STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING ______ B. WING ______	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/15/2024

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

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E 000	Continued From page 1	E 000		

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E 000	Continued From page 3	E 000		

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E 000	Continued From page 4	E 000		

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E 000	Continued From page 5 Revisit conducted 12/15/23 for the 10/17/23 Standard Survey. This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 6	F 000		

Complaint #s: NJ00170384, NJ00164200, NJ00170066, NJ00166117, NJ00165047, NJ00164947, NJ00164148, NJ 00163966, NJ00162449

STANDARD SURVEY: 2/22/2024

CENSUS: 160

SAMPLE SIZE: 43 + 4 closed records

A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.

On 2/21/2024, during the recertification/complaint survey, the survey team identified an Immediate Jeopardy for F684 at a s/s of "J".

Based on interviews, medical records (MRs), and review of other pertinent facility documentation on 2/16/24 through 2/21/24, it was determined that the facility failed to obtain and administer an NJ ex order 26.4b1 on NJ ex order 26.4b1, for a resident with a known history of NJ ex order 26.4b1 and NJ ex order 26.4b1. This deficient practice was identified for 1 of 47 residents (Resident #157) reviewed for medication administration.

This IJ was identified on 2/21/24 at 4:35 PM. The IJ began on 2/21/2024 and continued until 2/22/2024 when NJ ex order 26.4b1

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F 000	Continued From page 7 The F684 continues at a "D" level, for no actual Harm with potential for more than minimal Harm that is not Immediate Jeopardy.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 2 of 32 residents, Resident #307 and #100 reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 2/12/24 at 10:34 AM, the surveyor observed Resident #307 in their room. Resident stated they were NJ ex order 26.4b1 At 10:45 AM, the surveyor reviewed the Electronic Medical Record (EMAR) for Resident #307, who was documented on the NJ ex order 26 Admission MDS, Section O - NJ ex order 26.4b1 . Review of the Admission Record (a one-page summary of important information about the patient) reflected Resident #307 was admitted to the facility on NJ ex order 26.4b1 with diagnosis that included but were not limited to NJ ex order 26.4b1	F 641	F641 Accuracy of Assessments 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 307 NJ ex order 26.4b1 Resident #307 NJ ex order 26.4b1 NJ ex order 26.4b1 revised to reflect NJ ex order 26.4b1 . Resident #100 NJ ex order 26.4b1 revised to reflect NJ ex order 26.4b1 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents residing in the facility have the potential to be affected by the deficient practice. All current residents and residents admitted and discharged in the last 90 days that received Hospice care and/or Heparin flushes will have a comprehensive review of their MDS assessments by the Regional MDS Nurse	4/9/24

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F 641	Continued From page 8 NJ ex order 26.4b1 Review of Resident #307 Order Summary from admission reveal a Physician Order (PO) dated NJ ex order 26.4b1 Review of Resident #307's Admission Observation revealed under section V. 'NJ ex order 26.4b1 ...3. d. NJ ex order 26.4b1 On 2/20/24 at 11:55 AM, the survey team conducted a phone interview the US FOIA (b)(6) who oversees MDS. The US FOIA (b)(6) stated for Resident #307, NJ I made an error." On 2/20/23 at 12:10 PM, the US FOIA (b)(6), provided the surveyor with a facility policy titled, "MDS Assessment Process" with a revised dated of 4/2023. Under the procedure section of the policy it states, 2. " ...the MDS coordinator will establish an assessment date for the Initial Assessment and distribute a schedule to the Interdisciplinary Team. The assessment reference date (ARD) will be set to reflect an accurate reflection of the resident's care needs within a specific reference period." The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual updated October 2019. The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. An RAI	F 641	Consultant to ensure that they were coded correctly, and a modification was completed and re-submitted if necessary. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? US FOIA (b)(6)) was re-educated by the Regional MDS Nurse Consultant on the policy titled MDS Assessment Process and importance of following the Resident Assessment Instrument (RAI) manual when coding the MDS assessment. The Regional MDS Nurse Consultant will run a monthly report in the electronic health record system to identify residents with physician's orders for Hospice care and/or receive Heparin flushes to ensure accuracy of the MDS assessment. This report will be run monthly x 3 months and then reviewed by the Quality Assessment and Assurance (QAA) committee to determine the need for additional review. 4. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur. The Regional MDS Nurse Consultant or designee will conduct monthly audits x 3 months to ensure the coding accuracy of MDS assessments sections O and N for residents who receive Hospice care and/or Heparin flushes. The results of these audits will be presented at the Quarterly Assessment and Assurance Committee (QAA) for review to ensure facility corrective actions for the deficient practice will not recur.	

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F 641	Continued From page 9	F 641		

(MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including Hospice residents: When a SNF or NF is the hospice resident's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.

On 2/21/24 at 10:45 AM, the survey team met with the US FOIA (b)(6) [redacted] The US FOIA (b) [redacted] stated, they would expect all MDS to be coded accurately and correctly. No further comments made.

NJAC 8:39-11.1, 11.2(e)(1)

2. On 2/14/24 at 11:57 AM, Resident #100 was observed sitting in wheelchair at their bedside. The resident was NJ Exec Order 2 [redacted] NJ Exec Ord [redacted] and NJ Exec Order 26 [redacted]

On 2/12/24 at 12:47 PM, the surveyor reviewed

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F 641	Continued From page 10 the electronic medical record for Resident #100. An Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, NJ ex order 26.4b1 A Review of a Quarterly MDS assessment, dated NJ ex order 26.4, under section NJ Ex documented the NJ ex order 26.4b1 A review of the Medication Administration Record for NJ ex order 26.4b1 and NJ ex order 26.4b1 revealed the NJ ex order 26.4b1 On 2/20/24 at 12:05 PM, the surveyor interviewed the US FOIA (b)(6) about the the Quarterly MDS documenting that Resident #100 NJ ex order 26.4b1 at the time of the assessment. The US FOIA (b)(6) reviewed the resident's medical records and acknowledged Resident #100 NJ ex order 26.4b1 The US FOIA (b)(6) stated it was an error and the MDS assessment would be modified. On 2/20/24 at 1:40 PM, the surveyor informed the US FOIA (b)(6) about the above concerns. On 2/21/24 at 10:50 AM, the US FOIA (b)(6) met with the survey team. The US FOIA (b) stated the US FOIA (b)(6) modified the MDS assessment as Resident #100 was not receiving an NJ Exec Order 26.4b1 medication at the time of the assessment.	F 641		

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F 641	Continued From page 11 A review of the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023), Chapter 3-page N-7 read: " ...N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) ... N0415E2. Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days) ..." NJAC 8:39-33.2 (d)	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		4/9/24

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F 657	Continued From page 12 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise a resident's comprehensive care plan to reflect the most current plan of care for 2 of 47 residents reviewed, Resident #5 and Resident #140. This deficient practice was identified by the following: 1.) On 2/12/24 at 1:09 PM, the surveyor observed Resident #5 in the room lying in their bed. NJ ex ord The surveyor reviewed Resident #5's medical records. The Admission Record (AR) reflected that Resident #5 was admitted to the facility on NJ ex order 26 with medical diagnoses which included but not limited to NJ ex order 26.4b1 . According to Resident #5's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4b the Brief Interview for Mental Status (BIMS) score of NJ ex order 26.4b1 . A review of Resident #5's comprehensive care	F 657	F657 Care Plan Timing and Revision 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 comprehensive care plan has been reviewed and updated and no longer reflects an actual left (leg) wound or that NJ ex order 26.4b1 Resident #140 comprehensive care plan was reviewed and updated and NJ ex order 26.4b1 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by the deficient practice. A comprehensive review of current residents with a healed wound, discontinued anti-coagulant medication and wander guard bracelet care plans will be conducted by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) or designee to ensure that resident care plans are up to date and have been revised as information	

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F 657	Continued From page 13 plan (CCP) which reflected a CCP for resident #5 titled, NJ ex order 26.4b1 and NJ ex order 26.4b1 . The surveyor reviewed the most current Physician's Order (PO) for NJ ex order 26.4b1 which revealed that Resident #5 NJ ex order 26.4b1 Further review of the PO did not reflect any PO for treatment to the NJ ex order 26.4b1. On 2/16/24 at 11:18 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the US FOIA (b) and herself were responsible in updating the resident's care plans. On 2/21/24 at 10:46 AM, the US FOIA (b) stated to the surveyor that Resident #5 NJ ex order 26.4b1 2.) On 2/12/24 at 1:09 PM, the surveyor observed Resident #140 standing by their room door. The resident was NJ Exec O and NJ Exec Order 26.4b1. The surveyor reviewed Resident #140's medical records. The AR reflected that Resident #140 was admitted to the facility on NJ ex order 26 with medical diagnoses which included but not limited to NJ Exec O NJ ex order 26.4b1 According to Resident #140's Q/MDS, an assessment tool used to facilitate the	F 657	about the residents and residents' condition change. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The ADON will provide in-services to licensed staff on the Comprehensive Person-Centered Care Plan Policy which includes assessments of residents are ongoing and care plans are revised as information about the residents' condition change. The systemic change will be that during the daily clinical meeting the Unit Managers will review residents who have new or discontinued orders will have their care plans reviewed to ensure necessary updates are made. The Interdisciplinary Care Team (IDCT) will also conduct comprehensive reviews of residents upon admission/readmission, quarterly and with a change in condition prior to the care plan conference which is held after admission/re-admission, quarterly and with a significant change in condition and will be reviewed by the Interdisciplinary Care Team members during the meeting to ensure that the comprehensive person-centered care plan is up to date. 4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? The DON or designee will conduct random audits of 10 residents weekly x 4, then monthly x 3 months of current	

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F 657	Continued From page 14 management of care, dated NJ ex order 26.4b1, the BIMS score of NJ ex order indicating NJ ex order 26.4b1 A review of Resident #140's comprehensive care plan (CCP) which reflected a CCP for resident #140 titled, "NJ ex order 26.4b1" Further review of the resident's CCP listed intervention included, NJ ex order 26.4b1 On 2/16/24 at 11:47 AM, the surveyor interviewed the US FOIA (b)(6) who stated that Resident #140 NJ ex order The US FOIA (b)(6) also stated that Resident #140 NJ ex order On 2/21/24 at 10:46 AM, the US FOIA (b)(6) stated to the surveyor that Resident #140's NJ ex order 26.4b1 was already discontinued since the resident was placed on an NJ Exec Order 26.4b1. A review of the facility's policy and procedure that was provided by the US FOIA (b)(6) titled, "Care Plans, Comprehensive Person-Centered" reflected under #11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change." On 2/20/24 at 1:40PM, the above concerns were discussed to the facility's US FOIA (b)(6). NJAC 8:39-11.2(i)	F 657	resident care plans to ensure they are up to date and have been revised as information about the resident and residents' condition change. The results of these audits will be reviewed at the Quality Assessment and Assurance (QAA) quarterly meeting to ensure the facility's corrective action for the deficient practice will not recur.	

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint Number: NJ164148 Based on observation, interview, and record review it was determined the facility failed follow standards of practice with regards to: a) following a physician's order for a medication with parameters (Resident #123), b) NJ ex order 26.4b1 NJ ex order 26.4b1 (Resident #123), c) documenting the application and placement of NJ ex order 26.4b1 (Resident #357), and d) ensuring an NJ ex order 26.4b1 (Resident #25). This deficient practice was identified in 3 of 43 resident reviewed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care	F 658	F658 Services Provided Meet Professional Standards 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #123's NJ ex order 26.4b1 was immediately added to the electronic medication administration record (eMAR) and the physician was also notified. The NJ ex order 26.4b1 order time was adjusted on the eMAR to accommodate resident NJ ex order 26.4b1. The NJ ex order 26.4b1 time was adjusted on the eMAR to accommodate the NJ ex order 26.4b1 . Resident #357 is NJ ex order 26.4b1. At time of discovery the order was previously adjusted for nurse to sign for application of NJ ex order 26.4b1 Resident #25's NJ ex order 26.4b1 was immediately scheduled to be changed on the eTAR and NJ ex order 26.4b1 was dated and a NJ ex order 26.4 2. How will you identify other residents having the potential to be affected by the	4/9/24

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F 658	Continued From page 16 supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 2/12/24 at 11:13 AM, the surveyor observed Resident #123 sitting in a wheelchair at their bedside. The resident was NJ ex order 26.4b1. The resident NJ ex order 26.4b1 The resident showed the surveyor their NJ ex order 26.4b1 On 2/14/24 at 9:35 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #123. An Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, NJ ex order 26.4b1 A comprehensive Minimum Data Set (MDS) assessment, dated NJ ex order 26.4b1, indicated a Brief	F 658	same deficient practice and what corrective action will be taken? All residents have potential to be affected by the deficient practice. The Director of Nursing (DON) or designee conducted an audit of current residents who receive medications for hypertension with parameters are entered into the eMAR correctly so that the licensed nurse can record the results to ensure the medication is administered per the physician's order. An audit of current residents on dialysis was completed by the Unit Managers (UM) to ensure medication times were adjusted to accommodate residents' dialysis schedule. An audit of current residents with heel lift boots was conducted by the UMs to ensure nurses can sign off on the eTAR for the application of heel boots. Finally, an audit was conducted on current residents with external urinary catheters to ensure connected suction tubing is dated and privacy covering is in place on the external urinary catheter drainage canister. No other residents were found to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Assistant Director of Nursing (ADON) or designee will provide in-services to licensed staff to ensure residents who take anti-hypertensive medications with parameters are entered correctly so the nurse can document the result on the	

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F 658	Continued From page 17 Interview for Mental Status (BIMS) was performed to determine the resident's cognition status. Resident #123 scored a NJ ex o of 15 indicating the resident NJ ex order 26.4b1 The MDS assessment also documented the NJ ex order 26.4b1 . A physician's order dated NJ ex order 26.4b read, NJ ex order 26.4b1 [NJ Exec Order 26 center's name, address, and phone number]" A physician's order dated NJ ex order 26.4b read, "NJ ex order 26.4b1 A physician's order dated NJ ex order 26 read, "NJ ex order 26.4b1 A physician's order dated NJ ex order 26.4b read, "NJ ex order 26.4b1 ..." A review of the electronic Medication Administration Record (eMAR) for NJ ex order 26.4b1 revealed: The NJ ex order 26.4b1 was signed as administered by the nurses. There was no documentation of the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b at the time of the medication's administration on the EMR. The NJ ex order 26.4b1 was NJ ex order 26.4b1 to the resident at 0900 [9AM], 1300 [1 PM], 1700 [5 PM], and 2100	F 658	eMAR. The ADON or designee will provide in-services to licensed staff to adequately adjust dialysis residents' medication with physician order to accommodate their dialysis schedule. In-services will be provided by the ADON or designee to licensed staff when obtaining orders for residents requiring heel boots to ensure it is entered correctly for nurse to document application of the device on the eTAR. A new electronic order template for external urinary catheter devices was created to include the dating and frequency for the tubing and to check placement of the privacy cover. In-service education will be provided by the ADON or designee to licensed staff on the policy and correct electronic order entry for external urinary catheters to include dating of tubing and placing a privacy covering over the external urinary catheter drainage canister. The admission chart review checklist and the 11-7 Nurse checklist will be updated to include checking medications with parameters are entered correctly so the nurse can document the result on the eMAR and to check orders for residents who receive dialysis have their medication times adjusted to accommodate dialysis schedule. The admission chart review checklist and the 11-7 Nurse checklist will also be updated to include checking orders for external urinary catheter devices to ensure they include dating of the suction tubing, and that the privacy cover is in place. 4. How the corrective action be	

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F 658	Continued From page 18 [9 PM]. The scheduled entry at 1300 was signed that the medication was administered for 11 of 13 days by the nurses. On NJ ex order 26.4b1 the entries at 1300 were signed "5", which indicated to see nurses note. The nurse notes on NJ ex order 26 and NJ ex order 26.4b indicated the resident was NJ ex order 26.4b1 The NJ ex order 26.4b1 to the resident at 0900 [9AM], 1200 [12 PM], 1700 [5 PM], and 2100 [9 PM]. The scheduled entry at 1200 was signed that the medication was administered for 11 of the 13 days by the nurses. On NJ Exec Order and NJ Exec Order 26 the entries at 1200 were signed "NJ Exe which indicated to see nurses note. The nurse notes on NJ ex order 26. and NJ ex order 26.4b indicated the NJ ex order 26.4b1 On 2/14/24 at 12:07 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) #2 who was assigned to care for Resident #123. LPN #2 stated medications with parameters were followed as ordered and vital signs, such as the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 were checked before administering the medication. The results of the vital signs were to be documented in eMAR when signing for the medication. The surveyor reviewed the eMAR with LPN #2. LPN #2 acknowledged there was no NJ Exe or NJ Exe documented for when the NJ ex order 26.4b1 NJ ex order 26.4b1 . LPN #2 stated NJ ex order 26.4b1 and the eMAR usually prompts the nurse to record the results when signing for a medication with parameters. LPN#2 further explained the eMAR did not prompt	F 658	monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? The DON or designee will conduct random audits of 10 residents with anti-hypertensive medications with parameters weekly x 4 weeks, then monthly x 3 months to ensure anti-hypertensive medications with parameters are entered so the nurse can document the result on the eMAR. The DON or designee will conduct random audits of 5 dialysis residents weekly x 4 weeks, then monthly x 3 months to make sure timing of medications accommodates dialysis schedule. The DON or designee will conduct random audits of 5 residents utilizing heel lift boots weekly x 4 weeks, then monthly x 3 months to make sure MD orders are in place for licensed staff to sign the eTAR for application of device. The DON or designee will conduct random audits of 3 residents with external urinary catheter devices weekly x 4 weeks, then monthly x 3 months to make sure tubing is dated and privacy covering is in place on the external urinary catheter drainage canister. These audit results will be reviewed at Quarterly Quality Assessment and Assurance Committee (QAA) meeting to ensure facility corrective actions for the deficient practices will not recur.	

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F 658	Continued From page 19	F 658		

recording the vital signs at the time of documenting the medication's administration and she did not document it in the EMR. LPN #2 acknowledged it was expected for the vital signs to be documented at the time of administration for medications with parameters.

The surveyor asked LPN #2 about the time Resident #123 NJ ex order 26.4b1 LPN #2 stated Resident #123 NJ ex order 26.4b1 LPN #2 further explained the resident NJ ex order 26.4b1 between 10 to 11 AM and returned after 3 pm. LPN #2 stated medications could be given an hour before or an hour after it was scheduled to be administered.

The surveyor reviewed with LPN #2, the entries on the eMAR for NJ ex order 26.4b1 scheduled at 1300 and NJ ex order 26.4b1 scheduled at 1200. LPN #2 acknowledged the resident NJ ex order 26.4b1 LPN#2 stated that the resident NJ ex order 26.4b1 LPN #2 could not speak to why the medication time was not clarified with physician. LPN #2 acknowledged medication should be timed to accommodate a resident's NJ ex order 26.4b1 and a medication order should be clarified with the physician if it cannot be given at its scheduled time.

On 2/14/24 at 12:31 PM, the surveyor interviewed the US FOIA (b)(6) about the above concerns. The surveyor reviewed with the US FOIA (b)(6) the eMAR for Resident #123. The US FOIA (b)(6) stated the nurses were to follow physician orders as written. The US FOIA (b)(6) stated it was expected for the nurses to

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F 658	Continued From page 20 document the NJ Exec and NJ Exec of the resident at the time of the NJ Exec Order 26.4b1 medication administration. The US FOIA (b)(6) acknowledged medications should be scheduled to accommodate a resident's NJ Ex Order 26.4 sessions and nurses should clarify orders if there was a schedule conflict. On 2/15/24 at 10:23 AM, the surveyor interviewed the US FOIA (b)(6) about the above concerns. The US FOIA (b) stated it was expected for medications to be timed to account for residents' NJ Ex Order 26.4 sessions. The US FOIA (b) further stated medications with parameters should be followed per physician's orders and the documentation of the NJ Exec and NJ Exec were expected to be documented in eMAR at the time of medication administration. On 2/20/24 at 1:40 PM, the surveyor informed the US FOIA (b)(6) of the above concerns identified for Resident #123. The surveyor reviewed the facility provided policy titled, "Care of Resident Receiving Dialysis", with a reviewed date of 1/5/2024. The policy read, " ...All medications and treatments will be scheduled according to dialysis times ...If dialysis times change throughout the residents stay, the medication times and treatments will change to accommodate the resident ..." The surveyor reviewed the facility provided policy titled, "1.0 Medication Preparation for Dispensing", with a revised date of 2/16/2022 under Procedure I. it read: "If required, obtain vital signs before medication administration" Under Procedure J. it read: " ...3. Medications are administered in a timely fashion as specified by	F 658		

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F 658	Continued From page 21 policy ...." Under Procedure K. it read: " ...Document necessary medication administration/treatment information (e.g., when medications are administered, medication injection site, refused medications and reason, prn medications, etc.) on appropriate forms ..." 2. On 2/16/24 at 1:20 PM, the surveyor reviewed the EMR for Resident #357 for NJ ex order 26.4b1 An Admission Record documented the resident had diagnoses that included but were not limited NJ ex order 26.4b1 A review of the physician orders revealed a discontinued order dated NJ ex order 26.4b1 for NJ ex order 26.4b1 The original order date was NJ ex order 26.4b1. A review of Residents #357's March Treatment Administration Record (TAR) revealed that from NJ ex order 26 evening shift through NJ ex order 26.4b night shift, the NJ ex order 26.4b1 were not checked for a total of NJ Ex opportunities. On 2/20/24 at 10:17 AM, the surveyor interviewed the US FOIA (b)(6) The US FOIA (b) stated, "The applying and checking of NJ Exec Order 26.4b1 would be on recorded in the TAR." The Surveyor reviewed the NJ Exec Order 26.4b1 TAR with the US FOIA (b) and noted that the order for checking the NJ Exec Order 26.4b1 from NJ Exec Order through NJ Exec Order 26 was left blank. The US FOIA (b) stated she'd have to look into that to see if the order was followed. On 2/20/24 at 1:39 PM, the survey team met with the US FOIA (b)(6)	F 658		

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F 658	Continued From page 22 (US FOIA (b)(6) and US FOIA (b)(6)). The US FOIA (b) stated the order for the NJ ex order 26.4b1 was entered into the medical records under the category of "other" and could not be signed off by the nursing staff. On 2/21/24 at 10:45 AM, the survey team met with the US FOIA (b)(6). The US FOIA (b) was unable to provide any US FOIA (b) notes or other documentation showing that the resident's NJ ex order 26.4b1 were being checked each shift. Facility policy was not available. No further comments or information was provided. 3. On 2/12/24 at 11:16 AM, the surveyor observed Resident #25 in their room. The surveyor inquired about the NJ ex order 26.4b1. The resident responded that it was for their NJ ex order 26.4b1. The surveyor identified that NJ ex order was not dated. The surveyor also observed the NJ ex order 26.4b1 On 2/16/24 at 10:57 AM, the surveyor observed the NJ ex order 26.4b1 On 2/20/24 at 11:08 AM, the surveyor observed the NJ ex order 26.4b1. The surveyor reviewed the medical record for Resident #25. A review of the Admission Record face sheet (an admission summary) reflected that the resident NJ ex order 26.4b1	F 658		

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F 658	Continued From page 23 NJ ex order 26.4b1 A review of the most recent Minimum Data Set (MDS), an assessment tool, reflected a brief interview for mental status (BIMS) score of NJ ex out of 15, which demonstrated NJ ex order 26.4b1. The NJ ex order 26.4b1 Resident #25 with an NJ ex order 26.4b1 On 2/20/24 at 11:50 AM, the surveyor interviewed Licensed Practical Nurse (LPN#3) who confirmed that Resident #25 had an NJ ex order 26.4b1. When interviewed regarding a NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1, LPN #3 responded that he/she was not aware of NJ Exec Order 26.4b1 and stated that it was not possible to NJ Exec Order 26.4b1. When asked how often the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, LPN #3 replied every 2 months and dated accordingly. On 2/20/24 at 12:03 PM, the surveyor requested that US FOIA (b)(6)) accompany the surveyor to Resident #25's room. US FOIA (b)(6) confirmed that the NJ ex order 26.4b1 was not dated and that there was NJ ex order 26.4b1 The sureveyor interviewed the US FOIA (b)(6) in reference to the policy for the NJ Exec Order 26.4b1 to be dated and if a NJ Exec Order 26.4b1 is to be applied, US FOIA (b)(6) stated that he/she would have to review the policy. The surveyor provided a copy of the policy and, upon review, US FOIA (b)(6) confirmed that a NJ Exec Order 26.4b1 was to be applied and NJ Exec Order 2 was to be dated. On 2/20/24 at 12:59 PM, the surveyor interviewed the US FOIA (b)(6)). The surveyor	F 658		

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F 658	Continued From page 24 requested to examine another NJ Exec Order 26.4b1 device setup. The US FOIA (b) produced all components. The surveyor asked if there was a NJ Ex Order 26.4b1 that came with the appliance. The US FOIA (b) could not identify or locate a NJ Exec Order 26.4b1. When provided with the printed NJ Exec Order 26.4b1 policy, the US FOIA (b) acknowledged that a NJ Exec Ord should be applied while at patient bedside. The US FOIA (b) also confirmed that the NJ Exec Order 26.4b1 should be dated. On 2/21/23 at 10:46 AM, the US FOIA (b) in the presence of the US FOIA (b)(6) and US FOIA (b)(6), confirmed that the NJ Exec Order 26 should have been NJ Exec Order 26.4 While the manufacturer NJ Exec Ord cannot be located at this time, the facility reported that it has developed NJ Exec Order 26.4b1. The US FOIA (b) also confirmed that according to policy, the NJ Ex Order 26.4b1 was to be dated and it was the responsibility of the US FOIA (b) US FOIA (b)(6), and nurses to ensure that the policy was followed. A review of the facility's 8/2023 "[..]Female External Catheter Protocol" included ...f. Apply privacy cover, make sure that the measurement guide is visible after application of the privacy cover ....l. Remove privacy cover. Empty canister in the bathroom ...5. Change standard suction tubing and suction canister every 60 days on 3-11 shift. Canister and tubing must be dated. NJAC 8:39-11.2 (b); 27.1 (a); 29.2(d)	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		4/9/24

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F 684	Continued From page 25 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint#: NJ166117 Based on interviews, medical records (MRs), and review of other pertinent facility documentation on 2/16/24 through 2/21/24, it was determined that the facility failed to obtain and administer an NJ ex order 26.4b1, for a resident with a known NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 47 residents (Resident #157) reviewed for NJ ex order 26.4b1. Resident #157 was admitted and needed NJ ex order 26.4b1, NJ ex order 26.4b1. The facility's failure to obtain and administer the NJ ex order 26.4b1, NJ ex order 26.4b1 of Resident #157. This resulted in an Immediate Jeopardy (IJ) situation. This IJ was identified on 2/21/24, and an IJ template was presented to the US FOIA (b)(6) on 2/21/24, at 4:35 PM. The IJ began on 2/21/2024 and continued until 2/22/2024, when the facility presented an acceptable removal plan which included initiating in-services for all facility staff on Unavailable Medications Policies, which were updated. This was verified on-site on 2/22/24.	F 684	F684 2/21/2024 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #157 NJ ex order 26.4b1 and NJ ex order 26.4b1 2. How will the facility identify other residents having the potential to the affected by the same deficient practice? • All current residents with medication orders have the potential to be affected. All current residents exhibiting a new change in condition requiring monitoring have the potential to be affected. • A comprehensive medication administration audit was conducted to ensure that all residents with medication orders received their medication as ordered or that it was documented otherwise per physician order. It was determined that no other residents were affected by this practice. • A comprehensive shift-to-shift report audit was conducted to ensure that no residents with a new change in condition required immediate treatment for a crisis situation. It was determined that there	

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F 684	Continued From page 26 This deficient practice was evidenced by the following: Review of the Admission Record for Resident #157 indicated that the resident was admitted to the facility with diagnoses which included but NJ ex order 26.4b1 NJ ex order 26.4b1). Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b1, revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated a NJ ex order 26.4b1 Review of the Nurses Progress Notes (NPN) dated NJ Exec Order 26 at 9:48 AM, indicated that Resident #157 was observed at 8:27 AM having NJ ex order 26.4b1 At this time Resident #157 NJ ex order 26.4b1. Review of the medical records for Resident # 157 indicated NJ ex order 26.4b1 at 3:20 PM. NJ ex order 26.4b1 indicated NJ ex order 26.4b1 Review of the Physician's Orders (PO) included an order dated NJ ex order 26.4b1 entered in the medical records at 12:35 AM and signed by the Physician at 3:01 PM. The documentation in the Nurse Progress Notes (NPN) revealed, "eMAR (electronic medication administration	F 684	were no other residents affected by this practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The policy on Resident Change in Condition was reviewed and revised to assure residents receive immediate treatment in a crisis when the need is evaluated and determined by the nurse to emergency medical services (911). Licensed nursing staff have been educated by the Assistant Director of Nursing on the change in condition policy to ensure residents receive immediate treatment in a crisis. Licensed nursing staff have been educated by the Assistant Director of Nursing on monitoring residents during a change in condition and to document the changes and interventions in the resident's electronic health record. The policy for Medication Shortages/Unavailable Medications was reviewed and updated to reflect current practices. Licensed nursing staff have been educated by the Assistant Director of Nursing on the Medication Shortages/Unavailable Medications policy updates to ensure residents receive medication as ordered in a reasonable time with emphasis on the importance of administering antiseizure medication for maintaining seizure prevention. Weekly audits of residents transferred to the hospital will be conducted by the Director of Nursing or designee for the next two quarters to assure the monitoring	

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F 684	Continued From page 27 record)-Medication Administration Note for NJ ex order 26.4b1 SWALLOW WHOLE WITH LIQUID DO NOT DIVIDE TABLET Awaiting Pharmacy to deliver." Review of the Electronic Pharmacist Review (EPIC) dated NJ ex order 26.4b indicated, "Do not crush NJ Exec Order 26.4 Review of the PO included a second order dated NJ ex order 26.4b, entered into the medical records at 10:26 AM and signed by the Physician at 3:01 PM. The documentation in the NPN indicated, "eMAR-Medication Administration Note" for NJ ex order 26.4b1 waiting Pharmacy to deliver." Review of the NJ ex order 26.4b1 eMAR, NJ ex order 26.4b1 at 9:00 AM and 9:00 PM, the times scheduled for administration. On 2/21/24 at 10:55 AM, the surveyor met with the US FOIA (b)(6)) in the presence of the US FOIA (b)(6)) who acknowledged that Resident #157 had a PO for NJ ex order 26.4b1 . On 2/21/24 at 12:01 PM, the surveyor interviewed the facility provider pharmacist who clarified that NJ ex order 26.4b1 was not delivered to the facility until NJ Exec Order at 4:16 AM. The	F 684	of changes in condition were documented and that the mode of transfer was appropriate. The Director of Nursing will review the audits and determine the need for additional staff education and monitoring to ensure compliance. Daily medication administration audits will be conducted by the Director of Nursing or designee for the next two weeks and then weekly for the next two quarters on residents coded on the electronic medication administration record as "other/see nurse's note" to assure medications are administered timely. The Director of Nursing will review the audits and determine the need for additional staff education and monitoring to ensure compliance. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. • The Director of Nursing will present the findings from the weekly audits of resident hospital transfers to the quarterly Quality Assessment and Assurance (QAA) Committee for review for the next two quarters. The QAA Committee will determine the need for additional monitoring after the second quarter.	

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F 684	Continued From page 28 Pharmacist confirmed that NJ Exec Order 26.4b1 tablets cannot be crushed and stated, "missing a dose of NJ Exec Order increases the NJ Exec Order 26.4b1, this medication should not be missed." On 2/21/24 at 2:40 PM, the surveyor interviewed the US FOIA (b)(6) supervisor via telephone, who was involved with the evaluation of Resident #157 during the NJ ex order 26.4b1 The RN supervisor stated that she found Resident #157 NJ ex order 26.4b1 The US FOIA (b)(6) established that the physician evaluated Resident #157 through a video chat monitor. The physician ordered the resident to be NJ ex order 26.4b1. Review of facility policy effective and revised on 10/1/2018, titled "Medication Shortages/Unavailable Mediations," included but was not limited to: "When medications are not received or are unavailable for the customer, the licensed nurse will urgently initiate action in cooperation with the attending physician and the pharmacy provider." "Procedure:" for the policy titled, "Medication Shortages/Unavailable Mediations," included but was not limited to: "If a medication shortage is noted at the time of medication administration (Med-Pass), the licensed nurse or certified medication assistant must immediately initiate action to obtain the medication and not wait until the Med-Pass is completed." A review of the Care Plan (CP) indicated that Resident #157 had the NJ ex order 26.4b1 The documented	F 684		

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F 684	Continued From page 29 Interventions/Tasks in the CP related to Resident #157NJ ex order 26.4b1 *Administer medications as ordered .... *Educate resident and staff to report signs and symptoms (s/s) of suspected NJ Ex Order 26.4b1 . Signs and symptoms may include NJ Ex Order 26.4b1 Monitor for signs and symptoms, report to Medical Doctor (MD) and document. *During NJ Ex Order 26.4b1 *Document events prior to, during and post NJ Ex Order 26.4b1 Notify (MD) of all events that occurred. NJAC 8:39-27.1 (a)	F 684		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an	F 711		4/9/24

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F 711	Continued From page 30 assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to: a) ensure that the resident's primary physician accurately dated physician progress notes (PPN) during his visit to ensure that the resident's current medical regimen was up to date and b) ensure that the resident's primary physician wrote PPN at least every 60 days with alternating US FOIA (b)(6) visits. This deficient practice was observed for 2 of 47 residents, Resident #147 and Resident #58. This deficient practice was evidenced by the following: 1. On 2/22/24 at 10:51 AM, the surveyor reviewed a closed record for Resident #147 who was admitted to the facility on NJ ex order 26.4b and was NJ ex order 26.4b1 The surveyor further reviewed Resident #147 NJ ex order 26.4b1. The resident was admitted to the facility with diagnosis that included but not limited to NJ ex order 26.4b1 A review of the resident's PPN in the electronic medical record revealed the following was documented as "LATE ENTRY" (Any documentation that was recorded in the medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) designation which indicated that the following PPN were not written on the effective date (Date of service):	F 711	F711 Physician visits- Review Care/Notes/Orders 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 157 NJ ex order 26.4b1. Education was immediately provided to the resident's attending physician on the requirement of documenting accurately dated physician progress notes (PPN) in the residents' medical record. Resident #58 NJ ex order 26.4b1 and the attending physician was immediately provided with education on the requirement of frequency and documentation of physician's visits that may alternate with the nurse practitioner every 60 days. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. A comprehensive audit of current resident attending physician visits will be conducted by the LNHA and DON or designee to determine that current attending physicians are in compliance with the policy for visiting, documenting and dating their PPN in the medical record timely and accurately. 3. What measures will be put into place	

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F 711	Continued From page 31 1. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1 2. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1. 3. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1. 4. PPN with an effective date of NJ ex order 26.4b1 but with a created date of NJ ex order 26.4b1 5. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1 6. PPN with an effective date of NJ ex order 26.4b1 but with a created date of NJ ex order 26.4b1. 7. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1. 8. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1 9. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1 10. PPN with an effective date of NJ ex order 26.4b1 but with a created date of NJ ex order 26.4b1. 11. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1. 12. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1. 13. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1. 14. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1. 15. PPN with an effective date of NJ ex order 26.4b1, but with a created date of NJ ex order 26.4b1 16. PPN with an effective date of NJ ex order 26.4b1 but with a created date of NJ ex order 26.4b1. A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate care management dated NJ ex order 26.4b1 indicated the Brief Interview for Mental Status (BIMS) was not conducted due to NJ ex order 26.4b1	F 711	or what systemic changes will be made to ensure that the deficient practice does not recur? All current attending physicians will be in-serviced by the LHNA or DON and provided with a copy of the Physicians Visit policy to include documentation at least every 60 days with alternating Nurse Practitioner visits and education to document timely, accurate dates in their PPN in the resident electronic health record (EHR). The DON or designee will conduct a monthly review of current resident EHR to determine which physician visits are due and alert the physicians of the upcoming required visit. This monthly review will continue to be completed x 3 months and then reviewed by the Quality Assessment and Assurance (QAA) committee to determine the need for additional review. 4. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place? The LNHA or DON or designee will conduct weekly random audits x 4 weeks, then monthly x 3 months of 10 resident charts to ensure attending physicians' documentation meets the requirement in the Physician Visits Policy. The results of these audits will be reviewed during the facility Quarterly Quality Assessment and Assurance meeting (QAA).	

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F 711	Continued From page 32 Further review of Section NJ Exec Order 26.4b1 reflected under NJ Exec Order 26.4b1 and NJ ex order 26.4b1 Others which documented as NJ ex order 26.4b1. On 2/21/24 the facility's US FOIA (b)(6) provided the surveyor with a copy of the facility policy titled, "Physician Visits" with a reviewed date of December 2023. Under the policy explanation and compliance guidelines of the policy revealed under "1. The Attending Physician will visit residents in a timely fashion ..." and "5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation." On 2/22/24 at 11:55 AM, the surveyor discussed the above concern to the facility's Licensed US FOIA (b)(6) The US FOIA (b)(6) stated that the PPN which were documented as "Late Entry" were unacceptable. No further information was provided. 2. On 2/14/24 at 12:01 PM, Resident #58, resting in bed with their eyes closed. The resident NJ Exec Order 26.4b1. Resident #58 NJ ex order 26.4b1. There were no observed concerns. On 2/20/24 at 10:00 AM, the surveyor reviewed the hybrid medical records of Resident #58. An Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not	F 711		

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F 711	Continued From page 33 NJ ex order 26.4b1 . A quarterly Minimum Data Set (MDS) assessment, dated NJ ex order 26.4 indicated a Brief Interview for Mental Status (BIMS) was performed to determine the resident's NJ Exec Order 26.4b . Resident #123 had a result of NJ ex ord indicating the resident NJ ex order 26.4b1 A review of progress notes revealed a US FOI progress note dated NJ ex order 26.4b1 was found in the resident's electronic medical record. There was no primary physician progress note for Resident #58 from NJ ex order 26.4b1 to NJ ex order 26.4b1 The surveyor requested from the US FOIA (b) the physician progress notes for Resident #58. On 2/20/24 at 12:40 PM, the US FOIA (b) provided a copy of physician progress notes for Resident #58. A review revealed there were no PPN in the documentation provided. On 2/20/24 at 1:40 PM, the surveyor informed the US FOIA (b)(6) of the concerns regarding the physician progress notes and visits for Resident #58. On 2/21/24 at 9:38 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #2 assigned to care for Resident #58. LPN #2 stated the resident's primary physician visited every 1 to 2 months. LPN #2 stated the physicians would document progress notes in the electronic medical record (EMR). On 2/21/24 at 10:50 AM, the US FOIA (b)(6) and	F 711		

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F 711	Continued From page 34 NJ Exec Order 26.4b1 met with the survey team. The US FOIA (b) stated physicians were to document in the EMR their progress notes for their visits with residents. The US FOIA (b) stated the resident's primary physician preferred to hand write his progress notes and the physician's notes would be uploaded into the EMR. The US FOIA (b) provided a handwritten note from the primary physician dated NJ Exec Order 26. The surveyor asked the US FOIA (b) about the PPN prior to NJ Exec Order 26.4b1 that were not found in the EMR. The US FOIA (b) stated the facility spoke with the primary physician yesterday and the primary physician was under the impression the US FO progress notes were sufficient as he collaborates with the US FOIA The US FOIA (b) replied that the facility had the previous PPN for the physician and would provide further documentation. On 2/22/24 at 1:10 PM, the surveyor interviewed Physician #2 about his visits and progress notes. Physician #2 stated he was aware he had to visit residents at least every 2 months when alternating with US FO visits. Physician #2 further explained he communicated with his US FO who would visit residents and thought the US FOIA (b) progress notes were enough. Physician #2 stated that he was now aware that he was still required to document progress notes for his visits with residents and would ensure to do so in the future. The surveyor reviewed the facility provided policy titled, "Physician Visits", with a reviewed date of December 2023. The policy read under Policy Interpretation and Implementation, " ...4. After the first ninety (90) days, if the Attending Physician determines that a resident need note be seen by him/her every thirty (30) days, an alternate schedule of visits may be established, but not to	F 711		

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F 711	Continued From page 35 exceed every sixty (60) days. A Physician Assistant or Nurse Practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation ...5.The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation ..." On 2/22/24 at 1:54 PM, the surveyor met with the US FOIA (b)(6) tp discuss this issue and there was no additional documentation provided by the facility. NJAC 8:39-23.2(b	F 711		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to ensure meals were served at a palatable on 1 of 3 units reviewed for food temperatures. The deficient practice was evidenced by the following:	F 804	F804 Nutritive Value /Appear, Palatable/Prefer Temp 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? -There were no residents who were found to have been affected by deficient practice.	4/9/24

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F 804

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On 2/15/24 at 10:52 AM, the surveyor calibrated a state issued digital thermometer via the ice bath method to 32 degrees Fahrenheit (F) in the presence of the US FOIA (b)(6)).

At 11:29 AM, the surveyor and US FO observed the first food truck arrived on the NJ Exec floor NJ Exec O Unit. A regular diet consistency tray was identified by the surveyor and LPN #1. This tray was removed from the food truck and placed at the nurse's station in the presence of the surveyor and US FOIA The US FO replaced the resident's tray from the kitchen.

At 11:32 AM, the nursing staff began passing out the lunch trays.

At 12:18 PM, the last tray was delivered to the residents' and the surveyor tested the food temperatures with the reserved tray in the presence of the US FOIA The temperatures were as follows:

Hot tea 117.9 Fahrenheit (F)
Cranberry Juice 60.3 F
Milk 58.2 F
Applesauce 63.1 F
Rosemary Turkey 94.6 F
Cornbread Stuffing 101.4 F
Green Beans 93.1 F
Cranberry Sauce 95.2 F

At 12:25 PM, the surveyor interviewed the US FOIA The US FO stated that their kitchen equipment to maintain meal temperatures were working adequately and all the items on the lunch tray were within normal temperatures limits prior to leaving the kitchen, but the passing out of the lunch trays took entirely too long which caused

F 804

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
-All residents who eat meals in the 2nd floor dayroom have the potential to be affected by this deficient practice. A current list of resident names who prefer to eat in the 2nd floor day room was provided to the Chef Supervisor (CS) and a separate cart was delivered for the next meal and served as quickly as possible when received on the unit.

3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?
-Nursing staff will be provided in-servicing by the Assistant Director of Nursing (ADON) or designee on the policy for Food Temperatures with emphasis on serving resident meal trays as quickly as possible upon delivery to the unit to maintain safe and palatable food.
-The unit manager (UM) will identify residents eating meals in the dayroom and will provide a dietary alert sheet to CS or designee to ensure their meals are delivered on the 2nd floor day room cart.
-The UM and the CS will maintain a list of residents who prefer to eat their meals in the 2nd floor day room and the list will be checked monthly to ensure that it is up to date.

4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place?

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE EAST ORANGE, NJ 07017**

(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 804	Continued From page 37 the food items to lose their temperature. On 2/15/24 at 12:40 PM, the US FOIA (b)(6) provided the surveyor with facility policy titled, Food Temperatures with a revised dated of February 2024. Under the procedure section it states, 4. "Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures (i.e., hot/cold carts, pellet systems, insulated plate bases and domes, etc.)." 6. "Foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to the unit storage areas to maintain temperatures at or below minimum safe serving temperatures for cold foods and at or above 135 F for hot foods. Unit refrigerators will be monitored for temperatures that maintain foods at or below 41 F." On 2/21/24 at 10:45 AM, the surveyor team met with the US FOIA (b)(6) The US FOIA (b)(6) stated all meals should be delivered in the appropriate temperature ranges. The US FOIA (b) believed the passing of lunch trays took too long because the lunch tray that came up first had lunch trays for resident in their room as well as the dining room area. US FOIA (b) stated they are making corrective actions now. No further comments made by the US FOIA (b)(6) and/or US FOIA (b) prior to exiting the facility. NJAC 8:39-17.2(a) 2, (e)	F 804	-Chef Supervisor or designee will perform temperature checks on 3 trays weekly x 4 weeks and then 3 trays monthly x 3 months. -The results of the tray temperature checks will be presented by the CS at the quarterly Assessment and Assurance (QAA) committee meeting for review to ensure that the deficient practice will not recur.	

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F 812	Continued From page 38	F 812		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store and discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 2/12/24 at 09:29 AM, the surveyor in the presence of the US FOIA (b)(6) observed the following during the kitchen tour:	F 812	F812 Food Procurement, Store/Prepare/Serve/Sanitary 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified to have been affected by the deficient practice. In the deli refrigerator the pink liquid on the bottom shelf was immediately removed and sanitized and the egg salad that had a "use by" date of 2/11 was immediately removed and discarded. In refrigerator #2 the 2 light fixtures with	4/9/24

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F 812

Continued From page 39

1. On the inside the deli preparation refrigerator the surveyor observed a pink liquid on the bottom shelf, as well as a small container of egg salad with a created date of 2/8/24. The US FOIA (b)(6) stated the liquid was melted strawberry ice cream but could not state why the liquid had not been cleaned up. The US FOIA (b)(6) further stated the egg salad should have been discarded on 2/11/24 but could not state why it had not been thrown away.

2. In the walk-in refrigerator #2, the surveyor observed 2 light fixtures with attached wiring all with a grey dust like build up, two fans with a caked on black colored debris. Surveyor further observed opened containers which included: 1, one galloon fat free milk and 2, one gallon whole milks without open or use by dates. The US FOIA (b)(6) stated, "the maintenance department oversees cleaning the light fixtures and fans and would be alerted immediately. As for the milk containers we follow the expiration dates on the containers, but everything should be labeled with open and discard dates."

3. In the walk-in freezer, the surveyor observed 1 light fixture with attached wiring all with a grey dust like build up as well as multiple boxes stacked to top of ceiling. The US FOIA (b)(6) stated, they would reorganize the boxes in the freezer, so nothing is stored 18 inches from the ceiling per the regulations.

At 2/12/24 09:44 AM, the US FOIA (b)(6) joined the surveyor and US FOIA (b)(6) for the rest of the tour.

4. Under the chef prep area, the surveyor observed an open bottle of degreaser (top was missing). The US FOIA (b)(6) stated, the cap was lost and

F 812

attached wiring and the two fans identified were immediately cleaned. The opened container of one gallon of fat free milk and two opened containers of whole milk were removed and discarded. In the walk-in freezer, one light fixture with attached wiring was immediately cleaned and the boxes that were stacked up to the top of the ceiling were removed and reorganized to allow for the required 18 inches from the ceiling. The open bottle of degreaser under the chef prep area (top was missing), was immediately removed and discarded.

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All residents residing in the facility have the potential to be affected by the deficient practice. The US FOIA (b)(6)) was immediately educated by the LHNA on the facility sanitation policy, proper storage policy, and food dating policy, and cleaning of the storage area with emphasis on light bulbs, and wires. All the food in the kitchen was checked for proper storage and to ensure proper labeling with opened and use by dates. All other areas were thoroughly cleaned and sanitized per facility policy.

3. • What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?

The FSD or designee will reeducate all dietary staff on the facility sanitation policy to ensure that all cleaning frequencies are being followed. The cleaning schedule

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F 812	Continued From page 40	F 812		

discarded the bottle.

On 2/20/24 at 01:39 PM, the survey team met with the US FOIA (b)(6) to review concerns. US FOIA (b)(6) stated he would provide the surveyor with requested kitchen policies.

On 2/21/24 at 10:30 AM, the US FOIA (b)(6) provided the surveyor with multiple dietary policies including Cleaning and Sanitation of Food Services Areas, Food Storage, Labeling and Dating of perishable food products, and Chemical Storage. All policies were updated in February 2024. The Cleaning and Sanitation of Food Services Area policy states under the procedure, 3. "All staff will be trained on frequency of cleaning necessary ...5. Staff will be held accountable for cleaning assignments." The Food Storage policy states under procedures, "Cover, label and date unused portion and open packages. Complete all sections on a Morrison orange label or use the Medvantage/Freshdate labeling system." The Labeling and Dating of Perishable food product policy states under the policy, "Any opened perishable and/or non-perishable food items shall be labeled and dated to ensure food safety." The procedure section of the policy further states, 2. "All opened perishable food items will have an "Open" and "Use by date."" 3. "All perishable and left over food items shall be marked with a "Use by date"." 4. "All Perishable or leftover food shall be discarded after 72 hours." The Chemical Storage policy states under Purpose, "This policy aims to establish guidelines and procedures for the safe storage of chemical within Park Crescent's proper chemical storage is essential to

guide was updated to include the light bulbs, attached wires and fans. The FSD or designee will reeducate dietary staff on the facility labeling and dating policy to ensure that all perishable foods have an "opened" and "use by" date, which should not exceed 72 hours. The FSD or designee will reeducate all dietary staff on removing and discarding all perishable food items that have reached their "used by date". A reference guide for labeling, dating, and discarding perishable food items was placed in the storage areas for staff to refer to. The FSD or designee will reeducate all dietary staff on the facility storage policy to ensure that no items are being stored within 18 inches of the ceiling. A marker was placed in the storage areas 18 inches from the ceiling to assist staff in ensuring items are stored properly. The FSD or designee will reeducate all dietary staff on proper storage of chemicals that they should always be covered when not in use, to mitigate risks associated with chemical hazards.
4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e.
What quality assurance program will be put into place?
The LHNA or designee will conduct weekly audits x 4 weeks, and then monthly audits x 3 months of all facility cleaning frequencies to ensure that it is being conducted appropriately by dietary staff per facility policy. The LHNA or designee will conduct weekly audits x 4 weeks, and then monthly audits x 3

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F 812	Continued From page 41 mitigate risks associated with chemical hazards, including accidents, spills, and exposure, thereby ensuring the health and safety of employees, visitors, and the environment." On 2/22/24 at 2:30 PM, the survey team met with US FOIA (b)(6) no further comments made regarding the kitchen. NJAC 8:39-17.2(g)	F 812	months of all perishable food items that are labeled with an "opened" and "used" by date, and that and that they are not past the "used by" date and are discarded after 72 hours. The LHNA or designee will conduct weekly audits x 4 weeks, and then monthly audits x 3 months of all items in the kitchen that are not stored within 18 inches of the ceiling. The LHNA or designee will conduct weekly audits x 4 weeks, and then monthly audits x 3 months of all chemicals in the kitchen that they are closed properly. The results of these audits will be reviewed at the Quality Assessment and Assurance (QAA) meeting quarterly meeting with the LNHA to ensure that these deficient practices do not recur.	

New Jersey Department of Health

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # Complaint # Complaint # NJ00170384 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	S560 Mandatory Access to Care 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? -No residents were identified to be affected by the deficient practice. A review of the care residents received on day shift on 3/5/23,3/10/23,3/11/23,3/12/23,3/15/23, 3/17/23 revealed no complaints or grievances related to resident care were reported on these dates on the day shift. - A review of the care residents received on day shift on 6/4/23,6/5/23,6/10/23,6/11/23,3/14/23,3/16 /23,6/17/23 revealed no complaints or grievances related to resident care were	4/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/15/24

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S 560	Continued From page 1 Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.	S 560	reported on these dates on the day shift. - A review of the care resident received on day shift on 12/17/23,12/18/23,12/20/23,12/23/23,12/24/23,12/27/23,12/28/23,12/29/23,12/30/23, 12/31/23,01/01/24,01/06/24, revealed no complaints or grievances related to resident care were reported on these dates on the day shift. - A review of the care resident received on day shift on 1/28/24,2/4/24,2/5/24 revealed no complaints or grievances related to resident care were reported on these dates on the day shift. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice has the potential to affect all residents residing in the facility. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -US FOIA (b)(6) was re-educated by the DON on The State of New Jersey Department of Health requirement on the minimum ratio of one certified nurse aide (CNA) to every eight residents for day shift. -Staffing need are assessed daily and in event there is CNA shortage and ratio of one CNA to every eight resident on day shift is not being met then; nurse manager/supervisors will recruit CNA from previous or upcoming shift, utilize 5 agency companies, and CNA unit clerks will be utilized to assist with providing	

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S 560	Continued From page 2 (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the complaint staffing investigation weeks of 3/3/2023 to 3/18/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -03/05/23 had 19 CNAs for 166 residents on the day shift, required at least 21 CNAs. -03/10/23 had 19 CNAs for 171 residents on the day shift, required at least 21 CNAs. -03/11/23 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs. -03/12/23 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs. -03/15/23 had 20 CNAs for 174 residents on the day shift, required at least 22 CNAs.	S 560	resident care to meet day shift state requirements to meet minimum state staffing requirements of one CNA to every 8 resident on day shift. -Facility has implemented referral and sign on bonus; online advertisements are utilized to recruit new employees. -Facility is initiating increase in CNA rates and other options to increase CNA rates to assist in meeting minimum state staffing requirement of one CNA to every eight residents on day shift. -Facility is actively recruiting CNA candidates from local CNA training programs. 4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? LNHA, DON or designee will conduct weekly CNA staffing schedule audits x 4 weeks and then monthly x 3 months to ensure the minimum state staffing requirement of one CNA to every eight residents on day shift on the day shift. The DON or designee will report audit findings to LHNA and will review audit findings and report during Quality Assurances Performance Improvement (QAA) quarterly meetings to ensure facility corrective actions for the deficient practices will not recur.	

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S 560	Continued From page 3 -03/17/23 had 21 CNAs for 174 residents on the day shift, required at least 22 CNAs. -03/18/23 had 18 CNAs for 172 residents on the day shift, required at least 21 CNAs. 2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the complaint staffing investigation weeks of 6/4/2023 to 6/17/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -06/04/23 had 21 CNAs for 175 residents on the day shift, required at least 22 CNAs. -06/05/23 had 21 CNAs for 174 residents on the day shift, required at least 22 CNAs. -06/10/23 had 20 CNAs for 174 residents on the day shift, required at least 22 CNAs. -06/11/23 had 16 CNAs for 174 residents on the day shift, required at least 22 CNAs. -06/14/23 had 21 CNAs for 173 residents on the day shift, required at least 22 CNAs. -06/16/23 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs. -06/17/23 had 20 CNAs for 178 residents on the day shift, required at least 22 CNAs. 3. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the complaint staffing investigation weeks of 12/17/2023 to 1/6/2024, the facility was deficient in CNA staffing for residents on 12 of 21 day shifts as follows: -12/17/23 had 17 CNAs for 171 residents on the day shift, required at least 21 CNAs. -12/18/23 had 20 CNAs for 171 residents on the day shift, required at least 21 CNAs. -12/20/23 had 20 CNAs for 171 residents on the	S 560		

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day shift, required at least 21 CNAs.
-12/23/23 had 19 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-12/24/23 had 18 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-12/27/23 had 20 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-12/28/23 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-12/29/23 had 18 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-12/30/23 had 17 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-12/31/23 had 17 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-01/01/24 had 16 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-01/06/24 had 18 CNAs for 161 residents on the day shift, required at least 20 CNAs.

4. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2 weeks of staffing prior to survey from 01/28/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:

-01/28/24 had 15 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-02/04/24 had 18 CNAs for 162 residents on the day shift, required at least 20 CNAs.
-02/05/24 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs.

On 2/22/24 at 2:50 PM, the surveyor informed the Licensed Nursing Home Administrator, Director of Nursing, Regional Nurse Consultant, Vice President of Clinical Services, and Vice President

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION	**480 PARKWAY DRIVE EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 of Skilled Nursing Division about the concerns for CNA to resident ratios.	S 560		

PRINTED: 07/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING ______ B. WING ______	R-C **04/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

(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	{E 000}		
{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 04/24/2024 to verify the facility's Plan of Correction (POC). Based on observation, interview and record review, the facility was found to be in compliance with their POC and 42 CFR Part 483, Requirements for Long-Term Care Facilities. Census: 165 Sample: 3	{F 000}		

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

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

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)
315266	A. Building B. Wing	4/24/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

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 F0684 Reg. # 483.25 LSC	Correction Completed 04/09/2024	ID Prefix F0711 Reg. # 483.30(b)(1)-(3) LSC	Correction Completed 04/09/2024	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	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315266	A. Building B. Wing	4/24/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

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 F0641 Reg. # 483.20(g) LSC	Correction Completed 04/09/2024	ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 04/09/2024	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 04/09/2024
ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 04/09/2024	ID Prefix F0711 Reg. # 483.30(b)(1)-(3) LSC	Correction Completed 04/09/2024	ID Prefix F0804 Reg. # 483.60(d)(1)(2) LSC	Correction Completed 04/09/2024
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 04/09/2024	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

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060733	A. Building B. Wing	4/24/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

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 04/09/2024	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/22/2024	☐ 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
	315266	A. BUILDING **01** B. WING ______	**02/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/21/2024 and 02/22/2024 and Park Crescent Healthcare and Rehabilitation Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Park Crescent Healthcare and Rehabilitation Center is a five (5) story, Type I Fire Resistant building that was built in September 1968. The facility is divided into 13 smoke zones. The facility has a Diesel Emergency Generator.	K 000		
K 311 SS=E	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. 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 review of facility documentation on 02/21/2024 and 02/22/2024, in the presence of facility Management it was	K 311	K311 – Vertical Openings - Enclosure 1. What corrective action will be accomplished for those residents found to	4/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/15/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ______	**02/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

K 311

Continued From page 1
determined that the facility failed to ensure that 2 of 15 exit access stairwell doors tested, were capable of maintaining the 2 hour fire rated construction.
This is evidenced by the following,

On 02/21/2024 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility is a five-story (5) building with three (3) exit stairwells (South, Center and North) with illuminated exit signs above doors that Resident, Staff and Visitors would use in the event of an emergency to exit the building.

Starting at approximately 9:35 AM on 02/21/2024 and continued on 02/22/2024 in the presence of the facility's US FOIA (b)(6) and US FOIA a tour of the building was conducted.
Along the two (2) day tour, the surveyor inspected and conducted closure test of fifteen (15) exit access doors leading into exit stairwells with the following results,

On 02/21/2024:
1) At approximately 10:44 AM, when the surveyor tested the 4th. floor "North" stairwell door by opening to a 90 degree opening to the door frame, the door rubbed on the floor and did not self-close into it's frame.
This test was performed two additional times with the same results.
A review of an emergency evacuation diagram

K 311

have been affected by the deficient practice?
The Maintenance Director immediately repaired the doors on the 4th floor North stairwell and the first-floor center stairwell. Both exit doors now self-close into its frame, and positively latch.
2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
All residents residing in the facility have the potential to be affected by the deficient practice. The maintenance director inspected all other exit doors, no other doors were affected.
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?
The LHNA re-educated the US FOIA (b)(6) to routinely inspect all exit doors every month to ensure they are closing into the frame properly, positively latch and are not warped causing them not to be fire resistant.
4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place?
The LHNA will inspect all exit doors in the facility weekly x 4 weeks, then monthly x 3 months, to ensure that all of the doors are not warped and close properly. The LNHA will review the results of these inspections with the Maintenance Director at the Quality Assurance Performance Improvement (QAPI) quarterly meeting to ensure the facility’s corrective action for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ______	**02/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 2 posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. On 02/22/2024: 2) At approximately 11:07 AM, when the surveyor tested the 1st. floor "Center" stairwell door by opening to a 90 degree opening to the door frame and allowed to self-close, the door closed into its frame and did not positive latch into its frame. This test was performed one additional time with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. The two (2) stairwell doors would need to positive latch into their frames to maintain the 2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The facility US FOIA (b) and US FOIA confirmed the findings at the time of the observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 02/22/2024 at approximately 12:30 PM. Fire Safety Hazard. Life Safety Code 101, 2012 Edition NJAC 8:39- 31.2(e)	K 311	the deficient practice does not recur.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an	K 351		4/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 3 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/21/2024 and 02/22/2024, in the presence of facility management it was determined that: The Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 02/21/2024 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a five-story (5) building with three (3)	K 351	K351 Sprinkler system – Installation 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Maintenace Director immediately reached out to external vendor US FOIA (b) to install new fire sprinkler on the top landing of the center stairwell. Installation was completed by US FOIA (b)(6) 3/12/2024. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. Audit of entire building completed and no other areas were affected with this deficiency. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING 01 B. WING ______	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 4 exit stairwells (South, Center and North) with illuminated exit signs above doors that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:35 AM on 02/21/2024 and 02/22/2024 in the presence of the facility's US FOIA an inspection tour of the building was conducted. Along the two (2) day tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 02/21/2024: 1) At approximately 10:51 AM, the surveyor observed no evidence of fire sprinkler coverage inside the approximately nine feet by ten feet six inches (9' by 10'-6") top landing of the Center stairwell. At this time the surveyor asked the US FOIA "Do you see any fire sprinklers on the top landing. The US FOIA looked up and around and told the surveyor, No. Code requires fire sprinkler coverage in stairwells at the top landing , bottom landing and every other floor in between. The facility US FOIA confirmed the findings at the time of the observation. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 02/22/2024 at approximately 12:30 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	recur? LNHA educated US FOIA (b)(6) on the requirements to have the necessary fire sprinkler systems in the stairwells. The Maintenance Director will conduct inspections biannually to ensure that there are the necessary required sprinklers in the building according to the fire code. 4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place The Maintenance Director will conduct inspections biannually to ensure that there are the necessary required sprinklers in the building according to the fire code. The Maintenace Director will review with LNHA the results of the inspection at Quality Assurance Quarterly meeting.	
K 911 SS=E	Electrical Systems - Other	K 911		4/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ______	**02/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 5 CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 02/21/2024 and 02/22/2024, in the presence of facility management, it was determined that the facility failed to ensure that 3 of 17 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt,	K 911	K911 Electrical systems 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Ground Fault Circuit Interrupter (GFCI) outlets located in the 2nd floor dining room, resident salon and the 3rd floor dining room were immediately replaced and fixed by the Maintenance Director. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by the deficient practice. All other outlets in locations which require a GFCI were inspected by the maintenance director, there were no other ones that were faulty. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The LNHA reeducated the US FOIA (b)(6) [redacted] on the necessity to have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ______	**02/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 6 single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 02/21/2024 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the US FOIA (b)(6) provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a five-story (5) building. There are 102 Resident sleeping rooms and common areas that Residents and Visitors could use. Starting at approximately 9:35 AM on 02/21/2024 and continued on 02/22/2024 in the presence of the facility's US FOIA (b)(6) a tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested seventeen (17) electrical outlets in wet (with-in 6 feet of a sink) locations with three (3) electrical outlets that failed to de-energize when tested in the following location, On 02/22/2024: 1. At approximately 10:38 AM, the surveyor observed, measured and recorded in the 2nd. floor Residents dining room serving area, one (1) Duplex electrical outlet located 16 inches to the right of the sink (behind the ice machine) when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex	K 911	functioning GFCIs next to a water source. The Maintenance Director will inspect all outlets that require a GFCI, biannually to ensure they are functioning properly. 4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? The Maintenance Director will inspect all outlets that require a GFCI, biannually to ensure they are functioning properly. The Maintenance Director will review with the LNHA the results of this audit at the facility Quality Assurance Quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ______	**02/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

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K 911	Continued From page 7 electrical outlet did not de-energize as required by code. 2. At approximately 10:58 AM, the surveyor observed, measured and recorded inside the Residents Salon one (1) Ground Fault Circuit Interrupter (GFCI) electrical outlet located 41 inches to the right of a sink when tested with a GFCI tester to de-energize, the Ground Fault Circuit Interrupter electrical outlet did not de-energize as required by code. 3. At approximately 11:54 AM, the surveyor observed, measured and recorded in the 3rd. floor Residents dining room serving area, one (1) Duplex electrical outlet located 35 inches to the right of the sink (behind the ice machine) when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The facility US FOIA (b)(6) confirmed the findings at the time of the observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 02/22/2024 at approximately 12:30 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		4/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ___	**02/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

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K 918	Continued From page 8 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/21/2024 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	K918 Electrical Systems 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director immediately reached out to external vendor	

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	315266	A. BUILDING **01** B. WING ______	**02/22/2024**

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PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	**480 PARKWAY DRIVE** **EAST ORANGE, NJ 07017**

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K 918	Continued From page 9 The deficient practice was evidenced by the following: On 02/21/2024 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the and US FOIA (b)(6) if the facility had an Emergency Generator. The MD told the surveyor, yes we have one Diesel Emergency Generator. Starting at approximately 9:35 AM on 02/21/2024 in the presence of the facility's US FOIA a tour of the building was conducted. During the building tour at approximately 9:59 AM, an inspection outside of the building, where the Diesel Emergency Generator was located was performed. A request was made to the US FOIA "Do you have a remote emergency stop button for the generator." The US FOIA opened a door of the metal housing of the generator, then lifted a panel inside and pointed to the emergency stop button. The surveyor observed that the emergency stop button was not remote and located inside the generator's metal housing behind a metal panel on the control panel of the generator. At this time the surveyor asked the US FOIA Do you have a remote emergency stop button for the generator. The US FOIA said, no. The US FOIA confirmed the findings at the times of observation. The US FOIA (b)(6) was informed of the Life Safety Code deficiency during the survey exit on 02/22/2024 at approximately 12:30 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and	K 918	(NJ Ex Order 26.4b1) to install a remote manual stop station for the facility's emergency generator. The remote manual stop station was installed by Powerhouse generator company on February 29th 2024. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. Besides the generator which did not have remote manual stop station, there are no other generators on the facility property that require a remote manual stop station. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The remote manual stop station was installed on February 29th, 2024. The Maintenance Director will conduct biannual inspections on the remote manual stop station to ensure it is functioning properly. 4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? The Maintenance Director will conduct biannual inspections on the remote manual stop station to ensure it is functioning properly. The Maintenance Director will review the results of the inspections with LNHA at the facility Quality Assurance Quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315266	A. BUILDING **01** B. WING ______	**02/22/2024**

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K 918	Continued From page 10 5.6.5.6.1.	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315266	A. Building 01 - MAIN BUILDING 01 B. Wing	4/24/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK CRESCENT HEALTHCARE & REHABILITATION CENTER	480 PARKWAY DRIVE EAST ORANGE, NJ 07017

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 04/09/2024	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 04/09/2024	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 04/09/2024
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 04/09/2024	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

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO