order 2 as indicated by the droplet precaution signage posted on the door. RN #1 responded, "I don't have to wear full PPE because I just went in the room to answer the call light. I didn't have any	F 880	1. Resident #196 continued with NJ Exec. Order 26:4.b.1 based on the facility's protocols. The Registered Nurse was sent home and upon her return she received re-education regarding PPE (Personal Protective Equipment) protocols. The EX Order 26 bag for resident #73 was replaced and placed in a EX Order 26.4B1 and hooked to the bedframe where it remains elevated from the floor. 2. All residents within the facility have the potential to be affected. The facility has 5 residents who may be affected by the practice related to foleys. All 5 residents were monitored and observed by the Director of Nursing to ensure EX Order 26 bags were not touching the floor. All bags were noted to be properly secured and in place. 3. All nursing staff will be re-educated by the Infection Control Preventionist and/or designee related to PPE protocols and proper placement of EX Order 26 bags. This process will be monitored 1 x daily x 4 weeks then 1 x weekly x 2 months by the facility's Director of Nursing (DON) or designee. Facility has implemented a DPOC-Directed Plan of Correction. The facility has completed a RCA (Root Cause Analysis) with the assistance of QAPI Committee, Infection Preventionist and Governing Body. The facility has completed Directed In-Service Training for all staff, with competency validated by the Director of Nursing. Directed Plan of Correction and proof of Directed	

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	315228	A. BUILDING _____ B. WING _____	02/02/2023

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F 880	Continued From page 24 contact with the resident." The surveyor asked RN #1 after she returned to the medication cart in the hallway in front of room [redacted] if she was required to wear full PPE when entering a room with droplet precaution signage. RN #1 responded, "Your right. I just went in really quick to answer the call light and I didn't have any contact with the resident." The surveyor explained that the droplet precaution signage posted on the doorway to Room [redacted] indicated that staff were to wear full PPE prior to entering the room. RN#1 responded, "I agree. I just ran in quick, and I didn't touch the resident. You are right, I should have worn full PPE." The surveyor asked the RN if Room [redacted] was designated as a COVID positive room. The RN stated, "Yes, room [redacted] is a [redacted] room." On 1/26/2023 at 9:22 AM, the surveyor immediately conducted an interview with the Registered Nurse/Unit Manager (RN/UM #1) of the [redacted] floor unit. The surveyor explained that RN #1 had entered room [redacted], a [redacted] designated room, and had only donned an N95 mask and face shield. The surveyor further explained that the droplet precaution signage posted on room [redacted]s door indicated that the following was required upon entry to the room: "PPE required upon entry: Gown Gloves Mask-N-95 or higher Protective eyewear: Shield, Goggles, or Safety glasses." A review of Resident #197's medical record (MR) revealed that Resident #196 was tested for [redacted] and was	F 880	In-Service training for all staff has been submitted as required to the Department of Health. New employees will receive Directed In-Service training as a requirmentment of new hire orientation. 4. The DON and/or designee will be responsible for monitoring and completing audits. Results will be reviewed at the facility's monthly QAPI committee for three months. Directed Plan of Correction audits will be provided by the Administrator and/or designee and included in reporting to the facility QAPI committee and Governing Body to ensure compliance.	

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F 880	Continued From page 25 determined to have a [NJ Exec. Order 26:4.b.1]" result on [NJ Exec. Order 26:4.b.1] at 9:32 PM. Resident #197 resided in room [redacted] without a roommate. Resident #196 was removed off [NJ Exec. Order 26:4.b.1] and moved to a new room. RN/UM #1 stated, "I agree, full PPE is required in COVID rooms prior to entering the room. I will in-service her now. COVID-19 designated rooms and all rooms designated with droplet precaution signage on the door require staff to don full PPE, gown, gloves, N95 mask, and face shield prior to entering the room. Absolutely." On 1/26/2023 at 11:01 AM, the surveyors conducted an interview with the facility designated Infection Preventionist (IP). During the interview the surveyor asked the IP what the expectation is for staff entering resident rooms that have droplet precaution signage posted on the doorway. The IP explained, "My expectation is that they follow the signage and that they follow the education they were provided on wearing the appropriate PPE." The surveyor asked the IP what PPE would be required for a staff to enter a room with droplet precaution signage posted on the doorway. The IP responded, "I would expect staff to wear N95, gown, gloves, and face shield." The surveyor then inquired what staff are expected to wear answering a resident call light in a room with droplet precautions. The IP explained, " To enter the room to answer the call light, regardless of resident contact, it would require the staff member to wear full PPE including N95 mask, face shield, gown and gloves." On 2/2/2023 at 11:28 AM, the surveyor	F 880		

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F 880	Continued From page 26 interviewed the facility Licensed Nursing Home Administrator (LNHA) concerning the infection control breach that occurred with RN #1 entering room EX Order on the EX Order floor unit. The LNHA told the surveyor, "We had to make some changes with that RN. She was properly educated prior to the incident. She was in-serviced again after the incident." During the initial tour of the EX Order floor unit on 1/25/2023 at 10:17 AM, Resident #75 was observed resting in bed with eyes closed and with an EX Order 26.4B1. The EX Order 26.4B1 EX Order 26.4B1 was observed resting on the floor. On 1/27/2023 at 8:54 AM Resident #75 was observed awake, alert and nonverbal resting in bed. Resident #75's EX Order 26.4B1 EX Order was observed touching the floor. During an interview with the Surveyor on 2/1/2023 at 9:17 AM, Nurse's Aide (NA #1) stated, "I usually hook it on the side of the bed," when asked where should the EX Order 26.4B1 be placed when a resident is in bed. NA #1 further stated that the EX Order 26.4B1 should never be on the floor. During an interview with the Surveyor on 2/1/2023 09:20 AM, Licensed Practical Nurse (LPN #1) replied, "it should be below the waist," when asked where should the EX Order 26.4B1 be placed when a resident is in bed. LPN #1 further stated that the EX Order 26.4B1 bag should be kept off the floor. During an interview with the Surveyor on	F 880		

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F 880	Continued From page 27 2/1/2023 11:17 AM, Registered Nurse/Unit Manager (RN/ UM #2) replied, "they hang on the bed, never touch the floor," when asked where should the EX Order 26.4B1 be placed when a resident is in bed. A review of facility policy titled, Catheter Care, Urinary revealed, "Infection Control 2. Be sure the catheter tubing and drainage bag are kept off the floor."	F 880		
F 919 SS=D	NJAC 8:39-19.4(a) Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. 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 ensure their resident call system was intact, functioning properly and accessible in 1 of 9 rooms, as well as failed to follow their own facility policy, "Call Lights." This deficient practice was evidenced by the following: On 1/25/2023 at 10:34 AM, Resident #61 was noted resting in bed, alert and awake. The cord belonging to the call device was noted attached	F 919	1. Call bells for Resident #61 and Resident #58 were immediately replaced/repaired. Assigned CNA (Certified Nursing Assistant) for both residents received education regarding call light functioning. Assigned LPN (licensed practical nurse) for both Residents received education regarding call light functioning. 2. All residents who reside in the facility have the potential to be affected. Every	3/17/23

