STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. BUILDING _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	1045 E CHESTNUT AVE VINELAND, NJ 08360

(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 Complaint NJ #: 171634 STANDARD SURVEY: 03/18/24 to 3/28/24 CENSUS: 162 SAMPLE SIZE: 32 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation,	F 688	1. Immediate action: The Regional DON modified the resident□s order	5/12/24

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

Electronically Signed | 04/12/2024

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F 688	Continued From page 1 it was determined that the facility failed to a.) obtain a physician's order for application and removal times of an NJ Ex Order 26.4b1 and b.) develop a comprehensive care plan for the use of an NJ Ex Order 26.4b1 for 1 of 3 residents (Resident # 153) reviewed for NJ Ex Order 26.4b1. This deficient practice was evidenced by the following: The Admission Record indicated that Resident #153 was admitted to the facility with diagnoses that included, but were not limited to, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. The admission Minimum Data Set (MDS), an assessment tool that facilitates the care of a resident, dated NJ Ex Order 26.4b1, indicated that Resident #153 NJ Ex Order 26.4b1 and NJ Ex Order had the ability to NJ Ex Order 26.4b1. The MDS also reflected that Resident #153 had NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1. On 03/18/24 at 12:37 PM, the surveyor observed Resident #15 NJ Ex Order 26.4b1 at the nurse's station with a NJ Ex Order 26.4b1. The resident was NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The resident had no complaints of NJ Ex Order or NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 On 03/21/24 at 02:05 PM, the surveyor observed the resident sitting at the nurse's station NJ Ex Order 26.4b1 and the resident was wearing a NJ Ex Order 26.4b1. The surveyor reviewed the Physicians Order	F 688	immediately for the NJ Ex Order schedule to reflect the wearing schedule and the resident care plan was updated to reflect the changes. 2. Who was affected: All residents that wear orthotics had the potential to be affected. No other resident was affected by the deficient practice 3. Corrective action: a) All residents with orthotics orders were checked by the regional DON to verify that the wearing schedule is in place and that the device is included in care plan. b) Upon initiation of any orthotics device on resident, an order will be placed by the admissions nurse, nursing supervisor, or unit manager which include the wearing schedule is included in the treatment plan for the residents and that have an order is reflected in the care plan. 4. How will this process be monitored? The following corrective actions will be monitored to ensure that the deficient practice will not be repeated: a) The staff educator will provide education on 05/01-05/05 2024 to admission nurses, unit managers, nursing supervisors, and charge nurses on the importance of verifying each resident order; and to ensure that treatment or treatment plan is in place and is reflected in residents care plan. b) All unit managers will audit orthotic device orders quarterly, ongoing to ensure that all are correct. c) Audits will be conducted by unit manager and nursing administrations on a scheduled basis. Weekly x4, monthly x3,	

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F 688	Continued From page 2 (PO), dated NJ Ex Order 26.4b1, which indicated the following: NJ Ex Order 26.4b1. The surveyor reviewed Resident #153's Care Plan (CP) which did not include the resident's usage of a NJ Ex Order 26.4b1. On 03/22/24 at 11:16 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she had been employed in the facility for NJ Ex Order 26.4b NJ Exec Order 26. She stated that Resident #153 was NJ Ex Ord and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 and could NJ Ex Order 26.4b1. She continued to add that the resident could NJ Ex Order 26.4b1 and required total care with all aspects of activities of daily living (ADLs). She stated that the resident also required complete assistance with NJ Ex Order 26.4 and was NJ Ex Order 26.4b1 and had NJ Ex Order 26.4b1. She stated that the resident had a NJ Ex Order 26.4b1 which remained NJ Ex Order to the NJ Ex Order 26.4b1 and did not NJ Ex Order 26.4b1. She stated that the resident even NJ Ex Order 26.4b1 during the hours that he/she slept. She stated that the NJ Ex Order could be NJ Ex Order 26.4b1 when the resident got a shower, but then NJ Ex Order 26.4b1 had to NJ Ex Order 26.4b1. She stated that the NJ Ex Order was only NJ Ex Order 26.4b1 for showers and that NJ Ex Order 26.4 provided training on how to NJ Ex Order 26.4b1 . On 03/22/24 at 11:23 AM, the surveyor interviewed the US FOIA (b)(6) who stated that Resident #153 wore a NJ Ex Order 26 and the NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) of the NJ Ex Order 26.4b1. She stated that the facility was NJ Ex Order 26.4b1 to see how long the resident NJ Ex Order 26.4b1. The treating US FOIA (b)(6) (US FO) was present	F 688	Quarterly x2 and ongoing. All will be reported to the QAPI committee quarterly. Completion Date: May 12, 20024	

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F 688	Continued From page 3	F 688		

during the interview and explained that Resident #153 was NJ Ex Order 26.4b1 wearing the NJ Ex Order 24 hours a day. The US FOIA (b) then added that the NJ Ex Order could be removed for care and for NJ Ex Order 26.4b1. The US FOIA (b) reviewed the NJ Ex Order 26.4b1 order with the surveyor and confirmed that the order needed to be revised and clarified to include how long the NJ Ex Order could remain intact, when it could be removed and then stated that it could be NJ Ex Order 26.4b1 for care and for NJ Ex Order 26.4b1.

On 03/22/24 at 11:32 AM, the surveyor interviewed the US FOIA (b)(6) regarding Resident #153's NJ Ex Order 26.4b1. The US FOIA stated that the NJ Ex Order 26.4b1 was to be always worn 24-hours a day, but could be removed for care, NJ Ex Order 26.4b1 and weekly NJ Ex Orde . The US FOIA reviewed the PO with the surveyor and confirmed that the order for the NJ Ex Orc was an incomplete order and did not tell the reader all the information that should be included, such as when it should be applied and when it should be NJ Ex Order 26.4b1 She also stated that it should be documented on the CP and the Treatment Administration Record (TAR) regarding the application of the NJ Ex Order and removal times. The US FOIA stated that it would have been important to have a complete order so that staff knew why the NJ Ex Order was being used and any precautions associated with the use of the NJ Ex Order and so that the resident could be monitored for NJ Ex Order 26.4b1 associated with the use of the NJ Ex Order 2

On 03/22/24 at 11:38 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she would clarify the order for the NJ Ex Order 26.4b1 to include time of NJ Ex Order 26.4b1 and when to NJ Ex Order 26.4 the NJ Ex Order 2 The US FOIA (b)(6) also confirmed that there was no

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F 688	Continued From page 4	F 688		

documentation on the CP regarding the potential NJ Ex Order 26.4b1 and application and NJ Ex Order 26 of the NJ Ex Order 26.4b1.

On 03/25/24 at 09:06 AM, the surveyor interviewed the US FOIA (b)(6) who stated that residents were screened on admission for any special needs associated with the use of NJ Ex Order 26 or NJ Ex Order 26 She stated that NJ Ex Order 26.4 (NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1) was responsible to set up a schedule for NJ Ex Order or NJ Ex Order usage to include when the resident was supposed to NJ Ex Orde the device and when the device was to be NJ Ex Order 26.4b1 She stated that the NJ Ex Order 26.4b1 would then educate the staff on the device and how to NJ Ex Order and NJ Ex Order 26.4 the device. She confirmed that nurses were then responsible to get a physician's order for the NJ Exec Order and put the order on the Treatment Administration Record (TAR) so that the device could be signed off by the nurse. She stated that the NJ Exec Order use would then be included in the resident's CP. She confirmed that it would be important to get a physician's order for the device so that there is follow through. She continued to add that it would also be important to put the usuage of the NJ Ex Order on the CP because the CP directs the care of the resident.

The facility policy dated 04/2023 and titled, "Orthotic Devises" indicated that if limitations were evident and an orthotic device was indicated, a physician's order for such treatment would be requested. When the orthotic device was obtained, the orthotic device would be applied and observed. The policy also indicated that findings and recommendations would be documented in the resident's medical record. The wearing time for an orthotic device is based on

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F 688	Continued From page 5 the individual residents need (per physician's order therapist recommendations). The comprehensive Care Plan would be updated to include any changes in status, goals and recommendations which reflect the wearing of the orthotic device. NJAC 8:39 27.2 (m)	F 688		
F 695 SS=E	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, and record review, it was determined that the facility failed to provide the necessary NJ Ex Order 26.4b1 care and services for 1 (one) of 2 (two) residents (Resident # 100) reviewed for NJ Ex Order 26.4b1 services. This deficient practice was evidenced by the following: According to the Admission Record (AR) Resident #100 was admitted to the facility with diagnoses that included, but were not limited to, NJ Ex Order 26.4b1 and NJ Ex Order 26. .	F 695	1. Immediate action: a) The correct size replacement NJ Ex Order 26.4b1 kit was immediately placed at bedside by the US FOIA (b)(6) for emergency airway management. b) The NJ Ex Order 26.4b1 order was revised by the US FOIA (b)(6) to reflect that the NJ Ex Orde be disposable and disposed of everyday shift and as needed. 2. How was affected or had the potential to be affected? a) All residents who have a tracheostomy in the facility had the potential to be affected. b) An audit was immediately conducted by the ADON for all residents with	5/12/24

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F 695	Continued From page 6 The quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted], indicated that the resident was [redacted] and required extensive to total care with [redacted]. The MDS also indicated that the resident required [redacted] care ([redacted]. On 03/18/24 at 10:13 AM, during tour, the surveyor observed Resident #100 lying in bed with a [redacted] The resident was [redacted] and [redacted]. The resident communicated by [redacted]. The surveyor did not observe an emergency [redacted] kit [redacted] in sight near the resident. There was a [redacted] close to the resident's bed and an [redacted] ([redacted]) next to the resident's bedside. On 03/19/24 at 10:02 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that Resident #100 received [redacted] care every shift. LPN #1 stated that the necessary supplies that should be located at the resident's bedside was a [redacted] and [redacted]. She also stated there should be an emergency [redacted] located in the resident's room in case the resident [redacted] ([redacted].	F 695	tracheostomy. The audit was conducted as follows: i. Tracheostomy kits and size was correct ii. Ambu bag present as the bedside iii. Tracheostomy order to include inner cannula care is correct c) No other residents were affected by the deficient practice. 3. Corrective action a) Staff educator and ADON will educate 4 all nursing staff on 05/01-05/05 2024 on how to accurately read treatment orders and the need to follow treatment orders as they are written and/or query orders that seem questionable before administering treatment and accurately document that the treatment signed for is the actual treatment that was administered. 4. How this will be monitored The following corrective actions will be monitored to ensure that the deficient practice will not be repeated: a) The 11-7 nurse supervisors will conduct nightly audits to ensure that correct tracheostomy supplies are at the bedside of all trach residents. b) Weekly audits by nursing administrators and IP to verify that emergency trach supply is at the bedside of all residents with tracheostomy. c) The orders of all tracheostomy for new admissions and correct emergency tracheostomy supplies will be verified by nursing supervisors/admission nurse, ADON, and unit managers. d) Orders will be verified by nursing supervisors, admission nurse, ADON, and unit managers when residents are	

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F 695	Continued From page 7 LPN #1 accompanied the surveyor to the resident's room and located an emergency NJ Ex Orde kit NJ Ex Order 26.4b1 in the resident's bedside drawer. The US FOIA reviewed the physicians order in the presence of the surveyor and confirmed that the emergency NJ Ex Order 26.4b that was observed in the resident's drawer was the NJ Ex Order 26.4b1, NJ Ex Order 26.4b1. Another nurse (LPN #2) was standing at the nurse's station and stated that Resident #100 used to have a NJ Ex Order 26.4b1 however, the resident had NJ Ex Order 26.4b1 surgery on NJ Ex Order 26.4 and the NJ Ex Order 26.4b1 was changed a NJ Ex Order 26.4b1. Both LPNs confirmed that the emergency NJ Ex Order 26.4b1 kit NJ Ex Order 26.4b1 was not the right NJ Ex Or and should have been the correct NJ Ex Or of NJ or a NJ Ex Order 26.4b1. LPN #1 further reviewed Resident #100's Treatment Administration Record (TAR) in the presence of the surveyor and stated that the current treatment order dated NJ Ex Order 26.4b to "NJ Ex Order 26.4b1 and NJ Ex Orde [as needed] for NJ Ex Order 2 every shift for NJ Ex Order 26.4b1" was not a clear order and that the order did not specify how the NJ Ex Order 26.4 was supposed to be NJ Ex Order 26.4 and with what NJ Ex Order 26.4 the NJ Ex Order 26.4b1 was to be NJ Ex Order 26.4 with. LPN #1 continued to explain that the resident had NJ Ex Order 26.4b1, and she did not think that it needed to be NJ Ex Order 26.4b1. The US FOIA stated that it should be thrown away and replaced with a new one. The Order Summary Report (OSR) dated NJ Ex Order 26.4b1, indicated that the resident had a NJ Ex Orde of NJ Ex Order 26.4b1. The OSR also reflected a physician's order dated NJ Ex Order 26.4b: NJ Ex Order Care: NJ Ex Order 26.4b1 every shift and as needed for NJ Ex Order 2	F 695	readmitted or return from consultation or procedures. e) These audits will be completed weekly x4, monthly x 3, quarterly x 2. All findings will be reported to the QAPI committee quarterly. Completion Date: May 12, 2024	

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F 695	Continued From page 8	F 695		

management. This order was not reconsiled or clarified for [redacted].

The resident Care Plan (CP) dated [redacted], reflected an intervention to maintain [redacted] and [redacted] at the resident's bedside.

On 03/19/24 at 10:40 AM, the surveyor interviewed LPN #2 who stated that the current order to [redacted] and [redacted] for [redacted] needed to be clarified because the resident had a [redacted] that was not supposed to be [redacted] The [redacted] was to be thrown away and replaced with a new [redacted] every shift. LPN #2 stated that the order did not reflect that, however, when she was assigned to the resident, she changed the [redacted] for a new one every day. LPN #2 confirmed that the emergency [redacted] kit that was in the resident's drawer was the wrong [redacted] and needed to be the correct [redacted] in case the resident accidently [redacted] him/herself. Stated a spare [redacted] should always be the correct [redacted] or a [redacted]. LPN #2 further stated it was important to assure correct [redacted] in case of an emergency and to maintain the resident's [redacted]

On 03/19/24 at 10:41 AM, the surveyor interviewed the [redacted]) who stated that Resident #100 had [redacted] to his [redacted] and that when the resident's [redacted] changed, the orders should have changed to reflect the [redacted] of the resident's [redacted] She confirmed that the emergency [redacted] kit that was at the resident's bedside should have been the correct [redacted] or [redacted] for [redacted]

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management in case of an emergency. The [US FOIA (b)] also reviewed the [NJ Ex Order 26.4b1] care treatment order with the surveyor and confirmed that the resident had a [NJ Ex Order 26.4b1] and that the order [NJ E] clean the [NJ Ex Order 26.4b1] [] and [NJ Ex Ord] for [NJ Ex Order 2] management needed to be clarified because the staff should not be cleaning the [NJ Ex Order 26.4b1], they should be replacing it.

On 03/19/24 at 12:28 PM, the surveyor interviewed the [US FOIA (b)(6)] [] regarding Resident #100's [NJ Ex Order 26.4b1] care. The [US FOIA (b)(6)] stated the resident had surgery in [NJ Ex Order 26.4b1] and had a follow-up [NJ Ex Or] []. He stated that emergency supplies that should be kept at the resident's bedside would be the [NJ Ex Order 26.4b1], or a [NJ Ex Order 26.4b1], and an [NJ Ex Order 26.4b1]. He stated that it would be important to have this equipment for emergencies in case the resident [NJ Ex Order 26.4b1] and staff needed to keep the resident's [NJ Ex Order 26.4b1]. The [US FOIA (b)(6)] also confirmed that the order to [NJ Ex Order 26.4b1] [] and [NJ Ex Ord] for [NJ Ex Order 2] management was an inaccurate order and should have been discontinued. He stated that there should have been an order to change the [NJ Ex Order 26.4b1] during [NJ Ex Order 26.4b1] every shift.

The facility policy dated 04/2022 and titled, "Emergency Tracheostomy Care" indicated that the purpose of this procedure was to guide nursing for the need of emergent tracheostomy care should extubation (refers to removal of the endotracheal tube) occur. The policy specified that emergency intervention to prevent respiratory complications are to be implemented immediately to include: a replacement tracheostomy tube

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F 695	Continued From page 10 must be available at the bedside at all times should tracheostomy become dislodged. The facility policy with a revised date 03/2024 and titled, "Care of a Tracheostomy Resident" indicated Care of the resident included: Ensure that there is an emergency tracheostomy set up at the patient's bedside which includes a tracheostomy care kit, ambu bag, and a smaller size tracheostomy tube for immediate use. NJAC 8:39-19.4(a)	F 695		
F 804 SS=E	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: Complaint: NJ171634 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to serve hot and cold foods at an acceptable temperature for the residents. This deficient practice was identified on 1 of 3 nursing units ([redacted] Floor Dining Room) during the lunch meal service. The deficient practice was evidenced by the following: On 03/27/24 at 11:15 AM, the surveyor met with	F 804	1. Immediate action a) All hot food delivered to the resident floor noted to be below 135 degrees were heated by dietary staff to ensure temperature reading was same as leaving the kitchen. b) All cold items that were above 41 degrees were discarded by staff and replaced with items at proper temperature. 2. Who was affected a) All residents had the potential to be	5/12/24

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BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	1045 E CHESTNUT AVE VINELAND, NJ 08360

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F 804	Continued From page 11 the US FOIA (b)(6) in the kitchen and informed her a temperature test tray was requested for the NJ Exec Ord Floor. On 03/27/24 at 11:31 AM, the dining staff started plating trays for the food cart for the Third floor. The surveyor observed the US FOIA calibrate a digital thermometer in a cup of ice water, and the temperature read 32 degrees Fahrenheit (F). On 03/27/24 at 11:43 AM, the surveyor observed the cook plate a regular meal and the US FOI tested the food temperatures on the test tray: Sliced roast beef, 144.9 degrees F. Mashed potatoes with gravy, 146.5 degrees F. Mixed vegetables, 146.5 degrees F. Individual cups of pineapple chunks, 60.3 degrees F. During an interview at that time, the US FO stated that the pineapple chunks should have been 41 degrees F or below. On 03/27/24 at 11:49 AM, the NJ Exec Ord Floor food cart left the kitchen. The surveyor and the US FOIA accompanied the cart to the NJ Exec Ord Floor. On 03/27/24 at 11:51 AM, the food cart arrived on the NJ Exec Ord Floor. On 03/27/24 at 11:59 AM, all the trays were delivered from the cart. The US FOIA then tested the food temperatures on the test tray: Sliced roast beef, 118.9 degrees F. Mashed potatoes with gravy, 126.3 degrees F. Mixed vegetables, 103.5 degrees F. Individual cups of pineapple chunks, 65.3 degrees F.	F 804	affected by this deficient practice b) No residents were affected. 3. Corrective actions: a) Dietary staff was educated by FSD and IP on the importance of all food leaving the kitchen have temperatures above 135 degrees as hot items and below 41 as cold items. b) The dietary staff was educated by FSD and IP to not remove fruits or vegetables from walk-in refrigerator before needed; or to keep them on ice to maintain temperature if they are taken out in batches. c) The dietary staff was educated by IP and FSD that if cold item goes above the required temperature of 41 degrees, that item/s should be discarded immediately and not be placed on ice or in the refrigerator. d) The nursing staff will be educated by staff educatoro0n 05/01-05/05 2024 on the importance of distributing meals as soon as the dietary carts arrived each unit to prevent falling or rising of temperatures. 4. How this process be monitored The following corrective actions will be monitored to ensure that the deficient practice will not be repeated: a) The FSD will conduct daily audits to ensure staff compliance is being maintained with all identified deficient practices. b) IP will conduct weekly audit to verify compliance with all identified deficient practice. c) Audits will be conducted weekly by nursing administration, FSD, IP, and staff educator on the temperatures of meals,	

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F 804	Continued From page 12 During an interview at that time, the [redacted] stated that the hot food temperatures when they left the kitchen should have been between 120-130 degrees F and stated that the cold food temperature, "can go up to 50, I have to double check, at least 50 or below." The [redacted] stated that it was important to maintain proper food temperatures so foodborne illnesses were prevented and food complaints were avoided. On 03/27/24 at 12:36 PM, the surveyors met with the administration team, and they were made aware of the test tray food temperature concerns. A review of the facility document entitled, "Cooks Temp Log, Date: 3/27/24, Day: Wednesday, revealed under Lunch section: Menu Item: Roast Beef, Cook Temp: 170 Menu Item: Mash Pot, Cook Temp 188 Menu Item: Mix veg, Cook Temp 185 Menu Item: Pineapple Tidbits, Cook Temp 37 A review of the undated facility policy titled, "Food Temperatures," revealed, Procedure: 1.b. Hot food items may not fall below 135 degrees after cooking ...2. All cold food items must be maintained and served at a temperature of 41 degrees F or below. 6. Foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods. NJAC 8:39-17.4 (a)	F 804	supplements, and liquids before leaving the Kitchen. Audit will be conducted on the time the dietary cart arrives to each unit, the first attempt by staff to distribute trays, the temperature of a test tray on arrival and the temperature at the end of tray distribution. d) These audits will be completed weekly x 4, monthly x 3, quarterly x2. All findings will be reported to the QAPI Committee quarterly by FSD. Completion Date: May 12, 2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		5/12/24

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F 812	Continued From page 13 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: Based on observation, interview, and review of facility documentation it was determined that the facility failed to maintain equipment and kitchen areas in a manner to prevent microbial growth and cross-contamination. This deficient practice was observed and evidenced by the following: On 03/18/24 from 09:43 AM until 10:33 AM, the surveyor toured the kitchen in the presence of the US FOIA (b)(6) and observed the following: 1. On the clean pots and pans drying rack, there were two sets of two 4-inch long pans nested, with clear liquid between the pans. The US FO	F 812	1. Immediate actions: a) The deficient pots and pans were separated immediately by the FSD and placed in the cleaning sink to be washed. b) The deficient cutting boards were immediately removed and replaced by the FSD with new cutting boards. c) The ice machine was emptied and cleaned by a member of the dietary staff as soon as it was discovered. d) The slicer and the handle of the slicer were cleaned right away and covered by a member of the dietary staff. Staff was reminded by FSD to clean slicer and handle as soon as the task is completed and cover the slicer when it is not in use.	

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F 812	Continued From page 14 acknowledged that the pans were wet nested and stated that it was important to make sure the pans were dried correctly for bacterial prevention. 2. On the clean pots and pans rack there were: two large red cutting boards with brown smudges and scratches; one white cutting board with brown stains, black smudges, and scratches; one green cutting board with black smudges; two white cutting boards with brown stains and black smudges; and one dark green cutting board with black smudges and scratches. The [redacted] acknowledged the smudges, stains, and scratches and stated that it was important for infection control that the cutting boards were cleaned and sanitized. 3. The [redacted] lifted the lid to the ice machine and on the inside of the ice machine, on the white plastic guard, there was pink and black debris. The surveyor wiped the area with a white paper towel and the pink and black debris was observed on the towel. The [redacted] acknowledged the debris and stated that it should not have been on the ice machine. The [redacted] stated that the ice machine was used for resident hydration and that the staff was responsible for cleaning and sanitizing the machine monthly and that maintenance was responsible for cleaning the machine quarterly. The [redacted] further stated that it was important that the ice machine was cleaned and sanitized for infection control. 4. On a metal table was an uncovered deli slicer. There was white debris on the handle and on the slicer blade, and there was pink debris on the slicer arm. The [redacted] stated that the slicer was cleaned each time it was used and that it was cleaned this morning. The [redacted] acknowledged the	F 812	e) The debris and grease on the inside of the oven door was immediately cleaned by the cook. f) The open plastic wrap was discarded and replaced by the FSD with a new wrap with cover intact. g) All exposed coffee filters were discarded by the FSD and all staff reminded to keep them in the plastic bag until use. 2. Who was impacted a) All residents had the potential to be impacted b) No residents were affected. 3. Corrective actions a. The dietary staff was educated by FSD and IP on the importance of following the policies and procedures of the facility to prevent infections. b. Education provided to the dietary staff by IP and FSD on the importance of allowing pots and pans to dry separately to prevent wet nesting. c. The dietary staff was educated by FSD on the importance of cleaning cutting board properly to prevent infections and change them out when they have multiple scratches and appears dirty. d. The dietary and maintenance staff were educated by IP on the importance of following the cleaning schedule for the ice machine to prevent the buildup and mold. e. The dietary staff was educated by FSD and IP on the importance of disinfecting equipment as soon as the intended task is completed. The slicer should be covered when not in use, and that spills in the oven is cleaned as soon as the oven is cool and it is safe to do so.	

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F 812	Continued From page 15 debris and stated that it should not have been there. The US FO[redacted] further stated that it was important that the slicer was cleaned correctly for infection control. 5. On the floor of the bottom oven there was black debris, and on the inside of the oven doors there was brown greasy debris. The US FO[redacted] acknowledged that the debris should not have been there and that it was important that the ovens were cleaned for infection control. 6. On the cook area, there was an uncovered box of clear plastic wrap. The US FOA[redacted] stated that the wrap was used to cover food and acknowledged that the box should have had a cover. The US FO[redacted] stated that it was important that the plastic wrap was covered so no debris fell on to the wrap. 7. On the utensil rack, there was one large box that contained a clear bag of large coffee filters with a stack of filters resting on top of the clear bag. The filters were uncovered and exposed to air. The US FOA[redacted] acknowledged the filters were exposed to air and stated that it was important for infection control to keep the coffee filters covered. On 03/27/24 at 12:36 PM, the surveyors met with the administration team and were made aware of the kitchen concerns. A review of the undated facility policy, "General Food Preparation and Handling," revealed, Procedure: 1.a. The kitchen and equipment are clean and sanitized as appropriate. 5. Equipment, a. All food service equipment should be cleaned, sanitized, dried, and reassembled after each use. A review of the undated facility policy, "Cleaning	F 812	f. Education provided to the dietary staff by the FSD and IP on the importance of leaving the covering on all plastic wraps and foil papers to prevent environmental exposure. g. Education provided to the dietary staff by the FSD and IP on the importance of not removing coffee filters, cups, or any paper products out of their original containers if the intention is not to use them right away. After removing what is needed from each container, the containers should be resealed or closed. 4. How will this process be monitored? The following corrective actions will be monitored to ensure that the deficient practice will not be repeated: a) The FSD will conduct daily audits to ensure staff compliance is being maintained with all identified deficient practices. b) IP will conduct weekly audit to verify compliance with all identified deficient practice. c) These audits will be completed weekly x 4, monthly x 3, quarterly x 2, and reported to the QAPI committee quarterly. Completion Date: May 12, 2024	

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F 812	Continued From page 16 Instructions: Ice Machine and Equipment," revealed, Policy: The ice machine and equipment (scoops, etc.) will be cleaned on a regular basis to maintain a clean, sanitary condition. Procedure: 2. Wash the interior thoroughly ... A review of the undated facility policy, "Production, Storage and Dispensing of Ice," revealed, Procedure: 1. The ice dispenser is cleaned and sanitized at least monthly, and/or as needed. Inside and outside of the machine are cleaned. A review of the undated facility policy, "Cleaning Instructions: Cutting Boards," revealed, Policy: Cutting boards will be cleaned and sanitized after each use. NJAC 8:39-17.2(g)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		5/12/24

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F 842	Continued From page 17 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 18 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to maintain medical records that were accurate and consistent for 1 of 32 (Resident # 89) medical records reviewed. This deficient practice was evidenced by the following: According to the Admission Record, Resident #89 was admitted to the facility with diagnoses that included, but were not limited to, NJ Ex Order 26.4b1 [redacted] The admission Minimum Data Set (MDS), an assessment tool that facilitated a resident's care, dated NJ Ex Order 26.4b1, reflected that the resident had NJ Ex Order 26.4b1 [redacted] and required NJ Exec Order 26.4b1 [redacted] to NJ Exec Order 26.4b1 [redacted] assistance with activities of daily living. The MDS also indicated that the resident received NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 [redacted]). On 03/18/24 at 10:34 AM, during tour, Resident #89 was not present in his/her room because he/she was at NJ Ex Order 26.4b1 The US FOIA (b)(6)	F 842	1. Immediate action: a) Upon notification of the deficient findings, the regional Director of Nursing conducted an internal audit on the resident. This audit consists of the following: i. No other NJ Exec Order 26.4b1 or NJ Ex Order 26.4b1 was taken into the NJ Ex Order 26.4 [redacted]. ii. An alert was present for documenting NJ Exec Order 26.4b1 or NJ Ex Order 26.4b1 b) A new patients order was added by the ADON under direction of the MD to include NJ Ex Order 26.4b1 for the resident in the vital signs orders to include NJ Exec Order 26.4 [redacted] in affected NJ Exec O [redacted] c) All batch vital signs orders in point click care were updated by the regional DON to include NJ Exec Order 26.4b1 if a patient has any NJ Exec Order 26.4b1 [redacted] 2. Who was affected or had the potential to be affected a) All residents who have a port, shunt, internal catheter, stroke, or mastectomy, had the potential to be affected. b) An audit was conducted immediately by the ADON with all residents with ports,	

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F 842	Continued From page 19 US FOIA (b)(6) indicated that the resident went to [redacted] on Monday, Wednesday, Friday, and had an [redacted] (NJ Ex Order 26.4b1 [redacted]) in the [redacted]. Review of Resident #89s Care Plan, dated [redacted], indicated that the resident was on dialysis and had a "[redacted]" to the [redacted]. Review of the Medication Administration Record (MAR), dated [redacted], reflected a physician's order: [redacted] Alert [redacted]/[redacted] in the [redacted] There were nursing signatures on the MAR that indicated that the nurses were documenting that they were not taking the resident's [redacted] in the [redacted]. On 03/19/24 at 09:25 AM, the surveyor reviewed the vital signs (VS) record and there was documentation that nurses were taking [redacted] in the resident's [redacted] The physicians order dated [redacted] indicated that Resident #89 was on [redacted] alert and there were to be no [redacted] ([redacted] taken in the [redacted] nor [redacted] in the [redacted]. Review of the Electronic Medical Record (EMR) blood pressure exceptions indicated that the facility documented that [redacted] were taken in the resident's [redacted] on the following dates: - [redacted] at 10:26 AM. - [redacted] at 09:54 AM. - [redacted] at 21:12 (09:12 PM).	F 842	shunts, permacath, and mastectomy. c) No other residents were affected by the deficient practice. 3. Corrective action a) Staff educator and ADON educated all nursing staff right away with how to accurately read orders to ensure that correct orders are in place before starting vital signs and venipuncture. b) Education provided by ADON and staff educator to nurses on the need to follow orders as they are written and/or query orders that seem questionable before taking vital signs. c) Education provided by ADON and staff educator on the importance of accurately documenting the location in which vital signs are taken that are being documented. d) Education will be provided to all nursing staff and laboratory personal by the ADON on 05/01-05/05 2024 to check for limb alert bracelets before attempting to draw blood on any patient. e) Limb alert bracelets ordered by LNHA for all residents who have dialysis, permcath, any ports and mastectomy and will be applied upon receipt. 4 How this will process be monitored a) Unit managers and ADON will conduct audits to ensure that limb alert orders are in place and that vital signs and venipuncture are not being done in the affected arm. b) Weekly reports of order listing will be conducted to monitor for any limb alert orders by nursing administration. c) Orders will be verified by nursing supervisors/admission nurse, ADON, and	

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F 842	Continued From page 20 – NJ Ex Order 26.4b1 at 06:59 AM. On 03/19/24 at 09:45 AM, the surveyor interviewed Resident #89 who showed the surveyor his/her NJ Ex Order 26.4b1. The surveyor asked the resident if the nurses took the resident's NJ Exec [illegible] in the NJ Ex Order 26.4 and the resident stated, "NJ Ex Order 26.4b1" and then stated, "NJ Ex Order 2[illegible]". On 03/19/24 at 09:47 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she had worked in the facility for NJ Ex Order 26.4b1. The US FOIA stated that the resident was NJ Ex Orc and was NJ Ex Order 26.4b1 [illegible]. She also explained that the resident required NJ Ex Order 26.4b1 with activities of daily living (ADLs) and was NJ Ex Order 26.4b1 and wore NJ Ex Order 26.4b1. The US FOIA stated that the resident had an NJ Ex Order 26.4b1 in the NJ Ex Order 26.4. She explained that the nurse was responsible to check for NJ Ex Orc and NJ Ex Or NJ Ex Order 26.4b1 [illegible]) to make sure the NJ Ex Order 26.4b1 was functional. She stated that the resident was on NJ Ex Order 26.4 precautions and that no NJ Exec Order 26.4b1 were to be taken in the NJ Ex Order 26.4b. She stated that the resident goes out to NJ Ex Order 26.4 of Monday, Wednesday, and Friday. The surveyor reviewed the VS sheet with the US FOIA and asked the US FOIA why she documented on NJ Ex Order 26.4b1 at 06:59 AM, that she took the resident's NJ Exec Order 26.4b1 in the NJ Ex Order 26.4. The US FOIA stated that she must have documented in error and that she knew that she should not take the resident's NJ Exec Order 26.4b1 in the NJ Ex Order 26.4. She stated that it was an error in documentation. On 03/19/24 at 12:40 PM, the surveyor	F 842	unit managers on all new admissions, readmissions, or when residents return from consultation or procedures. d) These audits will be completed Weekly x4, Monthly x 3, Quarterly x 2. All findings will be reported to the QAPI committee quarterly. Completion Date: May 12, 2024	

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	315126	A. BUILDING _____ B. WING _____	C 03/28/2024

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F 842	Continued From page 21 interviewed the US FOIA (b)(6) who stated the nurses should not be documenting that they are NJ Ex Order 26.4b1 in the resident's NJ Ex Order 26.4 because the resident was on NJ Ex Order 26.4 precautions related to the residents NJ Ex. He stated that it would be important to document accurately and completely in the medical record because it was a legal document. He stated that he could not speak to why the nurses were not documenting correctly in the electronic medical record (EMR) pertaining to what arm they took the residents NJ Exec Order 26.4b1 in. He continued to add that the resident had not had any issues associated with his/her NJ Ex Order 26.4b1 and was sure that the nurses were just documenting incorrectly. On 03/25/24 at 12:30 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the nurses should have been documenting the NJ Ex Order 26.4b1 in which they took Resident #89's NJ Exec Order 26.4b1, and it would be especially important since the resident had restrictions ordered not to take the resident's NJ Exec Order 26.4b1 in the NJ Ex Order 26.4. The facility policy with a date of 03/2024 and titled, "Charting Documentation" indicated that the medical record should facilitate communication between the interdisciplinary team regarding the resident condition and response to care. Nursing documentation provides evidence of the care given to our residents. The policy also indicated that documentation in the medical record would be objective, complete, and accurate. NJAC 8:39-35.2 (d)	F 842		
F 880 SS=E	Infection Prevention & Control	F 880		5/12/24

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F 880	Continued From page 22 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; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 23 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: Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to follow appropriate infection control practices and perform hand hygiene as indicated during meal tray pass for 1 of 3 units ([redacted] Floor unit) observed. The deficient practice was evidenced as follows: On 03/18/24 the surveyor observed the following	F 880	1. Immediate action: a) All affected trays were discarded by the unit manager upon notification of the deficient practice and each resident provided with a new tray from the dietary department. b) The staff member was interviewed by IP Nurse and removed from the area and placed on suspension immediately. c) The [redacted] assigned to that	

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F 880	Continued From page 24 in the Dining area: At 11:52 AM, the US FOIA (b)(6) approached the lidded trash can with a plastic dome plate cover and trash in her hand then lifted the trash can lid with her hand and discarded the trash into the can. The US FOIA (went to the food cart, removed a meal tray from the cart and placed it in front of Resident #22. The US FOIA (then opened the resident's soda can, removed the lid from the pudding, removed the slice of bread from the plastic packaging and placed it on the plate, opened the juice lid, removed the silverware from the paper bag and placed them on the tray next to the plate, then cut up the food for the resident. The US FOIA (then took the plastic dome plate cover and trash and approached the trash can, lifted the lid with her hand, and discarded the trash. The US FOIA (then went to the food cart, removed a meal tray, and placed it in front of Resident #97. The US FOIA (opened the lid of the pudding, opened the juice, removed the food items off the tray and placed them on the table in front of the resident. The US FOIA (then took the tray and plastic dome plate cover in one hand and trash in the other, placed the tray and plate cover on a metal table and returned to the trash can, lifted the lid with her hand and discarded the trash. The US FOIA (went to the sink in the dining area, turned on the water, attempted to dispense soap but the soap dispenser was empty, attempted to obtain a paper towel but the towel dispenser was empty, turned off the water and went to Resident #113 who was seated at a table with their tray in front of them. The US FOIA (opened the resident's juice, removed the silverware from the paper bag, handed the spoon to the resident, and placed the remaining silverware on the table next to the plate. The US FOIA (removed the trash	F 880	unit was instructed by housekeeping Director to check and fill soap, paper towel, and sanitizer dispensers when in need replenishing. d) The trash can lid was removed from the dining area by housekeeper director and housekeeper alerted to empty trash can and replace lid as soon as dining services were completed. 2. Who was affected: All residents that were in the dining area had the potential to be affected. No residents were affected by this deficient practice. 3. Corrective Action: a. New step pedal trash cans were ordered that day by housekeeper director and will be placed in all dining areas. A mounted sanitizer was placed adjacent to the trash can that day, This sanitizer dispenser will be in addition to the one that is already mounted in dining rooms. b. HK will ensure that soap, sanitizer, and paper towel dispensers are filled every morning and as needed in all common areas to include dining room. c. All staff were in serviced that day and ongoing, by IP and Staff educator of the proper hand hygiene techniques during tray distribution. 4. How will this be monitored to prevent future deficiency? The following corrective actions will be monitored to ensure that the deficient practice will not be repeated: a. Regular meal distribution audits that monitor infection prevention practices to include hand hygiene will be conducted by IP, UM, nursing management, and staff educator.	

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F 880	Continued From page 25 from the table, approached the trash can, lifted the lid with her hand and discarded the trash. The US FOIA (b returned to Resident #97, moved the resident's plate closer to them and repositioned the fork on the plate. No hand hygiene (HH) was observed during the observation. On 03/18/24 at 11:59 AM, the surveyor interviewed the US FOIA (b who stated that hand hygiene during tray pass was always completed before and after passing each tray. The surveyor informed the US FOIA (b of the meal tray pass observation and that there was no HH observation. The US FOIA (b acknowledged she should have performed HH and that it was important to prevent contamination. On 03/18/24 at 12:08 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the CNAs were responsible for serving the meal trays and that staff should have performed HH when "in contact with something dirty," and that hand wipes were used in between residents. The surveyor informed the US FOIA of the meal tray pass observation and the US FOIA acknowledged that the US FOIA (b did not perform HH correctly. The US FOIA stated that it was important to perform HH correctly to prevent cross contamination. On 03/18/24 at 12:16 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the CNAs were responsible for serving meal trays and that HH was performed once the resident's tray was passed, if the resident wanted items removed from the tray, and when trash was discarded. The surveyor informed the US FOIA (b)(6) of the meal tray pass observation and the US FOIA (b)(6) acknowledged that the US FOIA (b did not perform HH	F 880	b. These audits will be completed every week times 4 weeks; every month times three months, quarterly time two months and ongoing. c. This will be reported to the QAPI committee for review quarterly. Completion Date: May 12, 2024	

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F 880	Continued From page 26	F 880		

correctly. She stated that it was important for infection control that HH was done prior to tray pass, in between each resident, and especially when the trash can was touched.

On 03/18/24 at 12:26 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the US FOIA (b) and nursing staff were responsible for serving meal trays and that HH was performed between each resident and any time that they touched anything the resident touched. The surveyor informed the US FOIA (b)(6) US FOIA (b)(6) of the meal tray pass observation and the acknowledged that the US FOIA (b) did not perform HH correctly. She stated that it was important for infection control that HH was performed before the resident's meal or silverware was touched, and after trash was touched.

On 03/18/24 at 12:32 PM, the surveyor interviewed the US FOIA (b)(6)) who stated that the US FOIA (b) was responsible for serving meal trays and that HH was performed in between each resident and as needed. The surveyor informed the US FOIA (b) of the meal tray pass observation and the US FOIA (b) acknowledged that the US FOIA (b) did not perform HH correctly. She stated that it was important for cross contamination prevention that HH was performed between each resident, after food items were opened and any time the trash was touched.

A review of the facility policy, "Hand Hygiene," revised date 2/2024, revealed, Policy Interpretation and Implementation, 6. Hand hygiene needs to be performed before and after patient contact, for meals and as needed when hands are visibly soiled.

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F 880	Continued From page 27 A review of the facility policy, "Assisting Residents with Meals," revised date 9/2022, revealed, Preparation: 11. Employees must wash their hands before serving food to residents. It is not necessary to wash hands between each resident tray; however, if there is contact with soiled dishes, clothing or the resident's personal effects, the employee must wash his/her hands before serving food to the next resident. A review of facility documentation entitled, Infection Control Inservice 2024, Department: Nursing/CNA revealed the CNA's name, signature and dated 2/28/24. The page CNA's Inservice, revealed, General: 2. The best way to prevent infections is by following the policies and procedures of the facility; performing hand hygiene (Most important) ...	F 880		
F 921 SS=E	NJAC 8:39-19.4 (m)(n) Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Complaint: NJ171634 Based on observations, interviews, and review of other facility documentation, it was determined the facility failed to maintain medication and treatment carts in a sanitary manner for 2 of 2 medication carts and 2 of 3 treatment carts on the	F 921	1. Immediate action: Upon notification of the deficient practice, the housekeeping director immediately removed hair and debris from all medication and treatment carts in the building to include the deficient carts. 2. Who was affected: All residents had	5/12/24

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F 921	Continued From page 28 Subacute unit, and 1 of 2 medication carts and 2 of 2 treatment carts on the North Hall unit. This deficient practice was evidence by the following: On 03/20/24 at 10:00 AM, the surveyor observed visible amounts of human hair built up in all 4 wheels of the North Hall "Front" medication cart. On 03/21/24 at 10:01 AM, the surveyor inspected all medication and treatment carts for the Subacute unit and observed the following: - Visible human hair in 2 of 4 wheels of the "Even" (side) Subacute medication cart. - Visible human hair in all 4 wheels on the "Odd" (side) Subacute medication cart. - Visible human hair in all 4 wheels of the "Even" (side) Subacute treatment cart. - Visible human hair in all 4 wheels of the "Odd"(side) Subacute treatment cart. On 03/21/24 at 10:06 AM, the surveyor inspected the medication and treatment carts for the North Hall unit and observed the following: - Visible human hair in all 4 wheels of the North Hall "Front" treatment cart. - Visible human hair in all 4 wheels of the North Hall "Back" treatment cart. On 03/21/24 at 10:01 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that housekeeping was responsible for cleaning the medication carts and thought they cleaned the carts overnight, but was not sure.	F 921	the potential to be impacted. No residents were affected by the deficient practice. 3. Corrective action: a) The housekeeping director removed hair and debris from all medication and treatment carts in the building to include the deficient carts. b) The policy for cleaning medication and treatment carts was updated to include the cleaning of medication and treatment carts and wheels and a quarterly schedule for cleaning medication and treatment cart was updated by housekeeping director. c) The housekeeping staff was in-serviced by the housekeeping director with the schedule for cleaning carts and wheels the next day, 4. How will this be monitored? The following corrective actions will be monitored to ensure that the deficient practice will not be repeated. a) Audits will be conducted by the housekeeping director, IP, unit managers, nursing supervisor, and charge nurse to ensure that carts and wheels are cleaned. i. Weekly x4, monthly x3, Quarterly x 2 and ongoing. All will be reported to the QAPI committee quarterly. Completion Date: May 12, 2024	

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F 921	Continued From page 29	F 921		

On 03/21/24 at 10:06 AM, the surveyor interviewed LPN #2 who stated she and the other nurses cleaned the outside surfaces of the medication and treatment carts before and after their shifts.

On 03/21/24 at 10:07 AM, the surveyor interviewed the US FOIA (b)(6) who stated the nurses cleaned the carts before their shift and between every shift. She continued to explain that the nurses cleaned the inside areas of the cart if something spilled, otherwise the nurses kept the inside of the cart clean and organized as they worked. The US FOIA further stated that the cleaning of the carts entailed wiping down all equipment and surfaces including the drawer faces, top, sides, and back of the carts.

On 03/21/24 at 10:16 AM, the surveyor interviewed the US FOIA (b)(6) for the North Hall and Subacute units who stated that the housekeeping department cleaned the outside of the medication carts. The US FOIA (b)(6) further stated that cleaning of the medication carts was housekeeping's responsibility and the Porters (supports services in various settings, such as hotels and hospitals have duties that include maintaining cleanliness) cleaned the medication carts at night. The US FOIA (b)(6) stated that she cleaned the medication carts by cleaning the entire outside of the cart, but did not know who cleaned the wheels on the carts.

On 03/21/24 at 10:19 AM, the surveyor interviewed the US FOIA (b)(6) for the North Hall unit who stated that the 3:00 PM to 11:00 PM shift had a schedule for cleaning the medication and treatment carts and that housekeeping would inform the nursing staff to remove all items out of

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the medication cart so it could be cleaned inside and out.

On 03/21/24 at 10:23 AM, the surveyor interviewed the US FOIA (b)(6) and US FOIA (b)(6) who stated that it was housekeeping's responsibility to clean the medication carts and that nursing performed a daily cleaning of the carts as well. She stated that the Porter wiped down the medication carts a few times a week and had a quarterly schedule to do a detailed cleaning inside and outside of the carts. She continued to explain that housekeeping conducted thorough cleaning of two medication and treatment carts per week and had all items removed from the drawers so that the carts could be cleaned. She stated that sometimes housekeeping would take the carts outside and hose them down, but they usually just wipe them down with cleaner. The [redacted] stated that they had a "generic" quarterly cleaning schedule, but it was not completed for this year (2024) because she hasn't done it yet. The [redacted] provided the surveyor with a blank copy of the cleaning schedule. The surveyor asked the [redacted] if the facility had policy and procedures for medication and treatment cart cleaning and the [redacted] said "yes" but was not able to provide a copy to the surveyor.

Following the interview, the [redacted] accompanied the surveyor to the North Hall "Front" medication cart. In the presence of surveyor, the [redacted] observed the visible human hair built up in the 4 wheels of the medication cart and confirmed the observation of hair in all 4 wheels. The surveyor asked the [redacted] why it was important to clean the hair out of the wheels and the [redacted] replied because of infection control.

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The [redacted] later stated they did not have policy and procedure for medication and treatment cart cleaning, so the [redacted] told the [redacted] to write down what she did and that was provided to the surveyor as the "Med and Tx Cart Cleaning Policy".

On 03/22/24 at 10:00 AM, the surveyor interviewed the [redacted] who stated that the facility did not have a policy and procedure for the Medication and Treatment Cart cleaning, however she instructed the [redacted] and [redacted] to write what she did to clean the carts and label it as a policy. The [redacted] signed a copy of this typed housekeeping cleaning procedure and provided this document to the surveyor and stated that this was not an actual policy.

The surveyor reviewed the typed document that the [redacted] provided to the surveyor titled, "Med and TX Cart Cleaning Policy" which indicated the following:
-Wipe outside of the carts 3 times per week.
-Deep Cleaning is quarterly or as needed.
-If any broken drawers or part observed, notify nurse/supervisor.

The facility policy with a revised date of 11/2022 and titled, "Cleaning and Disinfection of Care Items and Equipment" indicated that resident-care equipment, including reusable items and durable medical equipment will be cleaning and disinfected according to current CDC recommendations for disinfection and OSHA blood born pathogen standard. The surveyor reviewed the policy and there was no documentation regarding cleaning of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. BUILDING _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	**1045 E CHESTNUT AVE VINELAND, NJ 08360**

(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 921	Continued From page 32 medication carts or treatment carts. The facility could not provide any additional information. NJAC 8:39-19.8	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060601	A. BUILDING: _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTH	1045 E CHESTNUT AVE VINELAND, NJ 08360

(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 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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 regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 2 of 2 weeks of staffing prior to the recertification survey dated 03/28/24. This deficient practice was evidenced by the following: 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	S 560	1. Immediate action: No residents were affected. 2. Who was affected: All resident had potential to be affected by this deficient practice none were affected. 3. Corrective Actions: Measures have been taken by the Staffing Coord, Nursing Administration and Administrator and will continue to be put into place to ensure the deficient practice will not recur. These measures include Bonuses are offered for double shifts, extra shifts, weekend shifts. The staff has been re-educated immediately on the call out and lateness policy by Nursing Management and Nurse Educator. Advertisement signs for open CNA positions are placed in front of the	5/12/24

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

Electronically Signed | 04/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) 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" for the following weeks provided by the facility revealed the following: For the 2 weeks of staffing prior to survey from 02/25/2024 to 03/09/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts, deficient in CNAs to total staff on 2 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -02/25/24 had 10 CNAs for 167 residents on the day shift, required at least 21 CNAs. -02/25/24 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs. -02/26/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -02/26/24 had 11 total staff for 165 residents on the overnight shift, required at least 12 total staff. -02/27/24 had 18 CNAs for 165 residents on the day shift, required at least 21 CNAs.	S 560	building, facility employs a recruiter and posts openings on Indeed, APPLOI, and all applicants are met with upon receipt of application. Staffing Coord will call, text, email CNA¬s to take an open shift as needed. We offer sign on bonuses and Job Fairs. We contract with a variety of agencies, we offer referral bonuses, career ladder program, Shift differential on weekends, offer CNA Training classes free of charge. 4. How this will be monitored: Corrective actions will be monitored by Staffing Coord daily. Director of Nursing/Designee will conduct weekly C.N.A. staffing schedule audits and will report audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes to the QAPI Committee quarterly with follow up to recommendations to ensure the deficient practice will not recur. This will be done weekly x4, monthly x3, quarterly x2. Completion Date: May 12, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060601	A. BUILDING: _____ B. WING _____	C 03/28/2024

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S 560	Continued From page 2 -02/28/24 had 19 CNAs for 165 residents on the day shift, required at least 21 CNAs. -02/29/24 had 17 CNAs for 165 residents on the day shift, required at least 21 CNAs. -03/01/24 had 14 CNAs for 165 residents on the day shift, required at least 21 CNAs. -03/02/24 had 9 CNAs for 165 residents on the day shift, required at least 21 CNAs. -03/02/24 had 8 CNAs to 18 total staff on the evening shift, required at least 9 total staff. -03/03/24 had 11 CNAs for 165 residents on the day shift, required at least 21 CNAs. -03/04/24 had 15 CNAs for 164 residents on the day shift, required at least 20 CNAs. -03/05/24 had 17 CNAs for 162 residents on the day shift, required at least 20 CNAs. -03/09/24 had 15 CNAs for 161 residents on the day shift, required at least 20 CNAs. During an interview with the surveyor on 03/26/24 at 10:06 AM, the Staffing Coordinator stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for 10 residents on the 3:00 PM - 11:00 PM shift, and one CNA for 14 residents on the 11:00 PM - 7:00 AM shift. During an interview with the surveyor on 03/25/24 at 10:15 AM, the Director of Nursing stated that staffing levels are based on the facility's census to determine the ratio.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or	S1405		5/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTH	1045 E CHESTNUT AVE VINELAND, NJ 08360

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S1405	Continued From page 3 advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment, or within thirty days if a Registered Nurse (RN) completed an assessment upon employment, for 10 out of 10 newly hired employees reviewed This deficient practice was evidenced by the following: On 03/22/24 at 10:00 AM, the surveyor reviewed the employee files of ten random newly hired individuals. The employee's Physical Examination forms revealed the following:	S1405	1.Immediate actions: No residents were affected by the deficient practice. 2. Who was affected: All residents had the potential to be affected by this deficient practice. None were affected 3. Corrective actions: IP Nurse will develop a pre-employment screening form to be completed by all new hires. An RN will conduct an assessment upon hire and a physical will be conducted by the Physician within 30 days of employment date. 4. How this will be monitored: The employee health nurse will conduct a weekly audit and ongoing to ensure all new hires had their physical either prior to	

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S1405	Continued From page 4 - Employee #1 had a Date of Hire (DOH) of [NJ Ex Order 26.4b] and the form was signed by the examining physician on [NJ Ex Order 26.4b]. There was no evidence of an RN assessment upon employment. - Employee #2 had a DOH of [NJ Ex Order 26.4b] and the form was signed by the examining physician on [NJ Ex Order 26.4b]. There was no evidence of an RN assessment upon employment. - Employee #3 had a DOH of [NJ Ex Order 26.4b] and the form was signed by the examining physician on [NJ Ex Order 26.4b]. There was no evidence of an RN assessment upon employment. - Employee #4 had a DOH of [NJ Ex Order 26.4b] and the form was signed by the examining physician on [NJ Ex Order 26.4b]. There was no evidence of an RN assessment upon employment. - Employee #5 had two DOHs listed, [NJ Ex Order 26.4b] and [NJ Ex Order 26.4b], and the form was signed by the examining physician on [NJ Ex Order 26.4b]. There was no evidence of an RN assessment upon employment. - Employee #6 had a DOH of [NJ Ex Order 26.4b] and the form was signed by the examining physician on [NJ Ex Order 26.4b]. There was no evidence of an RN assessment upon employment. - Employee #7 had a DOH of [NJ Ex Order 26.4b] and the form was signed by the examining physician on [NJ Ex Order 26.4b]. There was no evidence of an RN assessment upon employment. - Employee #8 had a DOH of [NJ Ex Order 26.4b] and the form was signed by the examining physician on	S1405	hire or within 30 days. The IP nurse will review for accuracy and completion weekly x4, monthly x3, quarterly x4. And ongoing. All findings will be reported to the QAPI committee quarterly. Completion Date: May 12, 2024	

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S1405	Continued From page 5 NJ Ex Order 26.4b1. There was no evidence of an RN assessment upon employment. - Employee #9 had a DOH of NJ Ex Order 26.4b1 and the form was signed by the examining physician on NJ Ex Order 26.4b1. There was no evidence of an RN assessment upon employment. - Employee #10 had a DOH of NJ Ex Order 26.4b1 and the form was signed by the examining physician on NJ Ex Order 26.4b1. There was no evidence of an RN assessment upon employment. During an interview with the surveyor on 03/22/24 at 11:04 AM, the Infection Preventionist (IP) stated that new hire employees must have their physicals completed within 30 days of hire or bring a copy of physical performed prior to being hired. During an interview with the surveyor on 03/22/24 at 11:25 AM, Employee Health (EH) stated that the facility coordinates with the Medical Director to have new hire physicals completed within 30 days of the employee's hire date. During an interview with the surveyor on 03/26/24 at 10:34 AM, the Director of Nursing (DON) stated that new hire physicals need to be completed within 30 days of the employee's date of hire. The DON further stated that on the new hire's first day of employment, the Registered Nurse would verbally ask if the new hire had any restrictions to working, but nothing was documented in the employee file. Review of the facility's policy titled, "Bishop McCarthy Center for Rehabilitation and Healthcare," dated 08/2020, included, "All new employees will receive a physical exam within two	S1405		

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S1405	Continued From page 6 weeks prior to the first day of employment or upon employment. New employees will be offered to receive a physical at the facility with the medical director or designee. If the new employee receives a nurse assessment by an RN upon employment, the physical examination may be deferred for up to 30 days from the first day of employment at the discretion of the Employee Health Nurse."	S1405		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.	S1410		5/12/24

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S1410	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined that the facility failed to ensure that a new employee received the NJ Ex Order 26.4b1 test NJ Ex Order 26.4b1), also called a NJ Ex Orde as required for 1 of 10 new employee files reviewed. The deficient practice was evidenced by the following: On 03/22/24 at 10:00 AM, the surveyor reviewed the employee files of ten random newly hired individuals. According to Employee #9's "Physical Examination" form, the employee's date of hire was NJ Ex Order 26.4b1. Review of Employee #9's "Time Card" revealed the employee's first day of work was NJ Ex Order 26.4b1. According to Employee #9's "Employee NJ Ex Test Form," the employee was given his NJ Ex Order 26.4b1 test on NJ Ex Order 26.4b1. During an interview with the surveyor on NJ Ex Order 26.4b1 at 11:04 AM, the Infection Preventionist (IP) stated that new hires are given their NJ Ex Order 26.4b1 test on their first day of employment. The IP further stated that any nurse in management could administer the test. During an interview with the surveyor on 03/22/24 at 11:25 AM, Employee Health (EH) stated that on the new hires' first day of employment, the Nurse Educator administers their NJ Ex Order 26.4b1	S1410	1.Immediate actions: No resident was affected by this deficient practice. 2. Who was affected: All residents had potential to be affected by this deficient practice. None were affected. 3.Corrective actions: The US FOIA (b)(6) was in-service by the IP nurse immediately on administering all first step PPD on the day of hire. All new hires will have their first step PPD on their first day of orientation. 4. How this will be monitored: The employee health nurse will complete weekly audits to ensure all first step PPD□s will be in compliance. The IP nurse will monitor and ensure compliance. This will be done weekly x4,monthly x3, quarterly x2. All findings will be reported to the QAPI committee quarterly. Completion Date: May 12, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1410	Continued From page 8 test. During an interview with the surveyor on 03/26/24 at 10:34 AM, the Director of Nursing (DON) stated new hires should have their NJ Ex Order 26.4b1 test done upon hire. During a follow-up interview with the surveyor on 03/28/24 at 9:36 AM, in the presence of the survey team and the DON, the IP stated that Employee #9 started working at the facility on NJ Ex Order 26.4b1, but there was no one available to give him the NJ Ex Order 26.4b1 test. The IP further stated that Employee #9 should not have started working without being given the NJ Ex Order 26.4b1 test. Review of the facility's policy titled, "Bishop McCarthy Center for Rehabilitation and Healthcare," dated 08/2020, included, "The first step of a two-step Mantoux tuberculin skin test (TST) will be given on the employee's scheduled start date and must be read and documented within 48-72 hours of administration."	S1410		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315126 Y1	A. Building B. Wing Y2	5/13/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	1045 E CHESTNUT AVE VINELAND, NJ 08360

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 F0688	Correction	ID Prefix F0695	Correction	ID Prefix F0804	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	05/12/2024	LSC	05/12/2024	LSC	05/12/2024
ID Prefix F0812	Correction	ID Prefix F0842	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	05/12/2024	LSC	05/12/2024	LSC	05/12/2024
ID Prefix F0921	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/12/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/28/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060601 Y1	A. Building B. Wing Y2	5/13/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	1045 E CHESTNUT AVE VINELAND, NJ 08360

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/12/2024	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 05/12/2024	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 05/12/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/28/2024	☐ 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
	315126	A. BUILDING **01** B. WING _____	**03/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	**1045 E CHESTNUT AVE** **VINELAND, NJ 08360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 03/22/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/22/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Bishop McCarthy Center for Rehab and Healthcare is a three-story building that was built in 1976. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does approximately 50 % of the building per the Maintenance Director. The current occupied beds are 162 of 173.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6.	K 311		5/12/24

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

Electronically Signed | 04/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. BUILDING **01** B. WING _____	**03/28/2024**

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K 311	Continued From page 1 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure two of three stairways and the elevator shaft were sealed with fire rated material in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 8.6.5. This deficient practice had the potential to affect all 162 residents who resided at the facility. Findings include: An observation on 03/22/24 at 12:30 PM of two metal-clad (MC) cables type MC wires penetrated the second-floor red stairway near the elevator revealed they were not sealed with fire rated material. An observation on 03/22/24 at 12:34 PM of a hole approximately 6" in x 5" in the elevator shaft on the second floor near the red stairway revealed it was not sealed with fire rated material. An observation on 03/22/24 at 12:43 PM of two MC cables type MC wires and three low voltage wires that penetrated the third-floor green stairway near room 314 revealed they were not sealed with fire rated material. During interviews at the time of the observations, the US FOIA (b)(6) confirmed the wires which penetrated the stairways and the hole in the elevator shaft were not sealed with fire rated material.	K 311	K-0311 (F) Vertical Openings-Enclosure 1. Immediate actions: The MC Cables that penetrated the second-floor red stairway have been sealed by the maintenance director on 3/23/24 with NJ Ex O [redacted] rated caulk as per the UL design. The 6X5 hole in the elevator shaft has been sealed by the maintenance director on 3/23/24 with NJ Ex Order 26.4 [redacted] rated caulk as per the UL design. The MC Cables and Low voltage wiring on the third-floor green stairway has been sealed by the maintenance director on 3/23/24 with 3M Fire rated caulk as per the UL design. On 3/23/24 maintenance director inspected all stair tower and elevator shafts for additional penetration and any that were found have been repaired with NJ Ex Order 26.4 [redacted] rated caulk as per the UL design. Please see attach photos of all completed work. 2. Who was affected: All residents had the potential to be affected by this deficient practice. No residents were harmed. 3. Corrective actions: Upon notification of the deficiency, the regional maintenance director completed education with Maintenance staff to monitor and inspect above the ceiling for penetration. This inspection has been added to the maintenance monthly round	

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	315126	A. BUILDING **01** B. WING _____	**03/28/2024**

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BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	**1045 E CHESTNUT AVE** **VINELAND, NJ 08360**

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K 311	Continued From page 2 NJAC 8:39-31.1(c), 31.2(e)	K 311	log. These corrections have now insured the safety of all residents. 4. How this will be monitor: Maintenance Director or designee will inspect random areas above the ceiling for new penetrations monthly any found will be repair immediately. This information will then be entered on a log and will be reported to the QAPI meeting quarterly. Completion Date: May 12, 2024	
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 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	K 324		6/3/24

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	315126	A. BUILDING **01** B. WING _____	**03/28/2024**

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the exhaust termination for the kitchen exhaust hood was installed in accordance with NFPA 96 Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition) Section 7.8.3. This deficient practice had the potential to affect all 162 residents who resided at the facility. Findings include: An observation on 03/22/24 at 12:12 PM revealed the kitchen exhaust termination was only 6' from an exit door and not the required 10-feet and was only 10-feet from an operable window at a 45-degree angle and not the required 21.25-feet. During an interview at the time of observation, the US FOIA (b)(6) confirmed the kitchen exhaust termination was only 6-feet from the exit door and only 10-feet from the window. NJAC 8:39-31.2(e) NFPA 96	K 324	K-0324 (E) Cooking Facilities 1. Immediate actions: In order to avoid any openings from having ventilation back into the building from the exhaust discharge, a solid wall with no penetrations has been made of metal material with fire caulk around the fasteners has been installed on the side and above the exhaust to maintain proper distances from the windows and doors. The entire enclosure is fire rated. 2. Who was affected: All residents had the potential to be affected by this deficient practice. No residents were harmed. The wall will act as a protected wall to prevent harm. 3. Corrective actions: On 3/23/24 regional maintenance director completed Education with Maintenance staff to monitor and inspect exhaust equipment and exhaust termination. This will be done monthly and has been added to the preventative maintenance log. 4. Who will monitor: Maintenance Director or designee will inspect random exhaust equipment for deficiencies monthly. This information will be entered on a log and will be reported to the QAPI committee quarterly. Completion Date: June 3, 2024	
K 371 SS=E	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101	K 371		5/12/24

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	315126	A. BUILDING **01** B. WING _____	**03/28/2024**

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BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	**1045 E CHESTNUT AVE** **VINELAND, NJ 08360**

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K 371	Continued From page 4 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke barrier was sealed with fire rated material in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 8.5.2.2. This deficient practice had the potential to affect 55 residents who resided on the third floor of the facility. Findings include: An observation on 03/22/24 at 12:50 PM revealed one low voltage wire penetrated the smoke barrier on the third floor near room 315 was not sealed with fire rated material. During an interview at the time of observation, the US FOIA (b)(6) confirmed the low voltage wire penetrated the smoke barrier was not sealed with fire rated material. NJAC 8:39-31.1(c), 31.2(e)	K 371	K-0371 (E) Smoke Compartments 1. Immediate actions: Upon notification of the deficiency, The Low Voltage wire penetrating the smoke barrier outside of room 315 has been sealed on 3/23/24 by maintenance director with 3M Fire rated caulk as per the UL design. All smoke barriers have been inspected by the maintenance director for penetration on 4/3/2024 and no additional findings. 2. Who was affected: All the residents had the potential to be affected by this deficient practice. No residents were harmed. All penetrations found have been sealed to prevent any harm to the residents. 3. Corrective Actions: Education has been completed by regional director on 3/23/24 with all maintenance staff. Maintenance to monitor and inspect smoke compartment walls for penetrations monthly. These inspections have been added to the maintenance	

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K 371	Continued From page 5	K 371	monthly rounds log. 4. Who will monitor: Maintenance Director or designee will inspect random areas above the smoke barrier for penetration monthly and repaired as needed. This information will then be entered on a log and will be reported to the QAPI committee quarterly. Completion Date: May 12, 2024	

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)
315126	A. Building 01 - MAIN BUILDING 01 B. Wing	6/18/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	1045 E CHESTNUT AVE VINELAND, NJ 08360

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 K0311	Correction Completed 05/12/2024	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 06/03/2024	ID Prefix Reg. # NFPA 101 LSC K0371	Correction Completed 05/12/2024
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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON
3/28/2024

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