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F 919	Continued From page 28 to the wall, hanging and resting on the floor. On 1/26/2023 at 10:14 AM, a tour of the same room that both Resident #58 and Resident #61 resided in, revealed that the calling device was not functioning. The distal end of the call device was not intact. During an interview with the Surveyor, Resident #61 stated, "It's broken," when asked, could you tell me where your call device is located. Resident #61 replied "yes" when asked, did you inform anyone. Resident #61 further stated that the call device was broken for approximately 1 to 2 weeks. During an interview with the surveyor on 1/26/2023 at 1:57 PM, Certified Nursing Assistant (CNA #1) stated "I always make sure they have their call bell," when asked, if a resident needed help, how would they call for help? CNA #1 further stated, most of the residents know my name or will call out. "Most of the time they use their call lights. I would look for the call light to see if residents need assistance. They make me nervous, so I just check on them all the time. I do my round, then I go up and down to make sure they are in the safest position possible. I have a few nonverbal residents so I keep checking on them because they can't tell you if they need help or not." CNA #1 replied "Yes, when I first come in, in the morning and start rounds, every room I go in, I check to make sure the call lights work." CNA #1 confirmed that she was assigned to care for Resident #58 and Resident #61. In addition, CNA #1 replied "no" when asked if any of the calling devices of her assigned residents were not functioning. During an interview with the surveyor on	F 919	call bell in the facility was audited for functioning and need-for-repair. Wall outlets that were not functioning to 100% capacity were replaced. Facility vendor confirmed the system was up and fully functional by 1.30.23. Tap bells provided to any/all residents where the call bell was not fully functioning during repair period. 15-minute rounds were initiated during the repair period. 3. All caregivers are being educated regarding Call Light policy, including functioning, placement, and ensuring that the call bell is in working order. Staff were in-serviced to report any non-functioning call bell immediately to the Maintenance Department via our preventative maintenance system to ensure timeliness, as well as as providing a tap bell until the call light is functioning. The Maintenance Director and/or designee will conduct 1 x weekly call bell system checks, ongoing, to ensure the system is in good working order. Call bell system checks include checking interior call light (inside resident room) and exterior dome light over resident door. System checks will be completed weekly, one hallway per week, totaling 4 hallways per month, ensuring all resident call bells throughout the facility have been audited monthly. 4. The Maintenance Director and/or designee will report call bell system audit findings to the QAPI committee monthly for three months to ensure compliance.	

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F 919	Continued From page 29 1/26/2023 at 2:11 PM, Licensed Practical Nurse (LPN #2) when asked, if a resident needed help, how would they call for help,replied , "There is different ways, there is a call bell, that's what we go by, if resident needed assistance they would use their call light. The call bell always has to be in reach." When asked, who ensures that the call bell is within reach, LPN #2 stated, "everybody, before you leave the patient you always make sure the call bell is in reach." LPN #2 confirmed that she was assigned to care for Resident #58 and Resident #61. LPN #2 further stated that all the call devices in her assigned area were functioning and none of her assigned residents had a tap bell. During an interview with the surveyor on 1/26/2023 at 2:24 PM, the Registered Nurse/ Unit Manager (RN/UM #2) replied, "Every resident gets a call light and we educate them on how to use it, the call lights are checked every shift, the aides check to see if they come on." when asked, how does a resident call for help. When asked are there any call bells that are not functioning RN/UM #2 replied "No." The RN/UM #2 further stated, "we do not have anyone with a bell" when asked, are there any Residents with a tap bell. On 1/26/2023 at 2:28 PM, RN/UM #2 and the surveyor toured the room of Resident #58 and Resident #61, and RN/UM #2 confirmed that the calling device was not functioning. During an interview with the surveyor on 1/26/2023 at 2:43 PM, the Administrator replied, "We have a bunch of tap bells, staff are aware of where they are," when asked, what is your process when you have a call device that is not	F 919		

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F 919	Continued From page 30 functioning. The Administrator further stated, when the CNA goes to provide care, they should be checking the call bell for functioning. "I have maintenance up there now." During an interview with surveyor on 1/27/2023 at 8:59 AM, Resident #61 stated "they brought it here last night after you left," referring to his call device. The calling device was observed attached to Resident #61's linen, within reach. A review of facility policy titled, "Call Lights" last updated on 1/2022, revealed, "Purpose: To use a light and/or sound system to alert staff to patient needs. ...Procedure: ...6. Always position call light conveniently for use and within the reach of the resident. ...8. Check lights when providing care to ensure that cord length is appropriate , and that light is in working order. Report defective call lights promptly to maintenance for immediate repair and arranges for alternate call system or change patient's room and frequent checks on resident." NJAC 8:39 31.8(c)9	F 919		

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S 000	Initial Comments The facility was 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 deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 14 of 14 day shifts and 5 of 14 evening shifts and 1 of 14 overnight 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,	S 560	1. The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes. 2. All residents have the potential to be affected. 3. Human Resource Director and/or designee will focus recruitment and retention strategies as following: identify vacant positions daily and attempt to fill	3/17/23

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

Electronically Signed | 02/17/23

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S 560	Continued From page 1 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 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. As per the "Nursing Staffing Report" completed by the facility for the weeks of 01/08/2023 to 01/14/2023 and 01/15/2023 to 01/21/2023, the staffing to residents' ratios that did not meet the minimum requirements as documented below: The facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in CNAs to total staff on 5 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -01/08/23 had 7 CNAs for 97 residents on the day shift, required 12 CNAs. -01/09/23 had 9 CNAs for 96 residents on the day shift, required 12 CNAs. -01/10/23 had 10 CNAs for 93 residents on the day shift, required 12 CNAs. -01/10/23 had 4 CNAs to 12 total staff on the evening shift, required 6 CNAs.	S 560	positions with current CNA staff or agency; work diligently with Administrator, Director of Nursing and Recruiter to advertise, recruit and hire sufficient CNA staff; continue to develop programs, such as tuition reimbursement and Baylor programs, (work 36 hours paid for 40 hours) to increase retention of staff. Facility will offer the following bonuses to recruit and retainnurse staffing: sign-on bonuses for new hires, referral bonuses for current staff who refer new employees, pick up shift bonuses for current CNAs, LPNs, and RNs who assist to fill vacant positions, bonuses to encourage per diem staff to change to full time status; as well as shift differentials for 11-7 LPNs and RNs. Continue to work with CNA and LPN class instructors to identify potential students. 4. Human Resource Director and/or Designee will provide statistics to the QAPI committee monthly for three months. Statistics will include open CNA positions versus new hires, reporting on successful strategies-to-hire based on percentages, and turnover rates.	

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S 560	Continued From page 2 -01/11/23 had 10 CNAs for 93 residents on the day shift, required 12 CNAs. -01/11/23 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs. -01/12/23 had 10 CNAs for 93 residents on the day shift, required 12 CNAs. -01/13/23 had 11 CNAs for 93 residents on the day shift, required 12 CNAs. -01/14/23 had 8 CNAs for 95 residents on the day shift, required 12 CNAs. -01/14/23 had 4 CNAs to 11 total staff on the evening shift, required 5 CNAs. -01/15/23 had 7 CNAs for 95 residents on the day shift, required 12 CNAs. -01/15/23 had 6 total staff for 95 residents on the overnight shift, required 7 total staff. -01/16/23 had 10 CNAs for 95 residents on the day shift, required 12 CNAs. -01/17/23 had 10 CNAs for 98 residents on the day shift, required 12 CNAs. -01/17/23 had 4 CNAs to 12 total staff on the evening shift, required 6 CNAs. -01/18/23 had 10 CNAs for 98 residents on the day shift, required 12 CNAs. -01/18/23 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs. -01/19/23 had 9 CNAs for 98 residents on the day shift, required 12 CNAs. -01/20/23 had 8 CNAs for 100 residents on the day shift, required 12 CNAs. -01/21/23 had 7 CNAs for 100 residents on the day shift, required 12 CNAs. During an interview with the surveyor on 1/27/2023 at 09:40 AM, the Human Resource/Staffing Coordinator (HR/SC) said It is my responsibilities to try to meet state ratio which is on 7AM-3PM shift 1 CNA to 8 residents, 3PM-11PM shift 1 CNA to 10 residents, and	S 560		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
S 560	Continued From page 3 11PM-7AM shift is 1 CNA to 14 residents. The HR/SC went on to say We do use agency; however, we have found quality of care and reliability were poor and I only now use 1 agency. The HR/SC said No we do not meet the requirements, but we make every effort to meet them. During an interview with the surveyor on 2/1/2023 at 1:32 PM, the Administrator said I am not meeting the minimum staffing requirements daily, not every shift. A review of a facility policy titled Staffing, Sufficient and Competent Nursing with revised date of August 2022, revealed under the Policy Interpretation and Implementation section Sufficient Staff 8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but not necessarily considered a determination of sufficient and competent staff.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060507 Y1	A. Building B. Wing Y2	3/20/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT COURT HOUSE, LLC	144 MAGNOLIA DRIVE CAPE MAY COURT HOUSE, NJ 08210

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 03/17/2023	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 2/2/2023	☐ 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
	315228	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT COURT HOUSE, LLC	**144 MAGNOLIA DRIVE** **CAPE MAY COURT HOUSE, NJ 08210**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/31/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/31/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The facility is a three-story building constructed in 1972. Offices, therapy, and service areas are located on the first floor with bedrooms located on the second and third floors. The facility has concrete flooring, concrete flat roofing and block bearing walls and stucco exterior. The facility is noted to be a type II (222) noncombustible with complete sprinkler system and complete fire alarm system with smoke detection in all bedrooms. The facility has a 250 KW (kilowatt) diesel generator that operates at 30% of load when tested. The facility has 101 occupied beds. The facility has six smoke zones on the second and third floors. .	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2023

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
	315228	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 1	K 345		
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 record review and interview, the facility failed to complete a smoke detection sensitivity test for all 97 photo electric smoke detectors in accordance with NFPA 72 (2010 edition) National Fire Alarm and Signaling Code, section 14.4.5.3.2. This deficient practice had the potential to affect all 101 residents. A review of fire safety records from the "Fire Alarm" folder revealed the most recent smoke detection inspection of 05/26/21 through 12/9/22. None of these inspections included a smoke detection sensitivity test. The facility had smoke detection in all bedrooms and at each four smoke doors, two on each floor. An interview with the Maintenance Director on 01/31/23 at 2:15 PM he stated he thought the smoke detection sensitivity tests had been completed for all 97 photo electric smoke detectors. An interview with the Administrator on 01/31/23	K 345	1. Fire alarm vendor was called to complete a smoke detection sensitivity test for all 97 photo electric smoke detectors. The Maintenance Director received training and education regarding the need for bi-annual sensitivity testing for electric smoke detectors. A review of records indicated that sensitivity testing was last completed on 01.15.21. 2. All residents who reside in the facility have the potential to be affected. 3. Sensitivity testing for all smoke detectors will be entered into the facility preventative maintenance software system to effectively manage preventative maintenance for the facility fire alarm system. Preventive maintenance reports will be audited by the Maintenance Director and/or designee monthly ongoing. Sensitivity testing was completed for all 97 photo electric smoke detectors on 02.14.23. (see attached	3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315228	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT COURT HOUSE, LLC	**144 MAGNOLIA DRIVE** **CAPE MAY COURT HOUSE, NJ 08210**

(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 345	Continued From page 2 at 4:30 PM verified the facility did not have the tests completed. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	completed work invoice and report) 4. Results for the facility fire alarm system will be reported by the Maintenance Director and/or designee to the QAPI committee monthly x 3 months to ensure compliance.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure sprinkler coverage was provided under exit staircase landings for three of three stairways in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010	K 351	1. Fire protection vendor was contacted to install an additional automatic sprinkler on the ground level, beneath the staircase lower landings, for the 3 stairwells in the facility to ensure adequate sprinkler coverage related to the wall-mounted	3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315228	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT COURT HOUSE, LLC	**144 MAGNOLIA DRIVE** **CAPE MAY COURT HOUSE, NJ 08210**

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K 351	Continued From page 3 edition) section 8.15.3.2.1. This deficient practice had the potential to affect all 101 residents. Findings include: An observation on 01/31/23 at 10:40 AM of the first floor or ground level stairway landing, located in the service area used as an exit leading to an exit discharge, revealed there was no sprinkler coverage. The nearest sprinkler head was located at the third floor landing. The third floor sprinkler head did not cover the first floor landing under the staircase. The lower level staircase at the exit discharge also had a electric heater on the wall. An observation on 01/31/23 at 10:50 AM of the first floor or ground level stairway landing, located in the central area near the elevator used as an exit leading to an exit discharge, revealed there was no sprinkler coverage. The nearest sprinkler head was located at the third floor landing. The third floor sprinkler head did not cover the first floor landing under the staircase. The lower level staircase at the exit discharge also had a electric heater on the wall. An observation on 01/31/23 at 11:00 AM of the first floor or ground level stairway landing, located in the office area used as an exit leading to an exit discharge, revealed there was no sprinkler coverage. The nearest sprinkler head was located at the third-floor landing. The third floor sprinkler head did not cover the first floor landing under the staircase. The lower level staircase at the exit discharge also had an electric heater on the wall.	K 351	heater in each stairwell. Estimate was completed, installation approval obtained. Maintenance Director received education regarding the need for adequate sprinkler coverage in facility stairwells. 2. All residents who reside in the facility have the potential to be affected. 3. The Maintenance Director and/or designee will perform monthly inspections of all sprinkler systems to ensure compliance. The Emergency Preparedness Procedures manual will be updated by the Maintenance Director to reflect changes. On 02.24.23 vendor installed three automatic sprinklers on ground level, beneath the three stairwells. (see attached completed work invoice and photo) 4. Sprinkler system audit findings will be reported monthly for three months by the Maintenance Director and/or designee to the monthly QAPI committee to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315228	A. BUILDING **01** B. WING _____	**02/02/2023**

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K 351	Continued From page 4 An interview with the Maintenance Director at the time of each observation verified there was no sprinkler coverage beneath the staircase at the lower landing. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 .	K 351		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 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	K 918		3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315228	A. BUILDING **01** B. WING _____	**02/02/2023**

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K 918	Continued From page 5 circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on observation, record review and interview, the facility failed to ensure the 250 KW (kilowatt) diesel emergency generator met requirements of NFPA 110, (2010 edition) Standard for Emergency and Stand by Power Systems sections 5.6.5.6 and 5.6.5.6.1 requiring a remote emergency stop. This deficient practice had the potential to affect all 101 residents. Findings include: An observation of the 250 KW diesel emergency generator on 01/31/23 at 11:50 AM revealed no remote stop switch was provided for the generator. To stop the emergency generator, a locked door on the generator enclosure had to be opened and a stop button on the panel of the generator had to be pressed. A review of the generator contractor report dated 12/09/22 located in the life safety code manual revealed there was no record of testing or observation of a remote stop switch. An interview with the Maintenance Director at the time of the observation verified no remote stop switch for the generator was available.	K 918	1. Vendor was contacted to install remote stop switch for facility generator. Estimate was completed, and installation approval obtained. The Maintenance Director received education regarding the need for a remote stop switch for the facility generator. 2. All residents who reside in the facility have the potential to be affected. 3. The Maintenance Director and/or designee will conduct monthly testing of generator and transfer switches. The Emergency Preparedness Procedures manual will be updated by the Maintenance Director to reflect changes. On 02.23.23 the electrical vendor installed a remote stop switch for the facility generator. (see attached completed work invoice and photo). 4. Generator and transfer switch audit findings will be reported monthly for three months by the Maintenance Director and/or designee to the monthly QAPI committee to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315228	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 6 NJAC 8:39-31.2(e) NFPA 99, 110 .	K 918		

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)
315228	A. Building 01 - MAIN BUILDING 01 B. Wing	3/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT COURT HOUSE, LLC	144 MAGNOLIA DRIVE CAPE MAY COURT HOUSE, NJ 08210

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 K0345	Correction Completed 03/17/2023	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 03/17/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 03/17/2023
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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/2/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO