STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	C 03/05/2024

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DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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E 000	Initial Comments This facility is not 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		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		4/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/19/2024

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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interviews, review of the facility's Emergency Preparedness Plan and Program (EPP), and related documentation, it was determined that the facility failed to 1) ensure that their EPP was reviewed and updated at least annually, and 2) failed to ensure that a copy of the EPP was sent to the local and county office of emergency management (OEM) for annual review. This deficient practice was evidenced by the following: On 03/04/2024 at 9:30 AM, a review of the facility's EEP and related documentation revealed that the EPP was not reviewed and updated annually. During and interview with the surveyor on 03/04/2024 at 11:30 AM, the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were unable to provide evidence that their EPP was reviewed and updated annually. In addition, there was no documentation provided from the local EOM	E 004	Element 1: Emergency Preparedness plan was reviewed on March 4th, 2024 and signed by the administrator and Director of Maintenance. Emergency Preparedness request for review was sent to the Offices of Emergency Management on 3/4/2024. Element 2: All residents have potential to be affected by the deficient practice. Element 3: Policy and procedure reviewed and noted to be in compliance. US FOIA (b)(6) to receive education from regional administrator regarding Emergency Preparedness Plan: Specifically including	

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E 004	Continued From page 2 acknowledging receipt of the EPP as required. On 03/05/23 at 12:31 PM, the U.S. FOIA (b) (6) stated that the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) are responsible for updating and maintaining the EPP. At that time the U.S. FOIA (b) (6) acknowledged that they were unable to provided documentation of the required annual reviews and updates. In a facility provided policy titled, "Emergency Management Plan," with a revised date of 12/2022, under number fifteen, indicated, "The Emergency Management Plan is reviewed and updated at a minimum annually to ensure its accuracy." NJAC 8:39-31.2(e).	E 004	minimum timeline for review and entities which need to receive copies of the plan. Element 4: Emergency preparedness plan to be reviewed by Administrator and Director of Maintenance twice annually, instead of once, to ensure minimum requirements are met as per policy. Copies to be sent to Office of Emergency Management. Audit of plan and confirmation of review to be conducted quarterly to ensure compliance. Findings to be presented to Quality Assurance team monthly x6 months. Responsible Party: Administrator/Director of Maintenance.	
F 000	INITIAL COMMENTS Standard Survey COMPLAINT #'S NJ 162241, NJ 162486,162716, 169130, 169732, 170671, 171057, 171347 Census: 211 Sample Size: 48 + 3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		4/1/24

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F 550	Continued From page 3	F 550		

self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:

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F 550	Continued From page 4 Based on observation, interview, and review of the medical record, it was determined that the facility failed to ensure a resident was NJ Exec Order 26 while in common areas of the unit and NJ Exec Order 26.4b1 as well as failed to transport a resident from one area of the facility to another in a dignified manner. This deficient practice was identified for 1 of 48 sampled residents reviewed for NJ Exec Order 2 (Resident # 89) and was evidenced by the following: During the initial tour of the NJ Exec floor on 02/27/2024 at 10:35 AM, the surveyor observed Resident #89 in Activity room/patient lounge on the NJ Exec floor in a reclining NJ Exec O chair. Resident #89 was dressed in a hospital gown, NJ Exec Order 26.4b and his/her NJ Exec Order 26.4b1 to room. 10 other residents were in the room along with activity staff. An unidentified U.S. FOIA (b) (6)) walked in the room looked at resident and left the room wNJ Exec Order 26.4b1 On 02/27/2024 at 12:20 PM, Resident #89 was pushed forward in the NJ Exec O chair out of lounge and put in hallway. Gown was observed to have brown colored stains on it. On 03/01/24 10:22 AM, the surveyor observed CNA #1 pulling resident #89 backwards down the hallway in his/her NJ Exec O chair. During an interview with the surveyor at that time, CNA #1 said "no it is NJ Exec Order 26.4b1 to NJ Exec a resident NJ Exec Order 26.4b1 in NJ Exec O chair. CNA #1 went on to say but the wheels are not moving when do it forward. A review of the Admission Record revealed Resident #89 was admitted with diagnoses	F 550	Element 1: Resident #89 was cleaned, NJ Exec Order 26.4 from a gown to clothing, without NJ Exec Order 26.4b1. Gown mentioned with a stain was cleaned and stains were removed. Wheels were checked by maintenance to ensure chair was functioning properly and could be pushed forward, not backwards. CNA #1 was in-serviced regarding dignity of residents and appropriate transport of residents. Any stains identified on resident gown, resident will be changed into a clean set. Element 2: All residents on the same unit as resident #89 had potential to be affected by this deficient practice. Environment rounds were completed by the administrator, maintenance director, and DON. The rounds specifically focused on the resident's environment in the key areas of: Clean equipment, dignity, resident rights, appropriate transport of residents who need assistance. Element 3: The staff educator will conduct education with all staff on residents' rights specifically focusing on providing a dignified environment and resident rights. Element 4: The Director of Nursing/ designee will conduct environmental rounds specifically focusing on providing a dignified	

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F 550	Continued From page 5 including but not limited to; NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, revealed Resident #89 had NJ Exec Order 26.4b1. The MDS also indicated Resident #89 had NJ Exec Order 26.4 [redacted] Section NJ Exec [redacted] revealed the resident was dependent on staff for NJ Exec Order 26. NJ Exec Order 26.4 and used a wheelchair for NJ Exec Order 26. During an Interview with the surveyor on 02/29/2024 at 11:17 AM, CNA #2 was asked what the process is when you report to work. CNA #2 replied we have permanent assignments. I do assignments or another staff for aides. We get the resident ready for breakfast or if going out on appointment. Then we pass trays and help residents to eat and then do ADL's (Activities of Daily living). When asked how you know what care a resident requires, CNA #2 replied I know every patient and what they like. Their preferences in clothes, food, liquids. I can tell other staff what residents need and will give them report if they are not familiar with any resident. I work both units and have great memory. The surveyor asked what care does Resident #89 require? CNA #2 replied he/she is NJ Exec Order 26.4b [redacted] care and is NJ Exec Order 26.4b2 [redacted] I take him/her to the NJ Exec Order 26.4b1 [redacted] NJ Exec Or [redacted] him/her up. We keep Resident #89 in NJ Exec [redacted] at nurses' station and if in bed every NJ Exec Order 26.4b1. The surveyor asked if Resident #89 has clothes and CNA #2 replied yes, he/she has clothes. I lay the clothes out when I give him/her care. The surveyor asked how is a resident to be NJ Exec Order 26 [redacted] when they are in	F 550	environment. Immediate corrections will be initiated when identified. The audits will be completed weekly X 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at Quality Assurance Team, monthly. Responsible Party: Director of Nursing/Designee	

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F 550	Continued From page 6	F 550		

the patient lounge at activities? CNA #2 said yes, it is a must to be NJ Exec Order 26 in common areas. CNA #2 confirmed yes, he/she should 100 % wear clothes when out of the room. When questioned what if a resident is dressed in a gown and they NJ Exec Order 26.4b1 and their NJ Exec Order 26.4b1. CNA #2 replied Aide should NJ Exec Order 26.4b1 and make sure the resident is NJ Exec Order 26.4 If not aide or nurse, they should tell the nurse/aide. 100 % all staff should intervene if NJ Exec Order 26.4b1. No, not supposed to happen. CNA #2 said "I think what happens with this resident is NJ Exec O has him/her in night gown and may put him/her at nurses' station and then NJ Exec NJ Exec Order 26.4b1. He/she should be NJ Exec Order 26 as he/she has plenty of clothes.

During an interview with the surveyor on 02/29/2024 at 11:36 AM, Licensed Practical Nurse (LPN #1) was asked how should a resident be NJ Exec Order 26 when they are in common areas or in activities? LPN #1 replied resident should be NJ Exec O and not in a gown. No one should be in activity with gown on. LPN #1 was questioned What if the gown the resident is in is stained? LPN #1 replied If resident is in gown with stains, someone should take resident and change outfit.

During an interview with the surveyor on 03/04/2024 at 10:10 AM, the U.S. FOIA (b) (6)) was asked How are residents to be NJ Exec Order 26 in common areas of the facility? The U.S. FOIA replied some residents NJ Exec Order 26.4b1 , per their preferences. When asked if Resident #89 can make his/her preferences known the U.S. FOIA NJ Exec Order 26.4b1 Resident #89 NJ Exec Order 26.4b1. The U.S. FOIA confirmed No gown should not be stained. The surveyor asked what if resident is in common

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F 550	Continued From page 7 area and they NJ Exec Order 26.4b1 and their NJ Exec Order [redacted], what should staff that are present do? I NJ Exec Order 26.4b1 and NJ Exec Order 26 him/her and encourage resident to NJ Exec Order 26.4b1 so as not to NJ Exec Order 2 in any type of way. The surveyor asked What if resident doesn't have clothes? The U.S. FOIA [redacted] said We have clothes in basement. We have facility center shirts and sweatpants and donated clothes. The surveyor asked What is the appropriate way that a resident in a NJ Exec O chair should be transported from location to location in the building? The U.S. FOIA [redacted] replied we use the NJ Exec Order 26.4b [redacted] and push them forward. When asked if it is NJ Exec Order 26.4b1 to pull resident NJ Exec Order 26.4b1 the U.S. FOIA [redacted] replied No mam' not pulled NJ Exec Order 26.4b1	F 550		
F 577 SS=D	NJAC 8:39-4.1(a) Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made	F 577		4/1/24

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F 577	Continued From page 8 respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to maintain the most recent State of New Jersey inspection results in a place readily accessible to the residents, families, and the public. This deficient practice was evidenced by the following: On 02/27/2024 at 09:00 AM, during initial entrance to the facility the surveyor observed the "State Results Binder" on a small table next to the reception desk. There was a set of double doors between the lobby and a hallway which led to the nursing units. The doors were locked and required a four-digit code to open the doors to enter the nursing units or to exit back to the entrance lobby, where the binder was located. On 02/28/2024 at 10:30 AM, the surveyor held a Resident Council meeting with 10 residents. During the meeting the surveyor asked the residents if they were aware of the survey results and the location. Ten of the ten residents told the surveyor they were not aware of the results being accessible to them or a location where they can view the results. On 03/04/2024 at 2:10 PM, the surveyor met with the U.S. FOIA (b) (6)	F 577	Element 1: Survey binders were immediately provided on the 1st and 2nd floor in an area accessible to all residents. The survey binder will remain at the front desk of facility lobby as well, in a conspicuous location. No residents NJ Exec Order 26.4b1 [redacted] Element 2: All residents had the potential to be affected by the deficient. Element 3: The administration in-serviced all alert and oriented residents on the State Inspection Survey Results and where the result binders were located in the facility. During the facilities monthly resident council meetings the location of the survey result binder will be reviewed with residents. All staff were in-serviced on the location of survey results and the necessity of keeping the most current survey results in the binders.	

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F 577	Continued From page 9 U.S. FOIA (b) ( ) regarding the accessibility of the binder. The U.S. FOIA (b) said himself and the U.S. FOIA (b) (6) were responsible for updating the binder and it was in the entrance lobby. The surveyor also informed the U.S. FOIA (b) that the residents were not aware of the survey results being accessible to them. No further information was provided to the surveyor. NJAC 8:39-9.4 (b)	F 577	Element 4: Administration/Activities Director will conduct random weekly audits x 1 month and monthly x 3 months to ensure survey result binders are in the appropriate location. Findings to be presented at Quality Assurance meeting monthly. Responsible Party: Recreation Director/Designee	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		4/1/24

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F 583	Continued From page 10 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to protect the confidentiality of a resident's health related information. This deficient practice was identified at 1 of 2 nursing stations and was evidenced by the following: On 03/01/2024 at 12:26 PM, at the 2nd floor nursing station, the surveyor observed a medication cart unattended with the Medication Administration Record (MAR) opened to full view, exposing a resident's personal identification which include the following information: The resident's name, photo, date of birth, medical diagnoses, allergies, diet, and medications. The MAR was displayed on a fixed laptop attached to the top of the medication cart located at the nursing station across from hallway "[redacted] The medication cart was locked. On 03/01/24 at 12:29 PM, the Licensed Practical Nurse (LPN #5) returned to her cart. At that time, the surveyor interviewed LPN #5 who stated, "I didn't realize I didn't lock the screen. I should have hidden the screen, I didn't realize." When asked what she should have done, she replied, "I should always lock the cart and hide the screen."	F 583	Element 1: LPN #5 closed laptop after returning to her cart. LPN #5 was educated regarding privacy/confidentiality of residents. Element 2: All residents had potential to be affected by the deficient practice. Rounds were made in throughout the facility to ensure all other nursing laptops were closed if not attended to. Element 3: The Director of Nursing reviewed the policy on Non Disclosure/HIPPA and found it to be in compliance. All staff will be in-serviced on the importance of ensuring that all residents private information is not available to anyone except staff who are required to do so. In addition, staff are immediately to close any laptop unattended to by a nurse. Element 4:	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 11 On 03/01/24 at 1:41 PM, during an interview with the U.S. FOIA (b) (6)), the U.S. FOIA stated that she expects that the MAR is closed to protect the personal identifying health information of the resident and that if left open it violates the Health Insurance Portability and Accountability Act (HIPAA). A review of a facility policy titled, "Non-Disclosure/HIPAA." with a revised date of 10/23, revealed under a policy statement, "All residents and facility information must be protected and may not be accessed, released, or used without proper authorization." NJAC 8:39-4.1 (a)(18)	F 583	A new laptop compliance log will be developed and will be utilized for weekly rounds by the Administrator/Designee to ensure compliance. The rounds will be performed twice a week, using a sample of 3 units per round for 4 weeks followed by monthly, until full compliance is achieved. Any negative findings will be addressed immediately. Findings of laptop compliance rounds will be presented and discussed at Quality Assurance meetings monthly and further systematic changes will be implemented if deemed necessary. Responsible Party: Administrator/Designee	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		4/1/24

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	315174	A. BUILDING _____ B. WING _____	C 03/05/2024

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F 584	Continued From page 12 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint #NJ169732 Complaint #NJ170765 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a) provide a homelike dining experience on 1 of 2 units, ([redacted] floor), and b) maintain the facility and equipment in clean and sanitary environment. This deficient practice was identified for 2 of 2 units, ([redacted] and [redacted] floor) and was evidenced by the following: Repeat deficiency from recertification survey of 09/20/2022	F 584	Element 1: Tablecloths were placed on tables in dining rooms the following day, 2/28/2024. Food was removed from trays going forward and placed directly onto the tables. [redacted] floor crash cart was cleaned of black rim around bottom of the cart. Cart was also cleaned of dried streaks. Suction machine was removed, cleaned, stocked, and covered appropriately. Wheelchair of sampled resident was cleaned immediately of debris and white stains. Chair in [redacted] corridor had plate of food	

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F 584	Continued From page 13 a.) During the initial tour of the 2nd floor on 02/27/2024 12:22 PM, Surveyor #1observed the nurse pass the first tray and no placemats observed on the trays. There were no tablecloths on the tables. All food and drinks were left on the tray for all residents and not placed directly on the tables. On 02/28/2024 at 12:05 PM, the 1st meal truck arrived at the dining room/patient lounge on the NJ Exec floor. Resident meals were observed being served on trays and not placed directly on the tables. During an interview with the surveyor on 03/05/2024 at 10:42 AM, Certified Nursing Assistant (CNA # 4) was asked How are trays served in Dining room/patient lounge for meals? CNA #4 responded "the ones (residents) that usually eat in Dining Room, their trays come up first. As soon as tray comes up put on bibs, wash hands and serve the trays. The surveyor asked Is the food served on the tray or removed? CNA responded that staff served the food on the tray. CNA #4 responded, correct when asked if the food was left on the tray. b.1.) During an environmental tour of the NJ Exec floor on 03/01/2024 at 10:38 AM, the crash cart behind nurses' station was observed to have dust along the black rim on the bottom of the cart. There were dried streaks on red back of cart and black rim at top of cart. The crash cart also had on top of cart is a suction with tubing connected. The end of the tube that would connect to the suction catheter is lying on the base of the machine uncovered and exposed. During an interview with Surveyor #1 on	F 584	removed immediately. Meal tray bedside table outside of room #214 was removed immediately. Privacy curtain of resident #171 was cleaned. Element 2: All residents had potential to be affected by the deficient practice. Element 3: The Administrator, Director of Nursing, and Director of Housekeeping reviewed the policy on Disinfecting/ Cleaning Environmental Surfaces, meal pass, and privacy curtains and determined the facility to be in compliance. Staff are being educated on maintaining an orderly and sanitary environment. specifically focusing on meal pass, dignity, disinfecting/cleaning surfaces, and privacy curtains. Element 4: An audit sheet was developed for observations during environmental rounds. The audit sheet will monitor meal pass, disposing of food/garbage, disinfecting/cleaning surfaces, and privacy curtains. Audits will be completed daily by the administrator/designee x1 weeks and then weekly x4 weeks, and monthly until compliance is met.	

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F 584	Continued From page 14 03/01/2024 at 11:05 AM, Licensed Practical Nurse (LPN #5) was asked who is responsible for checking and maintaining the crash cart. LPN #5 responded if it is used, we would restock. The 11-7 supervisor would restock. During an interview with Surveyor #1 on 03/01/2024 at 11:08 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1), was asked how is the suction machine to be stored? LPN/UM #1 responded "It's always been like that. I can get another one and change it if you want." Surveyor #1 again asked is this the way the tubing and suction machine should be stored, and she replied "yes, it's always like that." During an interview with Surveyor #1 on 03/01/2024 at 01:20 PM, the U.S. FOIA (b) (6) [redacted] was asked how should a suction machine be stored on the crash cart when not in use? The U.S. said "it should be wrapped in plastic cover. They usually put a trash bag and wrap it." Surveyor #1 asked if it is appropriate to have the tubing attached and lying on the base of the machine? The U.S. responded No, it should be fresh tubing and should be in the package. During an interview with Surveyor #1 on 03/04/2024 at 02:11 PM, the U.S. FOIA (b) (6) [redacted]) said the suction tubing is tubing connected at time of emergency. The tubing should not be connected and covered when not in use. b.2.) On 02/27/2024 at 12:55 PM, Surveyor #1 observed an unsampled resident sitting in his/her wheelchair. The wheelchair had dried debris on wheels, all support pipes. On 02/28/2024 at 09:23 AM, the unsampled	F 584	Results of these audits will be presented at monthly Quality Assurance Meeting Responsible Party: Administrator/designee	

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resident's wheelchair still has white stains on cross bars and metal pipes.

During an interview with Surveyor #1 on 03/04/2024 at 09:35, the [U.S. FOIA (b) (6)]) was asked who is responsible to clean the wheelchair and how often are they done. The [U.S. FOIA (b)] replied our nighttime porter is responsible and they are supposed to be cleaned once a week. The [U.S. FOIA (b)] responded "yes, we clean outside of medication carts once a week as well."

A review of the facility Wheel Chair Cleaning Schedule for [NJ Exec Order 25] revealed the unsampled resident's wheelchair was documented as having been cleaned on [NJ Exe].

A review of the [NJ Exec Order 26.4] Wheel Chair Cleaning Schedule revealed the unsampled resident wheelchair was documented as having been cleaned on [NJ Exec O].

On 02/27/2024 at 10:25 AM, during the initial tour of the facility, Surveyor # 2 observed a chair in the hallway of the [NJ Ex] corridor. The chair had a plate left on top of it. The plate had some pasta remaining on it. No residents were in the vicinity at the time of the observation.

On the same date at 10:32 AM, during the initial tour of the facility, Surveyor # 2 observed a chair at the end of the hallway in the '[NJ Exe] corridor. The chair had a smeared brown substance on the seat cushion.

On the same date at 10:34 AM, during the initial tour of the facility, Surveyor # 2 observed a meal tray on a bedside table in the hallway outside of room [NJ Exec O] The plate on the tray contained

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remnants of scrambled eggs. No residents were in the vicinity at the time of the observation.

On 02/28/2024 at 12:02 PM, Surveyor #3 met with Resident #171 who stated that he/she noted stains on the privacy curtain and that the housekeeper was told. Resident #171 thinks housekeeper is taking care of it. Surveyor #3 observed the privacy curtain with dark brown stains hanging in his/her room.

On 02/29/2024 at 09:58 AM, Surveyor #3 observed the privacy curtain with stains still hanging in Resident #171's room.

On 03/04/2024 at 08:45 AM, Surveyor #3 interviewed Resident #171 who stated that the privacy curtain still was not changed and that he/she has asked the housekeeper three more times.

Surveyor #3's review of Resident #171's quarterly MDS, an assessment tool, dated NJ Exec Order 26.4b1 3 indicated a Brief Interview of Mental Status (BIMS) of NJ Exe indicating NJ Exec Order 26.4b1.

On 03/04/2024 at 09:18 AM, Surveyor #3 interviewed Housekeeper #1 who stated that the porters do the privacy curtains and that "she keeps telling them, but they have a million things to do."

On 03/04/2024 at 09:32 AM, Surveyor #3 interviewed the U.S. FOIA (b) who stated that they try to wash the privacy curtains every month. She also stated that her and the porters check the curtains to determine which ones need changing. She further stated that she has a log of privacy curtains that have been changed. She denied

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F 584	Continued From page 17 knowing that Resident #171 wanted his/her curtain changed due to stains. Surveyor #3 reviewed the privacy curtain log which revealed that Resident #171's curtain had not been changed. No policy regarding privacy curtains was provided to Surveyor #3. NJAC 8:39-4.1(a)(12), 27.3(c) 31.4(a)(b)	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		4/1/24

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contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

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F 585	Continued From page 19 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide information and educate residents on the [NJ Exec Order 26.4b1] process. This was deficient practice was identified for 10 of 10 residents interviewed (Resident #9, 26, 46, 75, 82, 86, 125, 166, 172, and 446)) on the [NJ Exec Order 26.4b1] process during a Resident Council meeting conducted on [NJ Exec Order 26.4b1] at 10:30 AM and was evidenced by the following:	F 585	Element 1: During Resident Council meeting, administration to educate residents #9,26,46,75,82,86,125,166,172 and 446, as well as any and all other residents in attendance, about what a [NJ Exec Order 26.4b1] is, who the [NJ Exec Order 26.4b1] officer is, and how to file a [NJ Exec Order 26.4b1]	

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F 585	Continued From page 20 On 02/28/2024 at 10:30 AM, during the resident council meeting with ten [NJ Exec O] and [NJ Exec Order 26] residents, the surveyor asked the residents if they were aware of what a [NJ Exec Order 26.4b1] was and how to file a [NJ Exec Order 26.4b1] with the facility if necessary. Ten of the ten residents present during the meeting told the surveyor they did not know the definition of a [NJ Exec Order 26.4b1] or how to file a [NJ Exec Order 26.4b1] or [NJ Exec Orde] in writing. When the surveyor reviewed the resident council meeting minutes for NJ Exec Order 26.4b1 prior to having the resident council meeting, the minutes did not include education on the [NJ Exec Order 26.4b1] process being provided to the residents. On 02/28/2024 at 12:40 PM, the surveyor reviewed the admission packet that was given to all residents on admission. The packet did not include education on the [NJ Exec Order 26.4b1] process. On 03/01/2024 at 11:44 AM, the surveyor interviewed the [NJ Exec Order 26.4b1] officer who was the U.S. FOIA (b) (6). The surveyor asked how the residents were made aware of the [NJ Exec Order 26.4b1] process on admission. The [U.S. FOIA (] stated, "when we do an assessment, they get admission packet that has a page with the [NJ Exec Order 26.4b1] process, residents are told they can report it to any of the staff, and anyone can take down a [NJ Exec Order 26.4b1] and complete the form. The form will be filled out and forwarded to the correct people. There is a [NJ Exec Order 26.4b1] log that is kept". The surveyor requested to view the [NJ Exec Order 26.4b1] book, the [U.S. FOIA (] looked at the book on a shelf and stated, "I have to get it together". On 03/04/2024 at 02:10 PM, the surveyor	F 585	Element 2: All residents have the potential to be affected by deficient practice. Element 3: The policy titled “Grievances” was reviewed with no revisions needed. IDT was educated on the policy above, with emphasis on how to initiate a grievance with a resident who voiced a complaint. In-house residents were provided with written information on the grievance process, how to file a grievance, and who the grievance officer is. This written information is also provided to all new admissions by the social work department. Signage was posted in multiple locations in the facility to provide information about the grievance process, how to file a grievance, and who the grievance officer is. Grievance forms were placed at each nursing station to ensure they are readily available to residents and staff. Moving forward, the grievance process will be reviewed at monthly resident council meetings by the Grievance Officer or designee. Element 4: An audit of all new admissions will be conducted weekly x4 weeks, then a sample of 10 new admissions monthly x3 months, to ensure the residents (or resident representative when appropriate)	

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F 585	Continued From page 21 discussed the concern with the U.S. FOIA (b) (6) [redacted]. The U.S. FOIA stated that the residents did not know what the word grievance pertained to, and the surveyor then told the U.S. FOIA that it was clearly explained to the residents in attendance at the meeting. No other information was provided by the facility. On 03/05/2024 at 12:32 PM, the surveyor met with the resident council president, Resident #146. During the meeting Resident #146 told the surveyor, "I really didn't know we had a NJ Exec Order 26.4b officer." A review of a facility policy titled Grievances with a revision date of 02/01/23. The policy revealed that the facility will assist residents, their representative, family members or resident advocates in filing a grievance/concern form when concerns are expressed. The facility will investigate and resolve resident grievances in a timely manner to ensure residents' safety and protection of the resident rights. Number two of the policy indicated that upon admission, the resident or resident representative are provided with information on how to file a grievance/complaint. NJAC 8:39-4.1 (a) 35, 13.2 (c)	F 585	were provided with written information about the grievance process. All findings will be brought to the facility's Quality Assurance committee monthly for review and recommendations. An audit will be conducted weekly x4 weeks, then monthly x3 months, to ensure that the grievance process signage is displayed in the facility. All findings will be brought to the facility's Quality Assurance committee monthly for review and recommendations. The resident council minutes will be reviewed monthly x3 months to ensure ongoing education about the grievance process has been provided. All findings will be brought to the facility's Quality Assurance committee monthly for review and recommendations. Responsible party: Director of Social Work/designee	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		4/1/24

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(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a

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F 645	Continued From page 23 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed ensure a NJ Exec Order 26.4b1 was completed accurately for a newly admitted resident. This deficient practice was identified in 1 of 3 residents reviewed for NJ Exec Order 26.4b (Resident #150) and was evidenced by the following: On 02/27/2024 at 10:09 AM, during the initial tour of the facility, the resident was sitting in the bed with NJ Exec Order 26.4b1. A review of the Admission Record indicated Resident #150 had medical diagnoses which included but were not limited to NJ Exec Order 26.4b1	F 645	Element 1: Resident #150 NJ Exec Order 26.4b was reviewed by DSW/MDS and determined to be inaccurate. A new NJ Exec Order 26.4b was completed to reflect accurate information. NJ Exec Order 26.4b completed, did not require NJ Exec O Element 2: All residents have potential to be affected by the deficient practice. A full-house audit of all resident PASARRs will be completed to ensure that major mental illness diagnoses are accurately reflected on the PASARR. Any findings will be addressed immediately.	

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F 645	Continued From page 24 NJ Exec Order 26.4b1 A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, revealed the resident had a Brief Interview of Mental Status of NJ Ex meaning the resident was NJ Exec Order 26.4b1 On 02/28/2024 at 09:45 AM, the facility provided the surveyor with a NJ Exec Order 26.4b1 that was completed by the transferring acute care facility prior to entering the current facility. Question NJ Exec on the NJ Exec Order 26.4b1 was marked as 'NJ Exe for the resident having a NJ Exec Order 26.4b1 or evidence of a NJ Exec Order 26.4b1. On 02/29/2024 at 09:37 AM, the surveyor reviewed the first comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b. Under section titled 'NJ Exec Order 26.4b1' it included NJ Exec Order 26.4b1 as a NJ Exec Order 26.4b1 Further review of the MDS list showed that all of Resident #150 MDS completed at the facility from the initial date to NJ Exec Order 26.4b1 included a diagnosis of a NJ Exec Order 26.4b1. On 02/29/2024 at 09:47 AM, the surveyor reviewed the residents' active care plan which showed the following focus: Resident uses NJ Exec Order 26.4b1 medications related to NJ Exec Orde. Interventions included but were not limited to NJ Exec Order 26.4b1 as needed, give medications ordered by physician, monitor for NJ Exec Order 26.4b1, and monitor and report side effects to the physician. The care plan was initiated on NJ Exec Order 26.4b On 02/29/2024 at 10:31 AM, the surveyor	F 645	Element 3: Policy “PASARR Screens” was reviewed with no revisions necessary. The Social Work Department will be educated on “PASARR” by the regional director of social work on the above policy, with emphasis on reviewing the PASARR for accuracy upon receipt, and the process for correcting an identified inaccuracy. Social work is responsible for reviewing all PASARRs upon admission for accuracy. Element 4: The Director of Social Work/designee will audit all new admissions weekly x4 weeks, then a sample of 10 residents monthly x3 months, to ensure they have an accurately completed PASARR. All findings will be brought to the facility’s Quality Assurance committee monthly for review and recommendations. Responsible party: Director of Social Work/Designee.	

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F 645	Continued From page 25 interviewed the facility U.S. FOIA (b) (6)) regarding a resident's NJ Exec Order 26.4b2 on admission. The U.S. FOIA (stated that the admissions office receives the completed NJ Exec Order 26.4b from the sending facility. It then goes to the U.S. FOIA (and the U.S. FOIA (or the MDS coordinator check the NJ Exec Order 26.4b for accuracy. On 03/01/2024 at 11:44 AM, the U.S. FOIA (told the surveyor that she would check if residents had a NJ Exec Order 26.4b1 diagnosis on admission. The surveyor asked about Resident #150 NJ Exec Order 26.4b2 and the U.S. FOIA (told the surveyor it was inaccurate and, "I believe that would have to be updated". A review of a facility policy titled PASARR Screens, with last revised date on 12/2023, revealed Under the procedure section of the policy, that the admission department will obtain completed level one screens prior to admission, and upon admission the social worker will be responsible to ensure the completed Level one screen and level two is in the medical record. Number six indicated that the Director of Social work will conduct regular audits to ensure compliance of the screen/PASARR process. NJAC 8:39-27.1 (a)	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		4/1/24

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medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 27 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical needs and failed to implement focus and interventions that are specific to the resident's NJ Exec Order 26 care and NJ Exec Order 26.4b1 diagnosis. The deficient practice was identified for 1 of 2 Residents (Resident # 48) for NJ Exec Order 26 care and of 2 Residents (Resident #170) for NJ Exec Order 26.4b1 diagnosis, investigated for care plans. The deficient practice was evidenced by the following: 1. On 02/27/2024 at 10:43 AM during the initial tour of the facility the surveyor observed Resident # 48 sitting in the dining room. Resident # 48 was observed to have a NJ Exec Order 26.4b1 in a NJ Exec Order 26.4b1. On 02/29/2024 at 10:40 AM, the surveyor observed Resident # 48 lying in bed. The NJ Exec Order 26.4b1 was observed in a NJ Exec O attached to the bed frame. Resident # 48 said they cannot have a NJ Exec Order 2 due to having a NJ Exec Order 26.4b on his NJ Ex .The NJ Exec Order 26.4b1 was observed incontact with the floor. On 03/01/2024 at 10:50 AM, they surveyor observed Resident # 48 walking with the NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 hanging NJ Exec Order 26.4b1 around his/her NJ Exec Ord A review of Resident # 48's admission record revealed that Resident # 48 was admitted to the facility with the following diagnoses but not limited	F 656	Element 1: Facility corrected care plans for resident #48 and #170 to accurately reflect diagnoses and interventions, specifically NJ Exec Order 26 care and NJ Exec Order 26.4b1 Resident #48 care plan added NJNJ Exec Order 26 for NJ Exec Order 26 care. NJ Exec Order 26.4b1 of resident #48 was removed from contacting the floor. Resident #170 NJ Exe was changed from NJ Ex to NJ Ex to reflect the physician order. Element 2: All residents with catheter care and respiratory care plans had potential to be affected by deficient practice. Element 3: The Director of Nursing reviewed the facility's policy regarding “Care plans-comprehensive”, “oxygen therapy” “catheter care” and noted the policy to be in compliance with state and federal guidelines. All nursing staff received In-Service education regarding the development and review of comprehensive care plans. The lesson plan will concentrate on the following: Comprehensive person-centered care plans are to be developed and implemented for each resident to meet the residents' medical, nursing, and psychosocial needs that are identified in the comprehensive assessments. A copy of the lesson plan and attendance will be filed for reference and validation.	

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F 656	Continued From page 28 to NJ Exec Order 26.4b1 . A review of Resident # 48's Physicians orders revealed orders for NJ Exec Order 26 care every shift, NJ Exec Order 26.4b1 NJ Exec Order 26 NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 if NJ Exec Order 26.4b1 or with NJ Exec Order 26.4b1 . A review of the Annual Resident Assessment Instrument Minimum Data Set (MDS), dated NJ Exec Order 26.4 revealed Resident # 48 had a Brief Interview for Mental Status Score of NJ Exec indicating they were NJ Exec Order 26.4b1 . Section NJ Exec of the MDS revealed Resident # 48 was NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 : the ability to maintain NJ Exec Order 26.4b1 , adjust NJ Exec Order 2 before and after NJ Exec Order 2 or having a NJ Exec Order 26.4b1 . A review of Resident # 48's Care Plan initiated on NJ Exec Order 26.4b1 , revealed that he/she had an NJ Exec Order 26.4b1 , but failed to state that the resident NJ Exec Order 26.4b1 NJ Exec Order 26 care. On 02/29/2024 at 10:40 AM during an interview with the surveyor, Resident # 48 said that they NJ Exec Order 26.4b1 , write down the NJ Exec Order 26 of NJ Exec Orde and let the nurse know. On 3/01/2024 at 11:05 AM during an interview with the surveyor, License Practical Nurse (LPN) #1 replied, "[Resident #48] NJ Exec Order 26.4b1 care. I ask them if it is done and they tell me. Then I check it off on the TAR [Treatment Administration Record]." When asked where it is documented that Resident # 48 can NJ Exec Order 26.4b1 , LPN # 1 replied, "I don't know, maybe the Care Plan." LPN # 1 also stated, "If I see the NJ Exec on the floor, I remind them to pick it up."	F 656	Element 4: The Director of Nursing/designee will complete weekly audits of approximately 10% of all residents with respiratory care, oxygen, and catheter care, for 4 weeks, to ensure the comprehensive care plans were developed and interventions are implemented that represent the resident's current medical, nursing, and psychosocial needs. The Director of Nursing/designee will then conduct monthly audits x 3 months, to ensure ongoing compliance. The results of these audits will be presented at Quality Assurance monthly meetings. The Director of Nursing is responsible for oversight of this Plan of Correction.	

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On 03/04/2023 at 1:49 PM the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FOIA said that Resident # 48 is very adamant on NJ Exec Order 26.4b1 care, and that they should have made sure it was in their Care Plan.

A review of a facility provided policy titled, "CARE PLANS, COMPRHENSIVE" last reviewed on 10/2023 revealed under "Procedure" "1. the interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident." "8. The comprehensive, person-centered care plan will: (b) Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing." 2. During the initial tour of the facility on 02/27/2024 at 10:45 AM, the surveyor observed Resident # 170's room. The resident was not in the room at this time. The NJ Ex Order 26.4(b)(1) was on, and the NJ Ex Order 26.4(b)(1)

On 03/01/2024 at 10:21 AM, the surveyor observed Resident #170 in his/her room, sitting on the side of the bed. The resident had a NJ Exec Order 2 applied to his/her NJ Exec Orde which was delivering NJ Exec Order 26.4b1 Resident #170 states that he/she will NJ Exec Ord the NJ Exec Order 2 when he/she NJ Exec Order 26.4b1. Resident # 170 also said the nurse sets the NJ Exec Order 26.4b1 and that's what it stays on.

On 03/04/2024 at 9:33 AM, the surveyor observed Resident #170 in his/her bedroom

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sitting on the side of the bed. Resident #170 has NJ Exec Order 2 applied and is being delivered at NJ Exec Order 26.4b

A review of the Admission Record located in the electronic medical record (EMR) revealed Resident # 170 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1

A review of the Quarterly Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, Resident #170 had a Brief Interview for Mental Status Score of NJ Exec indicating they were NJ Exec Order 26.4b1 . Section revealed Resident #170 had active diagnoses of but not limited to NJ Exec Order 26.4b1 . According to section of the MDS Resident #170 had NJ Exec Order 26.4b1 when NJ Exec Order 26.4.

A review of the Physician Order Summary Report (POS) located in the EMR revealed a physician's order started on NJ Exec Order 26.4b1 that revealed apply NJ Exec Orde as needed to NJ Exec Order 26.4b1

A review of the Care Plan located in the EMR date initiated on NJ Exec Order 26.4b1 with a revised date of NJ Exec Order 26.4b1 revealed that there were not any focus, goals or interventions for the NJ Exec Order 26.4b1 diagnoses or NJ Exec Order 26.4b1 treatment.

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On 03/01/2024 at 10:32 AM, during an interview with Certified Nursing Assistant (CNA) # 3, the surveyor asked who is responsible for monitoring the resident's NJ Exec Order 26.4b1 settings. CNA #3 replied, the nurse monitors the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. If we see that a residents NJ Exec Order 26.4b1 is being delivered at the wrong NJ Exec O we can set it back to what it is ordered for. CNA #3 also said the resident should have a care plan for NJ Exec Order 2 use.

On 03/01/2024 at 11:17 AM, during an interview with Licensed Practical Nurse/Unit Manager (LPN/UM) # 1, the surveyor asked what the facility care plan process is. LPN/UM#1 replied, the unit manager completes the baseline care plan upon admission. Some areas that should be included are falls, skin care, incontinence, cancer, oxygen, hospice, smoking and anything that pertains to the resident. The surveyor then asked if there is a new order for NJ Exec Order 2 should that be added to the resident's care plan. LPN/UM #1 replied, "Yes, if it's a new order the unit manager will update the residents care plan to include the NJ Exec Order 26.4

On 3/04/2024 at 10:10 AM, during an interview with U.S. FOIA (b) (6)) the surveyor asked what the facility care plan process is. The U.S. FOIA (replied, the unit manager will do the initial care plan and will update them as needed. Surveyor then asked what some of the focus areas that are included on the care plan. U.S. FOIA (replied, any area that pertains to their medical diagnosis such as pain, skin concerns, falls, equipment like a brace, smoking, psychotropic drugs, foley catheters, and abuse. The surveyor then asked, should there be a care plan for

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[redacted] diagnosis? The [redacted] replied, yes, if they have a medical diagnosis involving [redacted] Surveyor lastly asked, if a resident is diagnosed with [redacted] is ordered [redacted] as needed, should they have a care plan for that? The [redacted] replied, "yes, absolutely."

A review of the facility policy titled: Care Plans - Comprehensive, with a revised date of 10/2023, revealed the following under "Procedure." "13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."

A review of the facility policy titled: Oxygen Therapy, with a revised date of 9/2022, revealed the following under "Policy". "Review the resident's care plan to evaluate for any special needs the residents may have."

A review of the facility job description for Licensed Practical Nurse, revealed the following under "Departmental". "Carry out direct care to residents based on their care plan. Review resident care plans for appropriate resident goals, problems, strengths, approaches, and revisions based on nursing needs."

A review of the facility job description for Unit Manager, revealed the following under "Departmental". "Responsible for the evaluation and monitoring of all levels of resident care through on-site observations and audits, including the monitoring and the evaluation of Care Plans for quality, appropriateness and effectiveness on their unit. Monitors all residents on oxygen, tube feedings, suctioning, pressure ulcer care protocols, and behavioral problems, and any other residents' needs."

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F 656	Continued From page 33 N.J.A.C. 8:39-11.2 (e)2	F 656		
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 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 the facility failed to update a care plan for a resident following a hospitalization and change in condition. This	F 657	Element 1: Resident #80 care plan was updated to reflect [NJ Exec Order 26.4b1] . [NJ Exec Order 26.4b1] was removed from care plan. [NJ Exec Order 26] has met	4/1/24

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F 657	Continued From page 34 deficient practice was identified in 1 of 48 residents reviewed for care plans (Resident #80) and was evidenced by the following: On 02/27/2024 at 09:22 AM, during the initial tour of the facility Resident #80 was observed in bed with eyes open. The surveyor did not observe a NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 supplies in the resident's room. Resident #80 told the surveyor that he/she used to have a NJ Exec Order 26.4b1 when they were admitted to the facility, but no longer had a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Review of the Admission Record revealed Resident #80 had medical diagnoses which included but were not limited to NJ Exec Order 26.4b1 Review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b revealed the resident had a Brief Interview of Mental Status of 15, meaning the resident had NJ Exec Order 26.4b1. Review of the MDS, a quarterly screening dated NJ Exec Order 26.4b, section NJ Exec Order 26.4b1 status was marked as "NJ Exec Order 26.4b for a NJ Exec Order 26.4b1. Review of discharge MDS dated NJ Exec Order 26.4b was marked as "NJ Exec Order 26.4b for a NJ Exec Order 26.4b1. The surveyor then reviewed the MDS dated NJ Exec Order 26.4b, a NJ Exec Order 26.4b-day assessment. Section NJ Exec Order 26.4b was marked as "NJ Exec Order 26.4b for a NJ Exec Order 26.4b1 On 03/04/2024 at 10:00 AM, the surveyor reviewed the physician orders which showed an order for a NJ Exec Order 26.4b1, NJ Exec Order 26.4b1. It was an active order dated NJ Exec Order 26.4b	F 657	with resident #80 to review NJ Exec Order 26.4b1 discrepancies NJ Exec Order 26.4b1. Element 2: All residents with a feeding tube have potential to be affected by the deficient practice. Element 3: The Director of Nursing reviewed the facility's policy regarding “comprehensive care plans” and noted the policy to be in compliance. The facility initiated a new procedure in which care plans are reviewed during morning report for any resident with a change in status. For any change in status, the team will review that the resident’s care plans are updated as required. The Interdisciplinary team and licensed nurses will receive In-Service education regarding the review and revision of comprehensive care plans. 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.	

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F 657	Continued From page 35 At the same time the surveyor reviewed the most recent NJ Exec Order 26. note dated NJ Exec Order 26.4b1 which indicated the resident was receiving a NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 The note also revealed the resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. On 03/04/2024 at 10:44 AM, the surveyor reviewed Resident #80's care plan. It was an active care plan with an initiation date of NJ Exec Order 26.4b A focus area of the care plan was that the resident requires NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 NJ Exec Orde and the interventions included but were not limited to administer NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 as ordered and provide local care to the NJ Exec Order 26.4b1. Another focus of the care plan was that the resident had a potential for NJ Exec Order 26.4b1 related to a NJ Exec Order 26.4b1. Interventions included to NJ Exec Order 26.4b1, vital signs, and notify physician for any changes. On 03/05/2024 at 10:44 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding the resident receiving NJ Exec Order 26.4b1 The U.S. FOIA told the surveyor that the resident no longer received NJ Exec Order 26.4b1 and she removed the NJ Exec Order 26.4b1 from the resident care plan. The U.S. FOIA stated, "the resident shouldn't have had a NJ Exec Order 26.4b1 on his/her care plan, but it was updated". The U.S. FOIA stated the NJ Exec Order 26.4b1 was removed during a hospitalization in NJ Exec Order 26.4b1. A review of a facility policy titled, "Care plans Comprehensive" and had a revision date of 10/2023. The policy indicated that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and	F 657	(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 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 A copy of the lesson plan and attendance will be filed for reference and validation. Element 4: The Director of Nursing/Designee will audit 10% of care plans weekly x4 and then monthly x3 or until compliance is met. Audit of all residents to ensure the comprehensive care plans were reviewed and revised at minimum quarterly to ensure the care plan accurately represent the resident's current medical, nursing, and psychosocial needs.	

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F 657	Continued From page 36 functional needs is developed and implemented for each resident. Under number 13 of the policy revealed that assessments of residents are ongoing and care plans are revised as information about the residents and resident's conditions change. Number 14 indicated that the interdisciplinary team reviews and updates the care plan when there has been a change in resident. NJAC 8:39-11.2 (e)	F 657	The results of these audits will be presented at Quality Assurance meeting monthly. The Director of Nursing/Administrator/designee is responsible for oversight of this POC.	
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: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure care and services are provided according to accepted standards of clinical practice, specifically by not providing a resident a medication that was available in the automated medication dispenser and failing to follow a physician's order for [NJ Exec Order 2] administration. The deficient practice was identified for 2 of 2 residents (Resident # 124 & # 170) investigated for Services Provided to Meet Professional Standards. The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title	F 658	Element 1: Resident #124 to receive the appropriate order [NJ Ex Order 26.4b1] without missing a dose. Resident #124 chart was reviewed and resident was assessed by staff to ensure no negative outcomes. Resident #170 [NJ Ex Order 26.4b] was changed from [NJ Ex Order 26.4b] corresponding to the physician's order. Nurses were in-serviced regarding appropriate steps to take if there is none of the order medication in-house.	4/1/24

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F 658	Continued From page 37 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes 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 case finding, 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." A review of Resident # 124's Quarterly Minimum Data Set (MDS) an assessment tool dated [redacted], revealed that he/she had a diagnosis of but not limited to, [redacted] The MDS also revealed Resident # 124 was taking an [redacted] medication [redacted]. A review of Resident # 124's Order Summary revealed a Physician's Order for [redacted] oral tablet [redacted]	F 658	Element 2: All residents have the potential to be affected by the deficient practice. The missed medication report was reviewed and residents with medication omissions were evaluated with no negative outcome noted for any identified resident. The medical records for all residents on O2 were reviewed to ensure the residents were receiving the prescribed amount of O2 as per Physician orders. Element 3: Licensed nurses will be educated on professional standards with emphasis on medication administration and treatment, and ensuring physician orders are followed correctly. Course content will include ensuring scheduled and PRN medications/treatments to all residents are administered. The In-Service will also include education that if the medication is not available, they should utilize the Pixus, and if still not available to notify the physician and follow his updated order. In-service also included ensuring physician orders are carried out as written, and the O2 amount is confirmed.	

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F 658	Continued From page 38 NJ Exec Order 26.4b1 to be given by mouth twice daily for NJ Exec Order 26.4b1. The order began on NJ Exec Order 26.4b1. A review of Resident # 124's Care Plan initiated on NJ Exec Order 26.4b1 revealed a focus of, "NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 R/T [related to] (potential/actual) NJ Exec Order 26.4b1 " The Care Plan revealed an intervention to, "Administer medications as ordered." A review of Resident # 124's Medication Administration Records (MAR) from NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 revealed that Resident # 124 did not receive the NJ Exec Order 26.4b1 on the following dates and times: NJ Exec Order 26.4b1 8:00 PM NJ Exec Order 26.4b1 8:00 PM NJ Exec Order 26.4b1 8:00 PM NJ Exec Order 26.4b1 8:00 PM A review of Resident # 124's Progress Notes located in the Electronic Medical Record (EMR) revealed that on NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1 was not available, ordered and awaiting delivery from the pharmacy. A review of the facility provided documents titled, "Inventory Snapshot, NJ Exec Order 26.4b1" revealed that on the following dates, the automated medication dispenser had at least NJ capsules of NJ Exec Order 26.4b1. The dates and inventory were as follows: NJ Exec Order 26.4b1 - NJ on hand NJ Exec Order 26.4b1 - NJ on hand NJ Exec Order 26.4b1 - NJ on hand NJ Exec Order 26.4b1 - NJ on hand On 03/04/2024 at 01:24 PM during an interview with Surveyor #1, Licensed Practical Nurse (LPN)	F 658	Element 4: The Director of Nursing/ designee will audit at least 10 residents for medication administration, and O2 orders, for proper administration procedures, daily x 5 days per week, x 2 weeks, then weekly x 4 weeks, and then monthly x 6 months, or until substantial compliance is achieved. The results of these audits will be submitted at Quality Assurance monthly. The Director of nursing is responsible for execution and monitoring of this POC.	

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1 replied, "You're supposed to reorder or check the back-stock." when asked by Surveyor #1 what is the expectation if the nurse cannot find a medication in the medication cart. LPN # 1 confirmed by stating, "You can check there too." after the Surveyor #1 asked if they can check the automated medication dispenser on the [redacted] floor.

On 03/04/2024 at 01:49 PM during an interview with Surveyor #1, the [redacted] replied, "Call the physician, notify the physician. First you should check the [brand name; automated medication dispenser]..." At that time, the [redacted] replied, "Yes." when Surveyor #1 asked if the nurses should be utilizing the medication dispenser system to check for the medication to administer. Finally, after Surveyor #1 revealed the facility's inventory of the [redacted] on the aforementioned dates, Surveyor #1 asked if Resident # 124 should have received the [redacted] on those dates. The [redacted] replied, "Yes."

The facility did not provide a policy for the automated medication dispenser.

During the initial tour of the facility on 02/27/2024 at 10:45 AM, the Surveyor #2 observed Resident #170's room. The resident was not in the room at that time. The [redacted] and the [redacted] was [redacted]

On 03/01/2024 at 10:21 AM, Surveyor #2 observed Resident #170 in his/her room, sitting on the side of the bed. Resident #170 had a [redacted] applied to his/her [redacted] which was delivering [redacted]. Resident #170

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F 658	Continued From page 40	F 658		

states that he/she will [redacted] the [redacted] when he/she NJ Exec Order 26.4b1. Resident #170 also said the nurse sets the [redacted] to [redacted] and that's what it stays on.

On 03/04/2024 at 9:33 AM, Surveyor #2 observed Resident #170 in his/her bedroom sitting on the side of the bed. Residents' walker is located within arm's reach. Resident #170 has [redacted] applied and is being delivered at [redacted].

A review of the Admission Record revealed Resident #170 was admitted to the facility with the following but not limited to diagnoses:
NJ Exec Order 26.4b1 [redacted]

A review of the Quarterly Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, dated [redacted], indicated Resident #170 had a Brief Interview for Mental Status Score of [redacted]/15, indicating they were NJ Exec Order 26.4b1. Section I revealed Resident #170 had an active diagnosis of [redacted] According to section [redacted] of the MDS Resident #170 had NJ Exec Order 26.4b1.

A review of the Physician Order Summary Report (POS) located in the EMR revealed a physician's order started on [redacted] as needed for NJ Exec Order 26.4b1

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F 658	Continued From page 41	F 658		

On 03/01/2024 at 10:32 AM, during an interview with Certified Nursing Assistant (CNA #3) Surveyor #2 asked who is responsible for monitoring the resident's NJ Exec Order 26.4b1 . CNA #3 replied, the nurse monitors the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. If we see that a residents NJ Exec Order 26.4b1 is being delivered at the wrong NJ Exec O we can set it back to what it is ordered for.

On 03/01/2024 at 11:08 AM, during an interview with Licensed Practical Nurse (LPN #2), Surveyor #2 asked LPN #2 what is the process for administering NJ Exec Order 26 LPN #2 replied, we will obtain a physician's order for the NJ Exec Order 2 with the NJ Exec and NJ Exec Orde Surveyor then asked who is responsible for monitoring the resident's NJ Exec Order 2 and NJ Exec Order 26.4b1 . LPN #2 replied, the nurse will check the resident's NJ Exec Order 2 according to the physician's orders. The nurse will also check the NJ Exec Order 26.4b1 to make sure the resident is receiving the proper NJ Exec O Surveyor #2 then asked LPN #2 to verify Resident #170's physician order for NJ Exec Order 26 LPN#2 verified that Resident #170 had an order for NJ Exec Order 26.4b1 as needed to maintain NJ Exec Order 26.4b1 as needed for NJ Exec Order 26.1 LPN #2 accompanied Surveyor #2 to residents' room to verify Resident #170's NJ Exec Order 2 on the NJ Exec Order 26.4b1 Resident #170 was not in the room at that time. LPN #2 turned on the NJ Exec Order 26.4b1 and verified that the rate was set at NJ Exec Order . LPN#2 stated, "It should be set at NJ Exec O according to the physicians order." LPN #2 then adjusted the rate to NJ Exec Order and said, I should have checked it.

On 03/01/2024 at 11:17 AM, during an interview

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with the Licensed Practice Nurse/ Unit Manager (LPN/UM #1) Surveyor #2 asked what is the process for administering [NJ Exec Order 26] LPN/UM #1 replied, there should be a physician's order for [NJ Exec Order 26] The order will show up on the residents Treatment Administration Record (TAR) and the nurse should sign off that they have checked the [NJ Exec Order 26.4b1] to ensure its correct.

On 03/04/2024 at 10:10 AM, during an interview with the [U.S. FOIA (b) (6)]) Surveyor #2 asked who is responsible for monitoring the resident's [NJ Exec Order 26.4b1]. The [U.S. FOIA] replied, the [NJ Exec Order 26.4b1] are monitored and frequently checked by the nurse. We also put a white label with the [NJ Exec] on the [NJ Exec Order 26.4b1] that tells staff what the [NJ Exec] should be set at. If the [NJ Exec] on the [NJ Exec Order 2] [NJ Exec Order 26.4b1] isn't set correctly the nurse should adjust it according to the physician's orders.

A review of the facility policy titled: Oxygen Therapy, with a revised date of 9/2022, revealed the following under "Policy". "Oxygen is administered according to physician order. Flow rate must be adjusted by a Licensed Nurse."

A review of the facility job description for Licensed Practical Nurse, revealed the following under "Departmental." "Carry out direct care to residents based on their care plan. Administers medications and treatments according to facility policies and procedures and nursing standards of practice. Performs nursing procedures as required per facility policy and procedure and nursing standards of practice."

NJAC 8:39-27.1

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure that residents with NJ Exec Order 26.4b1 and [redacted] received prescribed treatments to prevent [redacted] for 1 of 4 residents (Resident #112) reviewed for [redacted] This deficient practice was evidenced by the following: During the initial tour of the facility on 02/27/2024 at 10:36 AM, the surveyor observed Resident #112 lying in bed awake. The resident's [redacted]	F 688	Concern How the corrective action will be accomplished for any resident affected by deficient practice How we identified other residents/areas that could potentially be affected. Measures to ensure were/will be put into place to assist this area of concern. How the concern will be monitored and title of person responsible for monitoring. Dates when concern will be completed. F688 SS=D ROM/Mobility Based on observations, interviews, review of medical records and other facility	4/1/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 44 NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 was noted. When interviewed the resident stated that he/she had a NJ Exec Order somewhere that staff NJ Exec Order 26.4b1 The resident further stated that he/she wanted to NJ Exec Order 26.4b1. The resident's family member was present and agreed with the resident's statement and expressed a desire for the resident to resume NJ Exec Order 26.4b1 services. On 02/28/2024 at 2:47 PM, the surveyor observed Resident #112 lying in bed and the resident did not have a NJ Exec Order 26.4b1 on. The resident stated that he/she had not had it on yet. The resident's family member who was present confirmed that the NJ Exec Order 26.4b1 was not offered to the resident. According to the Admission Record (an admission summary), Resident #112 was admitted to the facility with diagnosis which included but were not limited to: NJ Exec Order 26.4b1 A review of Resident #112's Quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 which indicated that the resident was NJ Exec Order 26.4b1. Further review of the assessment revealed that the resident NJ Exec Order 2 which included NJ Exec Order 26.4 of care. Review of the NJ Exec Order 26.4b1 in	F 688	documentation, it was determined that the facility failed to ensure that residents with NJ Exec Order 26.4b1 and NJ Exec Order 26 received prescribed treatments to prevent NJNJ Exec Order 26.4b1 for 1 of 4 residents (Resident #112) reviewed for NJ Exec Order 26.4b1. Resident #112 had the NJ Exec Or placed on his NJ Exec Orde Resident was screened by noted NJ Exec Order 26.4b1 to determine if NJ Exec O is still needed. Resident care plan was updated to reflect NJ Exec Order 26.4b1. Family was made aware of attempts to place NJ Exec Order 26.4b1 and issues of NJ Exec Order 26 Documentation of is reflected on the CNA accountability as they are the staff placing it. Equipment/devices should be in the resident tasks, not in the orders or MAR/TAR. On during AM care, off during PM care.	

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F 688	Continued From page 45 Range of Motion section of the assessment revealed that the resident had NJ Exec Order 26.4b1 [redacted] of the NJ Exec Order 26.4b1 [redacted] and NJ Exec Ord [redacted]. Review of the Order summary report revealed an active order dated NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 [redacted] 10 am-6 pm daily with NJ Exec Order 26 [redacted] for NJ Exec Order 26 [redacted] as needed and NJ Exec Order 26.4b1 [redacted] Review of Resident #112's NJ Exec Order 26.4b1 Treatment Administration Record (TAR) and Medication Administration Record (MAR) indicated that there was no documented evidence that the physician's order for the NJ Exec Order 26.4b1 [redacted] was reflected on the TAR or MAR for nursing to document application and usage. Review of Resident #112's Progress Notes for the month of NJ Exec Order 26.4b1, did not include documented evidence that the resident's NJ Exec Order 26.4 [redacted] was applied in accordance with the physician's order or was NJ Exec Order 26 [redacted] by the resident. A review of Resident #112's Care Plan revealed an entry initiated on NJ Exec Order 26.4b1 and revised on NJ Exec Order 26.4 [redacted], with a focus of: NJ Exec Order 26.4b1 R/T (related to) NJ Exec Or [redacted] and NJ Exec Order 26.4b1. Goals included: The resident will remain free of complications related to NJ Exec Order 26.4b1 including NJ Exec Order 26.4b1 [redacted] (Target date NJ Exec Order 26.4 [redacted]). Interventions included: NJ Exec Order 26.4b1 10 am-6 pm daily with NJ Exec Order 26 [redacted] for NJ Exec Order 26 [redacted] as needed and NJ Exec Order 26.4b1 [redacted]	F 688	All residents with palm protectors or positioning orders have the potential to be affect by this deficient practice. All residents with palm protector orders were evaluated to ensure palm protectors were in place and instructions were on the resident's Kardex. Negative findings were immediately corrected. The facility policy on Appliances-appliances, splints, braces, slings was reviewed and determined to be in compliance with state and federal guidelines. The in-nursing educator/ designee will educate all nursing staff on residents with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. The in-service will specifically focus on application of palm protectors The DOR/ designee will audit all residents with palm protectors to ensure the palm protectors are applied as per C.N.A. tasks. Audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be submitted at QAPI. 4/1/2024 Element 1: Resident #112 had the NJ Exec Order 26.4b1 [redacted] placed on his NJ Exec Or [redacted] with a focus of NJ Exec O [redacted] This resident was screened by	

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F 688	Continued From page 46 (date initiated NJ Exec Order 26.4b)..NJ Exec Order 26.4b1 NJ Exec Order 10 am-6 pm daily with NJ Exec Order 26 for NJ Exec Order 26 as needed and NJ Exec Order 26.4b1 (initiated NJ Exec Order 26.4). During an interview with the surveyors on 02/29/2024 at 9:59 AM, Certified Nursing Assistant (CNA) #5 stated that Resident #112 required NJ Exec Order 26.4b1 care and NJ Exec Order 26.4b1 to their NJ Exec Order 26.4b1 CNA #5 stated that the resident also required a NJ Exec Order 26.4 to be placed in their NJ Exec Order after care. CNA #5 stated that the NJ Exec Order 26.4 was stored in the resident's top drawer. When asked when the resident last had the NJ Exec Order 26 on she stated that the resident had it on yesterday. The surveyor stated that the NJ Exec Order 26.4b1 was not observed in use as described. CNA #5 then stated that the resident sometimes NJ Exec Order 26 The survey then asked where CNA #5 documented details of NJ Exec . CNA #5 stated that she documented in Plan of Care (POC). CNA #5 then proceeded to show the surveyors the documentation record on the wall mounted computer kiosk and there was no entry noted that pertained to the NJ Exec Order 26.4b1 for CNA #5 to document resident usage or NJ Exec Order 26 CNA #5 stated that she last documented it yesterday and on NJ Exec Order 26.4b she might have been able to document usage. CNA #5 further stated that the order may have been removed when NJ Exec Order 26 was discontinued. CNA #5 stated that the resident NJ Exec Order 26.4b1 and NJ Exec Order 26 it as he/she NJ Exec Order 26.4b1. CNA #5 further stated that the resident would have it on tomorrow when they got out of bed. During an interview with the surveyor on 02/29/2024 at 10:05 AM, Licensed Practical	F 688	NJ Exec and NJ Exec Order 26.4b1 was identified. NJ Exec Order 26.4b1 services were not recommended. NJ Exec Order 26.4b1 did recommend continued use of the NJ Exec Order 26.4b1. Resident care plan was updated to reflect NJ Exec Order of NJ Exec Order 26.4b1. Family was made aware of attempts to place NJ Exec Order 26.4b1 and issues of NJ Exec Order 26 Documentation of is reflected on the CNA POC accountability for Resident #112, as the nursing staff are the ones placing it. Equipment/devices should be in the resident tasks, not in the orders or MAR/TAR. On during AM care, off during PM care. Element 2: All residents with palm protectors or positioning orders have the potential to be affect by this deficient practice. All residents with palm protector orders were evaluated to ensure palm protectors were in place and instructions were on the resident's Kardex. Negative findings were immediately corrected. Element 3: The facility policy on Appliances-appliances, splints, braces, slings was	

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F 688	Continued From page 47 Nurse (LPN #6) stated that Resident #112 required [redacted] care, [redacted] and was [redacted] with care. LPN #6 stated that the resident [redacted] of bed. LPN #6 stated that Resident #112 used a [redacted] from [redacted] that might be documented on the TAR. LPN #6 then proceeded to review the TAR in the presence of the surveyors and stated that an order was placed on [redacted] for a [redacted] from 10 am-6 pm daily. LPN #6 stated that she saw the [redacted] yesterday morning in the bed and was not sure if the resident put it on and took it off. LPN #6 stated that the aide should have documented usage in the POC and nursing should document usage on the TAR. LPN #6 stated that the resident's family member was [redacted] and could advocate for the resident as he/she [redacted]. During an interview with the surveyor on 02/29/2024 at 10:22 AM, the Director of [redacted] ([redacted]) stated that an order was placed for a [redacted] from 10 am to 6 pm with [redacted] for [redacted] and [redacted] by the [redacted] and was confirmed by the physician. The [redacted] stated that she would have expected that an aide would have put it on and the nurse would confirm use. The [redacted] explained that the purpose of the [redacted] was to [redacted] and [redacted] to prevent the [redacted] from [redacted] into the resident's [redacted] During an interview with the surveyor on 03/01/2024 at 10:59 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) #2 stated [redacted] were ordered daily from 10 am to 6 pm and was on the [redacted] for the CNA to apply. LPN/UM #2 stated that the aide should document	F 688	reviewed and determined to be in compliance with state and federal guidelines. The nursing educator/ designee conducted education beginning on 3/19/2024 on all nursing shifts on the topics of residents with limited mobility receiving appropriate services, equipment, maintaining skin integrity, assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. The in-service specifically focusses on application of palm protectors and skin integrity. Element 4: The Director of Rehabilitation/ designee will audit all residents with palm protectors to ensure the palm protectors are applied as per C.N.A. tasks. Audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be submitted at QAPI, monthly.	

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F 688	Continued From page 48	F 688		

usage and let the nurse know if it were [NJ Exec Order 26.

During an interview with the surveyor on 03/01/2024 at 11:51 AM, the [U.S. FOIA (b) (6)]) stated that an order was placed for Resident #112 for a [NJ Exec Order 26.4b1] to be worn from 10 am to 6 pm. The [U.S. FOIA (b)] stated that our POC now had a caveat (stipulation) that asked the aide to answer yes or no to indicate that all care was provided in accordance with the [NJ Exec Order 2] for the entire shift that covered all aspects of care on the [NJ Exec Order 26] The [U.S. FOIA (b)] reviewed the documentation and indicated that all care was documented as rendered which did not reflect resident [NJ Exec Order 26] The [U.S. FOIA (b)] stated that the resident was care planned for [NJ Exec Order 26.4b1] The [U.S. FOIA (b)] stated that the aide should report resident [NJ Exec Order 2] to the nurse. The [U.S. FOIA (b)] stated that the resident's family member was [NJ Exec Order 26.4b1] of the resident and their [NJ Exec Order 26.4b1].

During an interview with the surveyor on 03/04/2024 at 9:27 AM, the surveyor reviewed [NJ Exec Order 26.4b1] Evaluation and Plan of Treatment Notes dated [NJ Exec Order 26.4b], with the [NJ Exec Or] which revealed the following: Caregiver inservicing to be completed as appropriate, once [NJ Exec Order 26.4b1] is determined. Patient previous with [NJ Exec Order 26.4b1] wearing schedule of 10 am to 6 pm daily with [NJ Exec Order 26] for [NJ Exec Order 26] as needed for [NJ Exec Order 26.4b1] Caregiver inservicing completed at that time. Upon review and documentation review this day, resident with documented history of [NJ Exec Order 26.4b1], and staff noncompliance per resident's family member. Of note, patient with [NJ Exec Order 26.4b1] in last [NJ Exec Ord

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NJ Exec Order 26 possibly resulting in need for further caregiver training...The US FOIA (b) provided the surveyor with a staff in-service Topic: NJ Exec Order 26.4b [redacted] 10 am - 6 pm daily with NJ Exec Order 26 for NJ Exec Order 26 as needed and NJ Exec Order 26.4b1 [redacted], dated NJ Exec Order 26.4b which was signed by CNA #5.

During an interview with the surveyors on 03/04/2024 at 10:27 AM, the U.S. FOIA (b) (6) [redacted]) stated that staff were responsible to follow orders and tasks. The U.S. FOIA stated that NJ Exec Order 26 educated staff and the order was placed in tasks for the CNA to put on. The U.S. FOIA stated that the Unit Manager as responsible to ensure that the order was on the task (Kiosk) to sign. The U.S. FOIA stated that within the last two weeks as a result of an audit, the orders were placed on the TAR for nursing documentation. The U.S. FOIA stated that an audit was done and it was determined that when the order was placed in the computer the drop down box was not accessed to ensure that the order carried over to the TAR for nursing to document usage. The U.S. FOIA stated that if the resident NJ Exec Order 26.4b1 then she would have expected that the nurse would have been informed and documented the NJ Exec Order 26. The U.S. FOIA stated, "If it were not documented, it was not done." The U.S. FOIA explained that the order indicated that the NJ Exec Order 26.4b1 be placed on 7-3 and removed on 3-11 shifts and since it was not carried over to the POC (tasks) for CNA application it may be a system wide problem. The U.S. FOIA further stated that if the order were not in POC, then the aide may not be aware of the need to apply the NJ Exec Order 26.4b1. The U.S. FOIA reviewed the Care Plan in the presence of the surveyors and stated that resident behaviors included NJ Exec Order 2 of medication, treatments, care and

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F 688	Continued From page 50 NJ Exec Order 26.4b1 U.S. FOIA We do not go into specifics. The stated, "The NJ Exec Order 26.4b1 care plan entry did not include NJ Exec Order 26.4b1 but maybe it should have." Review of the facility policy, "Appliances-Sprints [sic.], Braces, Slings (Policy No. CA-27) (Last Date revised 04/2023) revealed the following: In order to protect the safety and well-being of our residents, and to promote quality care, this facility uses appropriate techniques and devices for appliances, splints, braces and slings. To assure all splints, braces, slings etc. are used appropriately and cared for properly and upper and lower extremities are maintained in a functional position. Procedure: ...Nursing: Ensures proper schedule for donning (put on) and doffing (take off) appliance is known by CNA staff and provides appropriately sign off of task options... NJAC 8:39-27.2(m)	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		4/1/24

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indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to maintain a [redacted] and provide services in a manner consistent with standards of practice for 1 of 2 residents reviewed for [redacted] care (Resident #80). This deficient practice was evidenced by the following:

On 02/27/2024 at 09:22 AM, during the initial tour of the facility, Resident #80 was observed in bed with eyes open. The surveyor observed a [redacted] hanging on the left side of the bed facing towards the doorway of the residents' room. The [redacted] was not in a [redacted], meaning the [redacted] did not have a [redacted] to [redacted]

Element 1:
Resident #80 [redacted] was placed into a [redacted], removed from the floor, and placed onto the far side of the bed so it was not facing the doorway where it could be seen. [redacted] appointment scheduled.

Element 2:
All residents with Foley catheters have potential to be affected by the deficient practice.

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F 690	Continued From page 52 the [redacted]. Review of the Admission Record revealed Resident #80 had medical diagnoses which included but were not limited to [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed the resident had a Brief Interview of Mental Status of [redacted]/15, meaning the resident had [redacted]. Review of section [redacted] titled [redacted] and [redacted] indicated the resident had an [redacted]. On 02/27/2024 at 10:52 AM, the surveyor observed Resident #80. The resident was in the bed as you entered the room. There was a roommate in the second bed. The roommate had two visitors at the time of the observation. The [redacted] was on the left side of the bed, facing the doorway and was not in a [redacted] On 02/27/2024 at 11:56 AM, the surveyor interviewed Resident#80 regarding the [redacted]. Resident #80 told the surveyor they had [redacted] for, "[redacted]". The surveyor asked if the resident saw a [redacted] and resident said, "I see a [redacted], but could not say whether he/she saw a [redacted] at the time of the interview. On 02/28/2024 12:07 PM, the surveyor entered Resident #80's room. The resident was in bed with eyes closed. The surveyor observed the [redacted] on the left side of	F 690	Element 3: Policy titled “catheter guidelines” was reviewed and determined to be in compliance with state and federal guidelines. An in-service will be conducted with all nursing staff on foley catheters specifically focusing on ensuring the residents have privacy bags, infection control, and follow ups with Urology. Element 4: The Director of Nursing/ Designee will complete audits of all foley catheters to ensure privacy bags are present, not facing the doorway, and not tubing on the floor. The audits will be completed for 5 residents, 3 times per week x 4 weeks, and then twice monthly x 3 months or until substantial compliance is met. The Director of nursing is responsible for execution and monitoring of this POC	

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the bed laying on the floor and it was not in a NJ Exec Order 26.4b1

On 02/28/2024 at 12:17 PM the surveyor interviewed Certified Nursing Assistant (CNA #2) regarding the resident's NJ Exec Order 26.4b1. CNA #2 looked in the resident's room and said, "The NJ Exec is on the floor, and it doesn't have a NJ Exec Order 26.4b1". The surveyor asked why it shouldn't be that way and she stated, "NJ Exec Order 26.4 control".

On 02/29/2024 at 01:16 PM, the surveyor reviewed the care plan which showed the following focus: The resident has a NJ Exec Order 26.4b1 R/T (related to) NJ Exec Order 26.4b1. One of the interventions was the following: NJ Exec Order 26.4 Care - NJ Exec Order 26.4b1 with soap and water, use NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 place NJ Exec Order 26.4b1 in a NJ Exec Order 26.4b1 while in bed and in wheelchair. NJ Exec Order 26.4b1 every shift. It was an active care plan with an initiation date of NJ Exec Order 26.4b1.

On 03/04/2024 at 01:02 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM #2) regarding care of NJ Exec Order 26.4b1 bags. RN/UM #2 said, "A NJ Exec Order 26.4b1 should be in a NJ Exec Order 26.4b1". The surveyor then asked why a NJ Exec Order 26.4b1 shouldn't be on the floor and RN/UM #2 responded, "NJ Exec Order 26.4 control and it can also NJ Exec Order 26.4b1 and we will have NJ Exec Order 26.4b1 The surveyor asked if it was wrong for the NJ Exec to be on the floor under the resident's bed and he responded, "Correct it shouldn't have been that way and the resident now has a NJ Exec Order 26.4b1."

A review of a facility policy titled Catheter guidelines, with a revision date of 09/11/23,

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F 690	Continued From page 54 revealed Under the section titled Indwelling urinary catheter management, number 5. revealed that urinary catheter use will adhere to the principles of dignity to include discrete use and privacy (ie. covering urinary catheter drainage bags). Under the section titled Infection Prevention and Control, number 1. indicated that urinary catheter care, utilization and management will follow current infection prevention and control standards of practice to include but not be limited to: a. position urinary drainage bags below the level of the bladder and secure to avoid kinks and tubing obstruction. Do not position catheter drainage bag touching the floor. NJAC 8:39-19.4 (a), 27.1 (a)	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to follow their own policy for storage of [redacted] equipment. This deficient practice was identified for 1 of 2 (Resident #154) residents reviewed for [redacted] concerns and was evidenced by the following:	F 695	Element 1: Resident #154 was evaluated with [redacted] noted. The resident's [redacted], [redacted] and [redacted] was immediately changed and placed in the [redacted] provided to avoid [redacted] All residents on O2 or nebulizers were	4/1/24

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F 695	Continued From page 55 During a tour of the facility on 02/27/2024 at 09:58 AM, Resident #154 was observed in bed. On 02/29/2024 at 03:19 PM, the surveyor observed the NJ Exec Order 26.4b1 [redacted] on an overbed table. The surveyor observed NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 exposed to air and uncovered. At that time, the surveyor observed NJ Ex Order 26.4(b) in the NJ Ex Order 26.4(b) of the NJ Exec Order 26.4b1 that was attached to the NJ Exec Order On 03/01/2024 at 08:09 AM, the surveyor observed the NJ Exec Orde and NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 exposed to air and uncovered. The surveyor observed NJ Exec Order 26.4 in the NJ Ex Order 26.4(b) of the NJ Exec Order 26.4b1 that was attached to the NJ Exec Order 2 On 03/01/2024 10:26 AM, the surveyor observed the NJ Exec Orde and NJ Exec Order 26.4b1 of the NJ Exec Order 26.4(b) [redacted] exposed to air and uncovered. The surveyor observed NJ Ex Order 26.4(b) in the chamber of the NJ Exec Order 26.4b1 that was attached to the NJ Exec Order When interviewed at that time, Licensed Practical Nurse (LPN #3) stated that when the NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b is not in use, it should be stored in a bag and should be NJ Ex when not in use. On 03/04/2024 at 08:48 AM, the surveyor observed the NJ Exec Orde of the NJ Exec Order 26.4b exposed to air and uncovered.	F 695	checked for compliance with facility policy. Element 2: All residents on Oxygen treatments and nebulizer equipment have potential to be affected by this deficient practice. Element 3: The facilities policy on oxygen was reviewed by administration and determined to be in compliance with state and federal guidelines. The in-service coordinator-initiated education to all nursing staffing on the policy and procedures for oxygen use, and nebulizer treatments, emphasizing that the tubing and chamber for nebulizers are to be dry, and stored in a plastic bag while not in use. The lesson plan and attendance record have been completed for validation. Element 4: The Director of Nursing/ designee will audit 5 residents on oxygen and or on nebulizer treatments per week x 4 weeks, then monthly for 6 months or until compliance is met to evaluate that the policies are being followed. The results of these audits will be submitted at Quality Assurance meetings,	

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F 695	Continued From page 56 A review of the medical record revealed Resident # 154 had diagnoses that included but were not limited to; NJ Exec Order 26.4b1 [redacted]. The Minimum Data Set (an assessment tool) dated NJ Exec Order 26.4 [redacted], reflected that this resident had Brief Interview of Mental Status of [redacted]/15 meaning this resident is NJ Exec Order 26.4b1 and utilized NJ Exec Order 26 [redacted] within the last [redacted] days. A review of a Physician Order Sheet (POS) revealed a physician's order dated NJ Exec Order 26 [redacted], which reflected that Resident # 154 was to receive NJ Exec Order 26.4b1 [redacted] inhale NJ Exec Order 26.4b1 [redacted] by NJ Exec Order 26.4b1 [redacted] route every 8 hours for NJ Exec Order 26.4b1 [redacted]. During an interview with the surveyor on 03/04/2024 at 01:49 PM, the U.S. FOIA (b) (6) [redacted] stated that the NJ Exec Order 26.4b1 [redacted] should be in a bag. During an interview with the surveyor on 03/05/2024 at 10:42 AM, the U.S. FOIA [redacted] stated that when the NJ Exec Order 26.4b1 [redacted] is not in use, it should be stored dry and in a bag. A review of a facility policy titled Nebulizer Medication/Covid 19 (last revised 1/2023) reflected under 24. when equipment is completely dry, store in a plastic bag with resident's name and the date on it. NJAC 8:39-15.1(a)	F 695	monthly. The Director of Nursing is responsible for the execution of this Plan of Correction.	

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F 725	Continued From page 57	F 725		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: C/O # NJ171057 Based on interview and review of the Nurse Staffing Report and Payroll Based Journal (PBJ) Staffing Data Report, it was determined that the facility failed to ensure to have sufficient nursing staff on a 24-hour basis to provide nursing care to	F 725	Element 1: 10 of 11 residents from aforementioned resident council were spoken with regarding call bell response time to receive feedback of current response time. (residents agreed to assist facility with feedback regarding response time)	4/1/24

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F 725	Continued From page 58 the residents. This deficient practice was evidenced by following: On 02/28/2024 at 10:30 AM surveyor #2 held a resident council meeting with 10 to 11 residents. Regarding the call bells, all in the group said the wait time was from 2 hours to 4.5 hours waiting for call bell to be answered, especially on evenings and night shift. They further stated, "weekends horrible". 5 of 5 residents stated the delay in call bell response time caused a [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1] episode. On 02/28/2024 at 12:05 PM surveyor #2 met with Resident #171 who stated that he/she constantly hears people calling for help. Resident #171 further stated that he/she hears call bells ringing for long periods of time. He/she thinks that staffing [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b1] at the facility. Resident #171 further stated his/her opinion is that the staff is [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] and that nurses are always doing doubles. 1. For the week of Complaint staffing from 03/12/2023 to 03/18/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows: -03/12/23 had 11 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/12/23 had 17 total staff for 189 residents on the evening shift, required at least 19 total staff. -03/13/23 had 13 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/14/23 had 21 CNAs for 189 residents on the	F 725	Facility implemented call bell audits in order to facilitate faster response time with-in reason. Element 2: All residents had potential to be affected by the deficient practice. Element 3: Facility has posted additional advertisements in order to find more CNAs. In addition, facility has offered sign on bonuses, bonuses for picking up additional shifts, and sought assistance from nursing agencies to bring on additional staff. Staff educator to provide education regarding call bell response times, adequate staffing par levels, and notification to [US FOIA (b)(6)] the event that staffing levels are not met. Education to also include ensuring resident needs are met. Element 4: The Administrator and DON will audit schedules to ensure direct care staff to resident ratio requirement is met. Audits will be completed weekly x 4 weeks and monthly until compliance is met.	

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F 725	Continued From page 59 day shift, required at least 24 CNAs. -03/15/23 had 20 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/16/23 had 23 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/17/23 had 19 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/18/23 had 17 CNAs for 194 residents on the day shift, required at least 24 CNAs. 2. For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 2 of 7 evening shifts, and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -11/12/23 had 9 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/12/23 had 18 total staff for 199 residents on the evening shift, required at least 20 total staff. -11/13/23 had 18 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/14/23 had 21 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/15/23 had 24 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/15/23 had 13 total staff for 199 residents on the overnight shift, required at least 14 total staff. -11/16/23 had 19 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/17/23 had 21 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/18/23 had 18 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/18/23 had 18 total staff for 199 residents on the evening shift, required at least 20 total staff. -11/18/23 had 13 total staff for 199 residents on the overnight shift, required at least 14 total staff.	F 725	The results of these audits will be presented at monthly QAPI. The Administrator and DON are responsible for execution and monitoring of this POC.	

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F 725	Continued From page 60	F 725		

3. For the week of Complaint staffing from 12/10/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 2 of 7 evening shifts, deficient in CNAs to total staff on 1 of 7 evening shifts, and deficient in total staff for residents on 6 of 7 overnight shifts as follows:

-12/10/23 had 12 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/10/23 had 16 total staff for 198 residents on the evening shift, required at least 20 total staff.
-12/10/23 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.
-12/10/23 had 13 total staff for 198 residents on the overnight shift, required at least 14 total staff.
-12/11/23 had 16 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/12/23 had 15 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/12/23 had 13 total staff for 198 residents on the overnight shift, required at least 14 total staff.
-12/13/23 had 23 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/13/23 had 11 total staff for 198 residents on the overnight shift, required at least 14 total staff.
-12/14/23 had 22 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/14/23 had 13 total staff for 198 residents on the overnight shift, required at least 14 total staff.
-12/15/23 had 19 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-12/15/23 had 19 total staff for 199 residents on the evening shift, required at least 20 total staff.
-12/15/23 had 12 total staff for 199 residents on the overnight shift, required at least 14 total staff.
-12/16/23 had 18 CNAs for 199 residents on the day shift, required at least 25 CNAs.

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-12/16/23 had 11 total staff for 199 residents on the overnight shift, required at least 14 total staff.

4. For the 3 weeks of Complaint staffing from 01/21/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 14 of 21 day shifts, deficient in total staff for residents on 2 of 21 evening shifts, deficient in CNAs to total staff on 1 of 21 evening shifts, and deficient in total staff for residents on 12 of 21 overnight shifts as follows:

-01/21/24 had 12 CNAs for 190 residents on the day shift, required at least 24 CNAs.
-01/21/24 had 13 total staff for 190 residents on the overnight shift, required at least 14 total staff.
-01/22/24 had 11 CNAs for 190 residents on the day shift, required at least 24 CNAs.
-01/22/24 had 9 CNAs to 21 total staff on the evening shift, required at least 10 CNAs.
-01/22/24 had 12 total staff for 190 residents on the overnight shift, required at least 14 total staff.
-01/23/24 had 16 CNAs for 190 residents on the day shift, required at least 24 CNAs.
-01/24/24 had 22 CNAs for 190 residents on the day shift, required at least 24 CNAs.
-01/25/24 had 22 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-01/25/24 had 12 total staff for 192 residents on the overnight shift, required at least 14 total staff.
-01/26/24 had 20 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-01/26/24 had 11 total staff for 189 residents on the overnight shift, required at least 13 total staff.
-01/27/24 had 22 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-01/28/24 had 8 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/28/24 had 9 total staff for 188 residents on

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the overnight shift, required at least 13 total staff.
-01/29/24 had 12 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/29/24 had 11 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-01/30/24 had 16 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/30/24 had 11 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-02/01/24 had 13 total staff for 192 residents on the overnight shift, required at least 14 total staff.
-02/03/24 had 19 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-02/03/24 had 11 total staff for 192 residents on the overnight shift, required at least 14 total staff.
-02/04/24 had 12 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-02/04/24 had 17 total staff for 192 residents on the evening shift, required at least 19 total staff.
-02/04/24 had 11 total staff for 192 residents on the overnight shift, required at least 14 total staff.
-02/05/24 had 16 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-02/06/24 had 18 CNAs for 191 residents on the day shift, required at least 24 CNAs.
-02/08/24 had 16 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-02/09/24 had 17 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-02/09/24 had 12 total staff for 189 residents on the overnight shift, required at least 13 total staff.
-02/10/24 had 12 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-02/10/24 had 18 total staff for 189 residents on the evening shift, required at least 19 total staff.
-02/10/24 had 10 total staff for 189 residents on the overnight shift, required at least 13 total staff.

5. For the 2 weeks of staffing prior to survey

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from 02/11/2024 to 02/24/24, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 3 of 14 evening shifts, deficient in CNAs to total staff on 2 of 14 evening shifts, and deficient in total staff for residents on 12 of 14 overnight shifts as follows:

02/11/24 had 14 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-02/11/24 had 18 total staff for 189 residents on the evening shift, required at least 19 total staff.
-02/11/24 had 10 total staff for 189 residents on the overnight shift, required at least 13 total staff.
-02/12/24 had 15 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-02/13/24 had 22 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-02/13/24 had 12 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-02/14/24 had 22 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-02/15/24 had 19 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-02/15/24 had 12 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-02/16/24 had 21 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/16/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/17/24 had 15 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/17/24 had 11 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/18/24 had 12 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/18/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/19/24 had 18 CNAs for 195 residents on the

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day shift, required at least 24 CNAs.
-02/19/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/20/24 had 13 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/20/24 had 10 total staff for 195 residents on the day shift, required at least 14 total staff.
-02/21/24 had 19 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/21/24 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs.
-02/21/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/22/24 had 20 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/22/24 had 18 total staff for 195 residents on the evening shift, required at least 19 total staff.
-02/22/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/23/24 had 19 CNAs for 207 residents on the day shift, required at least 26 CNAs.
-02/23/24 had 10 CNAs to 22 total staff on the evening shift, required at least 11 CNAs.
-02/23/24 had 11 total staff for 207 residents on the overnight shift, required at least 15 total staff.
-02/24/24 had 11 CNAs for 207 residents on the day shift, required at least 26 CNAs.
-02/24/24 had 19 total staff for 207 residents on the evening shift, required at least 21 total staff.
-02/24/24 had 9 total staff doe 207 residents on the overnight shift, required at least 15 total staff.

On 03/04/2024 at 10:47 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the CNA ratios are of 1 to 8 on day shift, 1 to 10 on evening shift, and 1 to 14 on night shift. She also stated that one LPN on each hall is ideal for 7-3 and 3-11 shifts. She further stated the facility has a 3-11 supervisor Monday through

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F 725	Continued From page 65 Friday and that day shift has Unit Managers also Monday through Friday. She also stated that on the 11-7 shift they staff four nurses (2 upstairs and 2 downstairs) and a RN supervisor. On 03/05/2024 at 09:28 AM, the surveyor interviewed the US FOIA (b)(6) regarding minimum staffing. She stated that the facility is separated into 4 units, 1A/1B, 1C/1D, 2A/2B, and 2C/2D. During the day shift Monday through Friday there should be eight to nine nurses in addition to four unit managers, on the evening shift eight nurses plus one supervisor, and on the night shift four nurses plus one supervisor. On the weekend day shift there should be eight nurses and one supervisor. She also stated that there should be four CNAs on each unit on each shift. She also stated that the shortage is all over and the management staff come in when needed to fill in; however, payroll will not show that expectations are met and will show staffing below the minimum required. A review of a facility policy titled "staffing hours" with revised date of 04/2023, includes: 1. Our facility maintains adequate staffing on each shift to ensure that our residents needs and services are met. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outline on the resident's comprehensive care plan. NJAC 8:39-5.1(a), 25.2 (b), 27.1 (a)	F 725		
F 728 SS=E	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use	F 728		4/1/24

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F 728	Continued From page 66 of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interviews and review of other facility documentation, it was determined that the facility	F 728	Element 1: 7 of 7 aforementioned nursing aids were	

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F 728	Continued From page 67 allowed Non-Certified Nursing Aides (NAs) to continue working as an NA after the specified 120 days from date of hire. This deficient practice was identified for 7 NAs, (NA1, NA2, NA3, NA4, NA5, NA6, NA7) during the NA review. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health memo dated April 21, 2023, sent to Nursing Homes included the following: Facilities are advised as follows: II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.10. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. After the surveyor review of NA files provided by the facility, on 03/04/24 at 12:50 PM the surveyor interviewed the US FOIA (b)(6) who both confirmed: NA1 - start date [redacted] and taken off the nursing schedule on NJ Ex Order 26.4b1 (120 days from start date was NJ Ex Order 26.4b1) NA2 - start date NJ Ex Order 26.4b1 and taken off the nursing schedule on NJ Ex Order 26.4b1 (120 days from start date was NJ Ex Order 26.4b1) NA3 - start date NJ Ex Order 26.4b1 and taken off the nursing schedule on NJ Ex Order 26.4b1 (120 days from start date was NJ Ex Order 26.4b1)	F 728	removed from the schedule going forward as they worked passed the allotted 120 days. There is currently one Nursing aid outside of the 7 mentioned who is currently employed and is within his 120 days, however the aid has not been on the schedule. Element 2: All residents who were present in the facility during the time that the 7 nursing aids were on schedule had the potential to be affected by the deficient practice. Element 3: Policy “staffing hours” was reviewed and no changes were deemed necessary. Any nursing assistants who were employed by the facility and passed their allotted 120 days were removed from the schedule. Education to be provided by regional administrator to US FOIA (b)(6) and HR regarding appropriate employment of nursing aids/clinical staff: specific focus of background checks, license verification. Element 4: New audit/tracking tool was developed to	

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F 728	Continued From page 68 NA4 - start date [NJ Ex Order 26.4b1] and taken off the nursing schedule on [NJ Ex Order 26.4b1] (120 days from start date was [NJ Ex Order 26.4b1]) NA5 - start date [NJ Ex Order 26.4b1] and taken off the nursing schedule on [NJ Ex Order 26.4b1] (120 days from start date was [NJ Ex Order 26.4b1]) NA6 - start date [NJ Ex Order 26.4b1] and taken off the nursing schedule on [NJ Ex Order 26.4b1] (120 days from start date was [NJ Ex Order 26.4b1]) NA 7 start date [NJ Ex Order 26.4b1] and taken off the nursing schedule on [NJ Ex Order 26.4b1] (120 days from start date was [DS FOIA (b)(6), NJ Ex O]) On 03/04/2024 at 10:02 AM, the [U.S. FOIA (b) (6)] said NA's do not have their own assignments. They are buddied with a Certified Nursing Assistant (CNA). They answer lights, pass water and assist the CNA with care. On 03/04/2024 at 02:32 PM the surveyor interviewed the [U.S. FOIA] who stated that the NAs should not have worked as a NA past 120 days. Review of policy "staffing hours" revised 04/2023, provided by facility on 03/04/2024 includes: 1. Our facility maintains adequate staffing on each shift to ensure that our residents needs and services are met. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outline on the resident's comprehensive care plan. N.J.A.C. 8:39-43.10	F 728	track nursing aides allotted 120 days of allowed after 16 hour training requirement is met. Audit tool will be completed weekly x4 and then monthly x3, as long as the facility employs nursing aids, or compliance is met. Findings of audit to be presented at Monthly Quality Assurance meeting. Responsible Party: Human Resources/ Designee	
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		4/1/24

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F 755	Continued From page 69 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent record review, it was determined that the facility failed to ensure the accountability of the narcotic Shift Count logs were completed in accordance with facility policy and accurately account for and document the administration of controlled medications. This deficient practice was identified	F 755	Element 1: Narcotic logs on 4 of 4 carts which were missing the shift count logs were completed immediately. No residents found to be adversely affected by missing count logs.	

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F 755	Continued From page 70 on 4 of 4 medication carts observed on 4 of 4 nursing units and was evidenced by the following: Repeat deficiency from recertification survey of 09/20/2022 On 2/28/2024 at 11:00 AM, the surveyor, in the presence of a second state surveyor and a federal surveyor, interviewed Licensed Practical Nurse (LPN #4), who stated nurses coming on duty along with the nurse going off duty are to count the narcotics in the medication cart together and sign the "Shift Count" log together to confirm the count is accurate and narcotics are accounted for. She confirmed there should be no missing documentation or blank sections for each shift change. At this point the surveyor, along with LPN #4, reviewed the medication cart and narcotic logs as well as the shift count logs for nursing unit "1A" medication cart "1A - back." The following was observed: 1. 02/05/2024: 11 PM and 2/15/24: 11 PM shift count was not documented. 2. The columns labeled "EDK box sealed?" and "is count correct?" were blank for 2/7/24: 7 AM and 2/23/24: 7 AM. 3. Coming on duty nurse's signature was missing for 2/9/24: 11 PM 4. Going off duty Nurse's signature was missing for 2/27/24: 7 AM On 02/28/2024 at 11:41 AM, in the presence of a second state surveyor, the surveyor interviewed LPN #3, who confirmed that narcotic shift count logs are to be completed by the incoming and	F 755	Element 2: All residents who receive narcotics have the potential to be affected by this deficient practice. Element 3: Facility policy “controlled substance management” was reviewed and determined to be in compliance with state and federal guidelines. The in-service coordinator educated license nursing on pharmacy services ensuring that the facility correctly counts narcotics on medication carts during change of shifts. Narcotic log should be counted by incoming and outgoing nurse to ensure accuracy. Element 4: The Director Of Nursing/designee will audit narcotic log counts on 1 cart per shift x7 days, then weekly x4, and monthly x3, or until compliance is met. Findings to be presented at Quality Assurance Monthly. Responsible party: Director of nursing/designee	

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outgoing nurses, together upon reconciling the medication cart's narcotics at the change of each shift and should not be pre-signed or completed. She further stated that declining inventory logs (logs to account for individual narcotics for each resident) are to be completed for each dose of that medication, immediately once it has been dispensed from its packaging prior to administering it to the resident. At this point the surveyor along with LPN #3 reviewed nursing unit "1C's" medication cart and narcotic logs. The following was observed on the "Shift Count" log:

1. The columns labeled "EDK box sealed?" and "is count correct?" were blank for 2/4/24: 3 PM, 2/11: 7 AM, 2/11: 3 PM, 2/18: 7 AM, 2/21: 3 PM, 2/25: 7 AM, 3 PM, and 11 PM.

2. Coming on duty nurse's signature was missing for 2/12: 11 PM

3. Going off duty Nurse's signature was missing for 2/21: 11 PM

4. 2/24: 11 PM shift count was not documented.

5. 2/28: 3 PM going off duty nurse's signature and "EDK box sealed?" and "is count correct?" columns were pre-filled and pre-signed.

The following [redacted] medications and doses were signed in the medication administration record (MAR) as being administered, but not documented as being dispensed in their corresponding declining inventory logs:

1. Resident #29's [redacted]: 7-10 AM.

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2. Resident #44's [redacted]: 9 AM.

3. Resident #82's [redacted]: 9 AM.

4. Resident #148's [redacted]: 9 AM.

On 02/28/2024 at 12:29 PM, in the presence of a second state surveyor, the surveyor interviewed LPN #1, who confirmed that [redacted] shift count logs are to be completed by the incoming and outgoing nurses, together upon reconciling the medication cart's [redacted] at the change of each shift and acknowledged that "if it's not documented it's not done." At this point the surveyor along with LPN #1 reviewed nursing unit [redacted] medication cart and [redacted] logs. The following was observed on the "Shift Count" log:

1. Going off duty Nurse's signature was missing for 2/4: 11 PM, 2/5: 7 AM, 2/9: 11 PM, 2/12: 11 PM, 2/13: 11 PM, 2/14: 7 AM,

2. Coming on duty nurse's signature was missing for 2/6: 11 PM, 2/9: 11 PM, 2/13: 3 PM, 2/27: 7 AM.

3. The columns labeled "EDK box sealed?" and "is count correct?" were blank for 2/7: 11 PM, 2/9: 11 PM, 2/13: 11 PM, 2/14: 7 AM, 2/18: 11 PM, 2/21: 3 PM, 2/22: 7 AM, 3 PM, 2/27: 7 AM.

4. 2/27: 3 PM, and 2/28: 7 AM shift counts were not documented.

On 02/28/2024 at 1:01 PM, in the presence of a second state surveyor, the surveyor interviewed

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LPN #2, who confirmed that narcotic shift count logs are to be completed by the incoming and outgoing nurses, together upon reconciling the medication cart's narcotics at the change of each shift and there should be no missing documentation. At this point the surveyor along with LPN #2 reviewed nursing unit "2D's" medication cart and narcotic logs. The following was observed on the "Shift Count" log:

1. Going off duty Nurse's signature was missing for 12/23/23: 11 PM, and 2/20/24: 11 PM.

2. Coming on duty nurse's signature was missing for 12/23/23: 3 PM, and 2/28/24: 7 AM.

3. 2/28: 3 PM going off duty nurse's signature was pre-signed.

On 02/28/2024 at 1:55 PM, the surveyor, in the presence of a second state surveyor, interviewed the U.S. FOIA (b) (6) who stated, that the expectation is that the nursing unit managers are to check the NJ Ex Order 26.4 logs daily to ensure the signing in and out of NJ Ex Order 26.4(b) and shift to shift reconciliation logs are being completed. She further stated there should be no missing documentation "at all" and the purpose of the NJ Ex Order 26.4 logs is to maintain accountability of the controlled medications. She confirmed there should be no pre-signed signatures for end of shift, and declining inventory logs should be filled out immediately once the medication dose is dispensed from the packaging.

On 02/29/2024 at 12:30 PM, the surveyor, in the presence of a federal surveyor, interviewed the facility's U.S. FOIA (b) (6)) by telephone, who stated NJ Ex Order 26.4 logs should not

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F 755	Continued From page 74 have blanks or dots, and declining inventory logs should be completed immediately "once the medication is poured or dispensed, not at the end of pass." Review of the facility's "Controlled Substance Management" policy with a last revised date of 8/2023 included but was not limited to, "2. Separate records shall be maintained on all controlled substances in the form of a declining inventory record. Such record shall be accurately maintained and shall include. a. the name of the resident. b. the name of the prescriber c. the prescription numbers d. the drug names e. the form of the medication f. the strength of the medication g. the strength of the dose administered. h. the date and time of administration i. the signature of the person administering the drug. 3. Such records shall be reconciled by the incoming and outgoing nurse. Two nurses must count the remaining medication at each shift, and any handoff of narcotic keys ..." The section titled "accounting procedures" further included, "1. All controlled substances shall be counted at the change of each shift by the incoming and outgoing nurse." NJAC 8:39-29.7(c)	F 755		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		4/1/24

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F 761	Continued From page 75 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a.) properly store and secure medications and properly label opened [redacted] medications and b.) properly secure [redacted] treatment carts when not attended. This deficient practice was observed in a.) 2 of 2 medication storage rooms and 4 of 4 medication carts on 4 of 4 nursing units reviewed for medication storage and labeling and in b.) 1 of 1 treatment carts observed during [redacted] observation. This was evidenced by the following: Repeat deficiency from recertification survey of	F 761	Element 1: Facility reviewed all findings mentioned in the Statement of deficiencies and corrected storage, securing, dating, and labeling of multidose medications. Facility ensured that all keys were available to nurses and that nursing carts were closed if not attended to. Multi-dose medications found in the storage room were removed and placed into medication room/fridge, dated and labeled. If medications were opened and	

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F 761	Continued From page 76 09/20/2022 a.) On 02/28/2024 at 9:39 AM, the surveyor, in the presence of a second state surveyor and a federal surveyor, interviewed Registered Nurse/Unit Manager (RN/UM #1), who stated all nurses are responsible to maintain the medication storage room's organization and cleanliness. She added that there should be no open medication containers in the storage room and any multidose medications that are stored in the medication room or refrigerator should be labeled and dated with the date opened. The RN/UM1 stated the medication refrigerator temperature is checked daily on the 11 PM nursing shift to ensure proper temperatures are maintained for refrigerated medications. At this point the surveyor, in the presence of the second state surveyor, federal surveyor, and RN/UM #1, reviewed the first floor's medication storage room. The following was observed: 1. One opened multi-dose vial of tuberculin purified protein derivative (an injectable medication used to test for tuberculosis infection) stored in the refrigerator and undated with the date it was opened. To which the RN/UM #1 confirmed should have been dated. 2. One opened bottle of ibuprofen 200 milligram (mg) tablets (medication used for pain) dated with opened date 1/28 and stored with unopened medication bottles. To which the RN/UM #1 stated it should not be in the medication room, rather in the medication cart. 3. Two opened boxes of bisacodyl 10 mg laxative suppository 12 count, each box containing eight (8) and undated.	F 761	found to be past appropriate timeline of 30 days (unless insulin which is 28 days) medication was discarded and replaced. Nursing storage rooms, medication fridges, and med carts were reviewed by the nursing leadership in order to ensure appropriate labeling/storage of drugs and biologicals Medication fridge temperatures were adjusted to fall with in normal range of 34-46 degrees. Element 2: All residents have potential to be affected by this deficient practice as all residents have stored medications. Element 3: The facility policy on “storage of medication” was reviewed and determined to be in compliance with state and federal guidelines. The facility policy on “multi dose vials” was reviewed and determined to be in compliance with state and federal guidelines. The facility implemented a new procedure in which the unit manager checks the medication carts weekly and removes any expired medications.	

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F 761	Continued From page 77 4. One large clear plastic, resealable bag with a pharmacy prescription label which indicated which resident the contents were prescribed and contained three cefapime (antibiotic) 2-gram (g) vials prescribed for a different resident. To this the RN/UM #1 stated she was unsure why these medications were stored that way and should be returned to the pharmacy. Further review of the February 2024 medication refrigerator temperature monitoring log indicated the following temperatures in degrees Fahrenheit (F): 2/1: 33 2/2: 34 2/4: 35 2/6: 31 2/7: 35 2/8: 35 2/9: 33 2/10: 31 2/11: 32 2/12: 31 2/13: 33 2/15: 35 2/18: 32 2/19: 34 2/20: 33 2/21: 30 2/22: 30 2/23: 29 2/24: 27 2/25: 28 2/26: 27 2/27: 29 On 02/28/2024 at 10:25 AM, the surveyor, in the	F 761	The in-service coordinator educated license nursing on ensuring medications are within the guidelines for manufacturer instructions including discarding after expiration dates/storage. The in-service coordinator educated nursing supervisors and nursing managers on appropriate temperatures to store medications at to avoid adverse effects. Element 4: The Director of Nursing/designee will audit 2 medication carts and 1 med room daily x7, then weekly x4, and monthly x6, to ensure there are no expired, mislabeled, non-dated medications or multi-dose medications in inappropriate places. These audits will be submitted at monthly Quality Assurance Meeting Responsible party: Director of Nursing/Designee	

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presence of a second state surveyor interviewed RN/UM #2, who stated everyone with access to the medication storage room, including nurses, are responsible to maintain the medication storage room's organization and cleanliness. He confirmed that there should be no open medication containers in the storage room and any multidose medications that are stored in the medication room or refrigerator should be labeled and dated with the date opened. The RN/UM #2 stated the medication refrigerator temperature is checked daily on the 11 PM - 7 AM nursing shift to ensure proper temperatures are maintained for refrigerated medications and verified by the unit manager on the 7 AM - 3 PM shift.

At this point the surveyor, in the presence of the second state surveyor and RN/UM #2, reviewed the first floor's medication storage room. The following was observed:

1. One expired 1000 milliliter (ml) bag of 0.9% sodium chloride (normal saline) intravenous (IV) solution with expiration date October 2023

2. One opened multi-dose vial of Novolog 100 units/ml insulin stored in the medication refrigerator labeled with an opened date of 10/16. The RN/UM2 confirmed this was opened and dated on 10/16/23 and is good for 28 days after opening and should have been discarded.

Further review of the February 2024 medication refrigerator temperature monitoring log indicated the following temperatures in degrees Fahrenheit (F):

2/1: 30
2/2: 30

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2/3: 30
2/4: 30
2/5: 29
2/6: 30
2/7: 30
2/8: 31
2/9: 30
2/10: 30
2/11: 30
2/12: 30
2/13: 30
2/14: 30
2/16: 30
2/17: 30
2/18: 30
2/19: 30
2/20: 29
2/21: 32
2/22: 32
2/23: 32
2/24: 32
2/25: 30
2/26: 30
2/27: 30

On 02/28/2024 at 11:00 AM, in the presence of a second state surveyor and a federal surveyor, interviewed the Licensed Practical Nurse (LPN #4) who stated nurses assigned to the medication cart are responsible for the organization and cleanliness of the cart. She further stated there should be no loose pills in the drawers, and all medications should be labeled and dated once opened, including multi-dose medications such as vials and inhalers should be labeled and dated on the vial, bottle, or device containing the medication. At this point the surveyor, along with LPN #4, reviewed nursing unit "1A's" medication cart "1A - back." The following was observed:

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1. Eight (8) loose pills of various shapes, colors, and sizes.
2. One opened vial of Lantus 100 unit/ml insulin undated.
3. One Lispro U-100 insulin vial opened and undated.
4. One opened fluticasone propionate (nasal spray) 0.54 fluid ounce bottle undated
5. One gentamicin solution 0.3% ophthalmic (eye drops) opened and undated
6. One Incruse umeclidinium inhalation powder 62.5 microgram (mcg) (medication used to treat lung disease) inhaler opened and undated.
7. One budesonide and formoterol fumarate dihydrate inhalation aerosol 160/4.5 (medication used to treat lung disease) inhaler opened and not dated or labeled.

On 02/28/2024 at 11:41 AM, in the presence of a second state surveyor, the surveyor interviewed LPN #3, who confirmed that opened multi-dose medications should be labeled with resident's name and dated with opened date, and there should be no loose pills in the cart drawers. At this point the surveyor along with LPN #3 reviewed nursing unit "1C's" medication cart. The following was observed:

1. Four (4) loose pills of various shapes, colors, and sizes.
2. One fluticasone propionate/salmeterol discus inhalation powder 100 mcg/50 mcg inhaler (medication to treat lung disease) opened and not dated.
3. One fluticasone propionate/salmeterol discus inhalation powder 500 mcg/50 mcg inhaler opened and not dated.
4. One budesonide and formoterol fumarate

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dihydrate inhalation aerosol 80 mcg/4.5 mcg inhaler opened and not dated or labeled.
5. One fluticasone propionate (nasal spray) 15.8 ml bottle opened and not dated or labeled.
6. One Systane solution (eye drops) bottle opened not labeled or dated.
7. One Systane solution bottle opened not dated.
8. One olopatadine hydrochloride ophthalmic solution 0.2% (eye drops) opened and not dated.
9. One carboxymethylcellulose sodium ophthalmic solution 0.5% (eye drops) opened bottle not dated.

Once the surveyor completed review of the medication cart, LPN #3 stated she would discard of the loose pills in the sharps container (a plastic container attached to the side of the medication cart, used to dispose of potentially sharp medical equipment). When the surveyor questioned that action, LPN #3 stated she was "not sure where to discard" and would "ask the unit manager."

On 02/28/2024 at 12:29 PM, in the presence of a second state surveyor, the surveyor interviewed LPN #1, who also confirmed that medication containers and vials should be labeled and dated once opened. At this point the surveyor along with LPN #1 reviewed nursing unit "2A's" medication cart. The following was observed:

1. One Anoro Ellipta inhalation powder inhaler (medication used to treat lung disease) opened and not dated.

2. One box of albuterol sulfate inhalation solution 0.083% 2.5 mg/ 3 ml (medication used to treat lung disease) which contained one opened and undated foil pouch containing 23 single use vials.

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3. One Incurse Ellipta 62.5 mcg inhalation powder inhaler (medication used to treat lung disease) opened and not labeled or dated.

4. One Ventolin HFA 90 mcg inhaler (medication used to treat lung disease) opened and not labeled or dated.

On 02/28/2024 at 1:01 PM, in the presence of a second state surveyor, the surveyor interviewed LPN #2, who stated that there should be no loose pills in the carts and that opened multi-dose medications should be labeled and dated once opened. At this point the surveyor along with LPN #2 reviewed nursing unit "2D's" medication cart. The following was observed:

1. 15 loose pills of various colors, shapes, and sizes.
2. One fluticasone propionate (nasal spray) opened and not dated.
3. One box of ipratropium bromide 0.5 mg and albuterol sulfate 3 mg (medication used to treat lung disease) containing one opened and undated foil pouch with four single dose vials.

On 02/28/2024 at 01:55 PM, the surveyor, in the presence of a second state surveyor, interviewed the U.S. FOIA (b) (6)) who stated, that expired medications should be removed immediately from medication storage areas, medication refrigerator temperatures should be maintained between 34- and 46-degrees F and that temperatures outside the acceptable range could compromise the efficacy of the medication and "could have negative effects for residents." The U.S. FOIA further stated that opened medication bottles should not be stored in the medication

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storage rooms, once opened, multi-use medications, "whether inhalers, insulin, or otherwise," should be labeled and dated with the date opened and preferably the resident's name, stored appropriately, and discarded after 30 days of opening. Furthermore, the [U.S. FOIA (b) (6)] included that medications should always be disposed of appropriately in the drug buster bottle and not in the sharps container.

On 02/29/2024 at 12:30 PM, the surveyor, in the presence of a federal surveyor, interviewed the facility's [U.S. FOIA (b) (6)]) by telephone, who stated multi-dose medications are good for 30 days after opening unless it is insulin, which expires 28 days after opening. The [U.S. FOIA (b) (6)] stated the insulin vial dated as being opened 10/16 should have been discarded. She further confirmed that best practice would be to label and date the medication device, bottle, inhaler, or vial itself once opened with the resident's name and date opened in case the medication and its box were to be separated. She stated refrigerated medications should be stored between 36- and 46-degrees F, and if not could affect the medication's potency. She stated medication refrigerator temperatures should be checked at least once a day to maintain appropriate temperature storage. She further included that medications should not be disposed of in the sharps container or flushed, rather in the medication drug buster or biohazard waste container, depending on the medication.

b.) On 02/29/2024 at 2:14 PM, the surveyor observed LPN #2 on the [NJ Exec Order 26.4b1] nursing unit [NJ Exec Order (b) (6)] prepare a [NJ Exec Order (b) (6)] care treatment cart for use by the nurses' station. She had the cart unlocked when she was approached by a resident in a

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wheelchair. LPN2 then walked away from the treatment cart to assist the resident back to their room, leaving the cart unlocked. The surveyor observed the unlocked cart and other nursing staff members walk past the unlocked cart a total of six times without acknowledging the cart not being secured. The surveyor did not observe any residents come near the treatment cart during this time, however there were seven residents around the nursing station in geriatric chairs and wheelchairs.

At 2:24 PM, once LPN #2 returned to the treatment cart, the surveyor asked about the unlocked cart, to which the LPN #2 acknowledged it was left unlocked stating, "I know its unlocked, I don't have a key for it that's why I left it." LPN #2 confirmed there were medications stored in the cart and should not have left it unlocked unattended.

On 02/29/2024 at 2:35 PM, the surveyor, in the presence of a federal surveyor, observed LPN #2 preparing NJ Exec Order care supplies from the treatment cart by a resident's room in the NJ Ex nursing unit hallway. LPN #2 walked away from the treatment cart to obtain gloves from the glove dispenser on the wall and perform hand hygiene with alcohol based hand sanitizer, leaving the treatment cart unlocked.

On 03/01/2024 at 1:41 PM, the surveyor, in the presence of a federal surveyor, interviewed the U.S. FOIA (b) (6) who stated the expectation is for medication and treatment carts are to be locked when not attended by the nursing staff. She stated treatment carts contain medications for wound and other care and leaving them unlocked could risk residents being

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able to access their contents.

A review of the facility's "Medication Storage" policy with a last revised date of 12/2023, under the section titled "policy," included but was not limited to, "to provide guidelines for proper storage of medications within the facility. this center will have medications stored in a manner that maintains the integrity of the product, ensures the safety of the residents, and is in accordance with department of health guidelines." The section titled "procedure" included, "medications will be stored in an orderly, organized manner in a clean area ... medications will be stored in the original labeled containers received from the pharmacy. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. Medication requiring refrigeration will be stored in a refrigerator that is maintained between 2 to 8 degrees Celsius (36 to 46 degrees F) ... temperature will be checked daily to ensure it is within the specified range. If temperature is out of range, the refrigerator thermostat will be adjusted.

A review of the facility's "Medication Administration" policy with revised date 12/2023, included but was not limited to, "the expiration date on the medication label must be checked prior to administering. When opening a multi-dose container, the date shall be recorded on the container ... during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide ... the cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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F 761	Continued From page 86 A review of the facility's "Multi-Dose Vials" policy with revised date 12/2022 included but was not limited to, "if a multi-dose vial has been opened or accessed (e.g., needle punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter) date ... Review of the facility's "Narcotic Destruction" policy with revised date 9/2023, included but was not limited to, "soiled, damaged, expired drugs, discontinued controlled drugs, oral solid medications, and liquids can be destroyed using drug buster/RX Destroyer disposal system." N.J.A.C. 8:39-29.4	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		4/1/24

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F 803	Continued From page 87 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Repeat deficiency from recertification survey of 09/20/2022 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide all the items that were on the corporate menu. This deficient practice occurred during one breakfast meal that was observed on the first floor and was evidenced by the following: Repeat deficiency from recertification survey of 09/22/2022 1. On 02/28/2024 at 09:24 AM, Resident #146 had not received their breakfast tray at that time. Resident #146 stated that they usually receive breakfast between 9-9:15 AM. The meal cart arrived on the unit at (9:30 AM and Resident #146 received his/her tray at 9:34 AM.) Resident #146 received scrambled eggs, bagel (whole) with cream cheese, an 8-ounce (oz) skim milk, 6 oz coffee, cold cereal portion control, a small muffin, and 4 oz orange juice. The facility menu provided to the survey team from the U.S. FOIA (b) (6) [redacted] revealed the following meal was to be served at breakfast on 2/28/2024: 4 fl oz (fluid ounce) Cranberry Juice, 6 fl oz Oatmeal, Egg Cheese biscuit 1, wheat toast 1 slice,	F 803	Element 1: Resident #146 received the correct meal as soon as the deficiencies were identified. Element 2: All residents have potential to be affected by the deficient practice. Element 3: Corporate Director of Food and Nutrition will in-service all dietary staff on the appropriate methods to ensure proper tray line accuracy and timing of food carts. Residents will be surveyed at meal rounds to ensure compliance. Element 4: The Food and Nutritional Services Director will conduct audits of timing and accuracy of trays x5 days, then weekly x4, then monthly x3. The Food and Nutritional Services Director will present findings of audits to	

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F 803	Continued From page 88	F 803	Quality Assurance Committee monthly.	

margarine 1, milk 2% 8 fl oz, coffee 6 fl oz, salt 1 pc (portion control), pepper pc, sugar packet. In addition, the alternate meal was listed as Cream of Wheat 6 fl oz, scrambled egg 1/4 c (cup), white toast 1 slice, and margarine 1. Resident #146 did not choose to receive the alternate meal and should have received an egg cheese biscuit as indicated on the regular menu, dated 2/28/2024 at breakfast.

2. On 02/28/2024 at 10:14 AM, the surveyor conducted an interview with the U.S. FOIA (b) (The surveyor asked the U.S. FOIA (b) why residents received scrambled eggs and not the menu indicated egg/cheese biscuit the U.S. FOIA (b) explained, "I'm confused, let me go check something. We don't have an egg and cheese biscuit. The meal ticket indicates that we serve scrambled eggs and toast." The surveyor compared the menu provided to the surveyor by the U.S. FOIA (b) and the corporate menu dated Week 1, Wednesday Day 4 for [facility name] F/W 23-24 (fall/winter 2023-2024). Review of both menus indicated that the main meal to be served for breakfast on Wednesday Week 1 was to be the following: Cranberry juice, oatmeal, egg cheese biscuit, 2% milk, and coffee. Review of both menus revealed that the alternate menu to be served was cold cereal, cream of wheat, scrambled eggs, white toast, and margarine. Both menus indicated that an egg and cheese biscuit was to be served as the main menu item at breakfast on Wednesday 2/28/2024 according to the corporate week 1 cycle menu. The surveyor asked the U.S. FOIA (b) if they had an egg and cheese biscuit available for breakfast as indicated by the corporate cycle menu. The U.S. FOIA (b) stated, "No, we don't have an egg and cheese biscuit. The surveyor asked the U.S. FOIA (b) if the egg cheese biscuit was prepared in

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F 803	Continued From page 89 house or was a frozen heat and serve product. The U.S. FOIA (b) stated, "We make them from scratch, not frozen prepared." The surveyor reviewed the facility policy titled Menu and Preference Policy, last date revised: 3/2023. The following was revealed under the heading POLICY: "Menus shall meet the nutritional needs of residents; be prepared in advance; and be followed.' NJAC 8:39-17.2(b)	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint # NJ00171057 Repeat deficiency from recertification survey of 09/20/2022 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to consistently serve foods at a safe and appetizing temperature. This deficient practice was evidenced by the	F 804	Element 1: Food and Nutritional Service Director/designee are taking temperatures before and during the tray line to ensure meals are served in accordance with the appropriate hot holding requirements. Temperature is also being taken at random prior to placement on trays by the administration/designee to ensure appropriate temperature. Every tray has	4/1/24

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F 804	Continued From page 90 following: On 02/27/2024 at 12:14 PM, during the initial tour of the facility Resident #146 stated that the food has improved but we need more variety, and the portions are small. Resident stated that meal trays arrive between 12:15 and 12:45, you never know. Sometimes food is cold, not what menu says is received. On 2/28/2024 at 10:30 AM, during the resident council meeting 8 of 8 residents attending the resident council meeting complained of "cold food" to the surveyor. On 02/28/2024 at 09:13 AM, the surveyor observed residents plates on a pellet covered with the bottom of another pellet. On 02/28/2024 at 09:24 AM, Resident #146 had not received his/her breakfast tray. Resident stated that they usually receive breakfast between 9-9:15 AM. Resident stated that they start to get a annoyed when the breakfast comes after 9:30 AM. Meal cart arrived on unit at 9:30 AM and staff started to distribute trays at 9:31 AM. Resident #146 received tray at 9:34 AM. Resident tray was observed to be delivered with only a top plastic pellet cover and no bottom pellet, leaving base of plate exposed on the tray surface and allowing heat to escape. On 02/28/2024 at 12:05 PM the surveyor observed that all meals/trays had no bottom pellets and had bottom pellets covering the food on the plate. The plate was observed to be sitting directly on the meal tray with no bottom pellet in place. The surveyor did not observe any heated element within the pellet.	F 804	been afforded with a bottom pellet warmer to maintain proper temperatures. Additionally, Food and Nutritional Service Director is conducting random test tray evaluations on different floors at various meals. Any areas of concern are and have been immediately corrected. Element 2: All residents have potential to be affected by the deficient practice. Element 3: Pellet warmer bases have been replaced. Ordered 3/6/2024 and delivered 3/18/2024. Cooks will log temperatures of food at beginning, middle, and/or end of meal service. Food will be reheated if applicable. The Registered Dietitian, The Food and Nutritional Services Director, and or designee, will meet with resident #146 to make sure the resident is satisfied with temperature and the food variety x 4 consecutive weeks. Corporate Director of Food and Nutrition in-serviced all dietary staff on safety of food temperatures and proper temperature logging procedures.	

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F 804	Continued From page 91 On 02/29/20924 at 10:59 AM the surveyors entered the kitchen, accompanied by the U.S. FOIA (b) (6) [redacted]). The surveyors observed that the food for the lunch meal was on the tray line and covered with aluminum foil. The surveyors observed the Cook conduct tray line temperatures at 11:17 AM. The following temperatures were observed: hamburger: 182 F (Fahrenheit) tater tots: 180 F spinach: 179 F mashed potatoes: 179 F mechanical hamburger: 190 F puree hamburger: 185 F pureed spinach: 179 F hot dogs: 184 juice: 40 F Upon completion of the lunch meal temperatures the surveyors exited the kitchen and returned at 02/29/24 at 01:09 PM and observed the lunch tray line actively in progress. The surveyors exited the kitchen at 1:15 PM. The surveyors returned to the kitchen at 1:30 PM to conduct a test tray. The initial food temperatures were conducted at 11:17 AM. The food was present on the tray-line except the hamburgers when the surveyors entered the kitchen. The surveyor observed during the tray-line temperature monitoring that the Food Temperature Log, dated 2/29/24. Menu Week 1 indicated that if the food had been in hot holding for greater than or equal to "2+" hours that food temps should be "re-temp.". The surveyors entered the kitchen 2 hours post observation of food on the tray-line (11:17 AM). Observation of the Food Temperature Log revealed that no foods had been "re-temped"	F 804	Element 4: Food and Nutritional Services Director to audit for proper food temperatures of all foods. Audits to occur daily x5, then weekly x4, then monthly x3 Food and Nutritional Services Director will present findings of audits to Quality Assurance Committee monthly.	

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after being on the tray-line for 2 plus hours. The surveyor then interviewed the [redacted]. On interview the [redacted] stated that the food was on the line for greater than 2 hours and that the food temps should have been re-checked.

The following time line was conducted to assess food temperatures at the lunch meal:

02/29/2024 01:44 PM test tray asked to be assembled.
02/29/2024 01:47 PM tray placed on 1 D Unit meal delivery cart.
02/29/2024 01:48 PM tray left kitchen with (2) surveyors and the [redacted] accompanying the 1 D Unit meal cart. (1 D unit meal cart is the last meal cart to be delivered.)
02/29/2024 01:49 PM cart dropped off on 1 D Unit.
02/29/2024 01:52 PM last tray passed to resident.

On 02/29/2024 at 01:54 PM the surveyors observed the [redacted] conduct food temperatures on the test tray. The following temperatures were observed:
02/29/2024 01:54 PM Spinach: 130.8 F
02/29/20244 01:54 PM Tater tots: 101.5 F
02/29/2024 01:56 PM Hamburger: 98.4 F
02/29/2024 01:56 PM Coffee:155 F
02/29/2024 01:58 PM Juice: 54.5 F

On interview the facility [redacted] was asked what the minimum temperatures should be for hot and cold foods. The [redacted] responded, "We want the food to be delivered at 150-160 F. The surveyors then asked the [redacted] why meals were delivered without a bottom pellet. The [redacted] responded, "A lot of our pellet bottoms are broken so we don't have enough right now for all the plates. I put an

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F 804	Continued From page 93	F 804		

order in."

The surveyor reviewed the facility policy titled Food Safety-Food Handling Policy, Last Revised Date: 09/2021. The following was revealed under the heading POLICY:

"Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized."

The following was observed under the heading PROCEDURE:

1. This facility recognizes that the critical factors implicated in foodborne illness are:
b. Inadequate cooking and improper holding temperatures;

The surveyor reviewed the facility policy titled Food Temperatures Policy, Last Date Reviewed: 3/2023. The following was revealed under the heading POLICY:

"Food temperatures of food items will be recorded on menu items and substitutions for meal service to maintain a high level of quality assurance and to monitor potentially hazardous food temperatures as per state and federal health regulations thus ensuring that foods are provided in a safe, palatable manner."

The following was revealed under the heading PROCEDURE:

2. Meal temperatures will be recorded at the beginning of meal service to ensure proper temperatures are achieved and repeated midway through at point of service if meal service

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F 804	Continued From page 94 exceeds 2 hours. 6. All employees are responsible to notify their supervisor of any food item that does not meet the regulated safe acceptable service ranges (at or below 41 degrees Fahrenheit or above 135 degrees Fahrenheit). NJAC 8:39-17.4 (a)(2)	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure that the resident's prescribed NJ Exec Order 26.4b1 and preferences were accurately identified and implemented for 1 of 3 residents (Resident #25) reviewed for dining services. This deficient practice was evidenced by the following: On 02/27/24 from 11:59 AM to 12:49 PM, the surveyor observed dining services in the first floor main dining room. At 12:19 PM, The surveyor observed a NJ Exec Order 26.4b1 as she called out	F 806	Element 1: Resident #25 did not experienced any [redacted] and had NJ Exec Order 26.4b1 as a result of the deficient practice. Residents will be offered a replacement suitable and comparative [redacted] if a resident does not want the main food option from the menu Resident #25 was provided with an appropriate alternate meal plan that ensures items are properly distributed by kitchen upon notification of mistake.	4/1/24

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F 806	Continued From page 95 for a condiment cart after the resident's meals had already been served and the residents had begun to eat their meals. The surveyor observed Resident #25's meal ticket and noted that the resident had not received creamer for his/her coffee, salt, pepper and a health shake (dietary supplement). When interviewed at that time, the resident stated that he/she needed assistance to get creamer for their coffee and salt and pepper. The resident was accompanied by another unsampled resident. On 02/27/24 at 12:34 PM, the surveyor interviewed Dietary Aid (DA) #1 who stated that the resident's meal tickets were printed out of order. DA #1 stated that not everyone had received the items listed on their meal ticket. DA #1 further stated that the person who normally prepared the meal tickets was out today. On 02/27/24 at 12:49 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that meals were served restaurant style. The U.S. FOIA explained that the resident's food orders were taken table by table. The U.S. FOIA stated that beverages were provided first, then when finished, the meal was provided. On 02/28/24 at 12:12 PM, the surveyor interviewed DA #2 who stated that she reviewed the resident's meal tickets before she brought the items out to the residents. Review of Resident #25's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: NJ Exec Order 26:4b1 [redacted]	F 806	Element 2: All residents had potential to be affected. Dietitian to obtain and keep updated list of residents on altered diets. Element 3: Education provided to kitchen staff and US FOIA (b)(6) by Corporate director of Food and Nutrition regarding supplements and accuracy of trays. Element 4: Food and Nutrition Services Director/Designee will meet monthly with resident council/food committee to address concerns with menu items. Food and Nutrition Services Director/Designee to conduct tray accuracy audits x5 days per week for 1 month, then x 3 days per week x 3 months, to ensure tray accuracy, or until substantial compliance is achieved. Food and Nutrition Services Director will present findings of audits to Quality Assurance Committee monthly.	

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NJ Exec Order 26.4b1 .

Review of Resident #25's Annual Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, revealed that the resident had a Brief Interview for Mental Status (BIMS) Score of NJ Ex out of 15, which indicated that the resident was NJ Exec O

Review of Resident #25's Active Physician's Orders revealed that on NJ Exec Order 26.4b1, the resident was ordered a NJ Exec Order 26.4b1 one time a day for NJ Exec Order 26.4b1 with lunch.

Review of Resident #25's Care Plan revealed an entry that was initiated on NJ Exec Order 26.4b, by the NJ Exec Order 26.4b1, with a Focus of: The resident has a NJ Exec Order 26.4b1 r/t (related to) NJ Exec Order 26.4b1 Goal: Receive NJ Exec Order 26.4b and NJ Exec Order 26.4b and will have NJ Exec Order 26.4b1 through the next review (Target Date: NJ Exec Order 26.4b). Interventions/Tasks: ... NJ Exec Order 26.4b1 and NJ Exec Order 2 as ordered... NJ Exec Order 26.4b1 as ordered...

Review of Resident #25's NJ Exec Order 26.4b Medication Administration Record (MAR) revealed an entry dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 one time a day for NJ Exec Order 26.4b1 with lunch. Review of the entry revealed the entry was documented to indicate that the resident NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 from NJ Exec Order 26.4b through NJ Exec Order 26.4b, though the NJ Exec Order 26.4b1 was not provided as

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indicated per surveyor observation on [NJ Exec Order 26.4b].

Review of the Progress Notes revealed a [NJ Exec Order 2] Note dated [NJ Exec Order 26.4b] at 15:01 (3:01 PM) which indicated the following: Note Text: Update: [NJ Exec Orde] [redacted] rt (related to) was recently sent out to the ER...Continue [NJ Exec Order 26.4b1] as ordered...

On 02/28/24 at 12:17 PM, the surveyor observed Resident #25 seated at a table in the [NJ Exec Order 26.4] main dining room accompanied by the same unsampled resident. The surveyor reviewed the resident's meal ticket and noted that the resident had not received their [NJ Exec Order 26.4b1]. The resident stated that he/she wanted and preferred a [NJ Exec Order] [redacted]. DA #2 was present at that time, and stated that she offered the resident a [NJ Exec Orde] [redacted] but the resident wanted coffee instead. The resident denied that he/she [NJ Exec Order 26.4] to have a [NJ Exec Order 26.4b1] and the unsampled resident who dined with Resident #25 was in agreement with the resident's statement. The unsampled resident had a BIMS score of [NJ E] out of 15, which indicated that the resident was NJ Exec Order 26.4b1. The unsampled resident was listed on the "Dining Room List" of regular residents who routinely dined in the [NJ Exec Order 26.4] dining room at lunch time.

On 02/28/24 at 12:22 PM, the surveyor interviewed the DFS who stated that Resident #25 should have had a [NJ Exec Order 26.4b1] regardless of other beverages served because it was a NJ Exec Order 26.4b1.

On 02/29/24 at 12:31 PM, the surveyor

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interviewed the NJ Exec Order 26.4b1 who stated that Resident #25 was ordered health shakes daily at lunch in NJ Exec Order 26.4b1. The NJ Exec stated that the NJ Exec Order 26.4b1 were provided by NJ Exec Order on the resident's meal tray and the nurses were responsible to document consumption. The NJ Exec stated that the resident's NJ Exec Order 26.4b1 and NJ Exec of NJ Exec were within the NJ Exec Order

On 03/01/24 at 11:41 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who was present in the first floor dining room. The U.S. FOIA (b) stated that the dietary staff were responsible to ensure that the resident's received their NJ Exec Order 26.4b1. The U.S. FOIA (b) further stated that she was not sure if the NJ Exec Order staff or nursing was responsible for tray accuracy. The NJ Ex Order 2 stated that nursing should know who was ordered NJ Exec Order NJ Exec Order 26.4b1 The U.S. FOIA (b) stated between NJ Exec Order and nursing they should have ensured that the NJ Exec Order 26.4b1 were consumed. The U.S. FOIA (b) stated that the aide responsible for POC (Plan of Care) should report the amount of supplement consumed by the resident to the resident's assigned nurse. The U.S. FOIA (b) stated that NJ Exec Order 26.4b1 were given for extra calories and protein that may not be consumed from the meal tray.

On 03/01/24 at 12:51 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #3 who stated that she was assigned to the NJ Exec Order 26.4 dining room today. LPN #3 stated that she provided the residents with NJ Exec Order 26.4b1 from her medication cart on the nursing unit if ordered and recorded the amount consumed. LPN #3 stated that the aides reported the amount of the NJ Exec Order NJ Exec Order 26.4b1 consumed by residents who ate in

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the dining room if she were not present. The surveyor showed LPN #3 the NJ Exec Order 26.4b1 that remained unopened on Resident #25's tray. LPN #3 stated that she had not realized that the resident received NJ Exec Orde from the dining room staff at lunch time. LPN #3 further stated that when she documented the amount of intake consumed by the resident on NJ Exec Order 26.4b, it was an error on her part because she thought that the documention referred to the NJ Exec Order 26.4b1 (another brand) that she provided to residents from her medication cart. Review of both the physician's orders and MARS/TARS (Treatment Administration Record), revealed that the resident was not ordered any other type of NJ Exec Order 26.4b1 as described by LPN #3.

On 03/04/24 at 11:02 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that staff who monitored the dining room were required to report back to the nurse the amount of NJ Exec Order 26.4b1 consumed and the nurse then documented it on the MAR or TAR. The U.S. FOIA stated that the resident should have received a meal ticket, and staff should make sure that the NJ Exec Order 26.4b1 was received. The U.S. FOIA stated that the resident was very NJ Exec Order 26.4b and NJ Exec Order 26 things. The surveyor informed the U.S. FOIA that the unsampled resident who regularly dined with Resident #25, was NJ Exec Order 26.4b1 and validated that the resident was not offered a NJ Exec Order 26.4b1 as indicated on their meal ticket by DA #2.

Review of the facility policy, "Nourishments-Supplements" Policy No: CN-9, (Last Reviewed 04/2023) revealed the following: To prevent or respond to unplanned and unfavorable weight loss and malnutrition, the

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F 806	Continued From page 100 Dietician will assess the nutritional status of all residents and recommends supplements as needed with Physician approval. Supplement:A product intended to add further nutritional value to the present diet. Adequate dietary intake of essential nutrients can help reduce the risk of weight loss, malnutrition, tissue breakdown and diseases... Procedure: The nursing staff and dietician should observe the resident's fluid and nutritional habits. ...Nursing staff should inform Dietician of resident's poor intake and refer dietician's recommendation to physician. ...Dietician should recommend a dietary supplement as agreed by Physician. Licensed Nurse shall transcribe the order on the MAR. Licensed Nurse documents tolerance and consumption on the MAR. Refusals and poorly accepted supplements should be documented on the EMAR (Electronic Medication Administration Record) and reported to the dietician for review. ...Refusal or poor intake acceptance should be reported to the Physician and Dietician for further evaluation. ...The Dietary Department should audit supplements to ensure they are ordered, tolerated and consumed. NJAC 8:39-17.4(a)(1)	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		4/1/24

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F 812	Continued From page 101 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 other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: Repeat deficiency from recertification survey of 09/20/2022 On 02/27/2024 from 9:32 AM to 10:21 AM, the surveyors, accompanied the U.S. FOIA (b) (6) [redacted]), observed the following in the kitchen: The surveyors observed a U.S. FOIA (b) (6)) in the kitchen. The U.S. FO had NJ Exec Order 26.4b1 [redacted] and was observed wearing a baseball style hat. The NJ Exec Order extended NJ Exec Order 26.4b1 and were exposed. The U.S. FO did not have a hair net in place and the hair was exposed.	F 812	Element 1: Dietary Aid was given hairnet to place immediately. Dented cans were removed and stored in an alternate location In-house opened juices were removed from refrigerator. Cauliflower noted in the freezer was removed 7 bags of lettuce "best if used by 2/22/2024" were removed from refrigerator. Lettuce and tortillas noted in the prep refrigerator were removed. Vents in the food prep area were cleaned to remove all dust. Milk noted in the walk-in fridge was removed from the floor and stored on a stand 6 inches from the floor. Electrical outlet box was cleaned of all brown/grease like debris. Hand towel dispensers were re-stocked.	

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F 812	Continued From page 102 In the dry storage room, a can of corn on the 4 wheeled mobile can rack had a significant dent and a can of artichokes on a shelf had a significant dent on the seam. On interview the U.S. FOIA (b) agreed that the cans should have been placed in the designated dented can area, In the dessert and juice refrigerator the surveyors observed (5) trays of portioned controlled, in house poured juices designated for resident use. The juices had no dates. The U.S. FOIA (b) was asked if they should be labeled according to facility policy. The U.S. FOIA (b) replied, "Yes". In the walk-in freezer the surveyors observed (3) bags of unopened cauliflower and 1 bag of unopened yellow squash that had been removed from their original container. The cauliflower and squash had no dates. In the walk-in refrigerator the surveyors observed (7) bags of unopened lettuce on various shelves with a manufacturer's "best if used by date" of "2/22/24." The U.S. FOIA (b) stated, " We just got them in, they must have come in that way." When asked who was responsible for checking the food in, the U.S. FOIA (b) stated, "We are." In the prep refrigerator, the surveyors observed an unopened bag of lettuce with a "best if used by" date of "2/22/24", and an unopened bag of tortillas labeled received "2/1" and use by "2/18/24." The surveyors observed (2) air conditioners in the food prep area near the tray line. A finger swipe by the surveyor determined that the vents of the air conditioners were covered with a black,	F 812	Element 2: All residents had potential to be affected by the deficient practices. Element 3: Corporate Director of Food and Nutrition will in-service all dietary staff regarding food procurement, storage, and food hygiene. Signs have been posted in designated areas to reinforce procedures. Element 4: Food and Nutrition Services Director/designee will audit food storage areas for proper storage, expired foods, employees wearing hair nets, and cleanliness of the kitchen. Audits to occur daily x5, then weekly x4, and then monthly x3. Food and Nutrition Services Director will present findings of audits to Quality Assurance committee monthly. Responsible party: Food and Nutrition Services Director/designee	

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dust-like substance. When asked when they were last cleaned the [redacted] replied, "Every two weeks, it is on the cleaning schedule, and we haven't turned it on in two months."

On 02/29/2024 from 10:56 AM to 11:28 AM, the surveyors, accompanied by the [redacted] observed the following during a follow up visit to the kitchen: In the walk-in refrigerator the surveyors observed approximately 6-7 stacks of plastic crates which contained juices and milk. The 6-7 bottom crates were stored directly on the floor of the refrigerator and did meet the 6-inch requirement for food to be stored off the floor.

The surveyors observed the electrical outlet box behind the coffee machine and adjacent to the counter of the hot food holding/prep area. The box was covered in unidentified brown/grease-like debris. The backsplash of the coffee station was also covered in brown unidentified debris, as well as the water supply line.

At 11:06 AM, the surveyor observed a kitchen staff at the designated handwashing sink. Upon completion of hand-hygiene the staff attempted to grab a hand towel, however, the hand towel dispenser was empty. The staff walked to the dish washing room to obtain a hand towel at the designated hand washing sink. The hand towel dispenser was also empty. When asked who was responsible for ensuring that hand towels were sufficiently stocked, staff stated that the housekeeping department was responsible for stocking the hand towel dispensers.

On 03/04/2024 at 01:49 PM, during an interview with the surveyor, the [redacted]

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U.S. FOIA (b) (6) agreed, all foods should be labeled, there should be no expired food in kitchen, and hair nets should be worn to encompass all the hair.

A review of facility provided policy titled "USE BY DATE POLICY," last reviewed on 2/6/2023 revealed under POLICY:
"All food items that are thawed, prepared or removed from their original container will have an expiration date or use by date: To ensure the freshness of all items being served; To provide a universal system of identification of expiration dates."
It was also revealed under PROCEDURE: 2. "All kitchen staff will be in serviced on labeling procedures" and 4. "All items sent to floors and taken out of original containers, will have an expiration/ use by date."

A review of the facility provided policy titled "PERSONAL HYGIENE POLICY," last revised on 01/2023 revealed the following under POLICY:
"All employees are required to follow acceptable personal hygiene practices to ensure that food is prepared, stored, and distributed in safe and sanitary manner, preventing the spread of food borne illness. "It was also revealed under the heading PROCEDURE:
4. Employees must wear hair nets and beard restraint required by local and federal health codes. No hair ornaments are permitted unless function as hair restraint. "
The surveyor reviewed the facility policy titled Food Safety-Food Handling Policy; last date revised: 09/2021. The following was revealed under the heading POLICY:
"Food will be stored prepared, handled and served so that the risk of foodborne illness is

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F 812	Continued From page 105 minimized." The following was revealed under the heading PROCEDURE: 7. "All kitchen staff will be in serviced on labeling procedures. All prepared items stored in cooling units will be labeled and dated."A review of an undated facility provided kitchen cleaning schedule titled "Nutrition Services Cleaning Responsibilities and Schedule" did not reveal any "Cleaning Duty" for the (2) air conditioners. A "Cleaning Duty" for the Tea and Coffee Machine revealed it was to be cleaned daily by the AM aide. N.J.A.C. 18:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		4/1/24

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conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 107 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of other facility documentation, it was determined that the facility failed to: 1.) donn (put on) the appropriate personal protective equipment (PPE) prior to entering an NJ Exec Order 26.4b1 to prevent the NJ Exec Order 26.4b1 2.) maintain proper NJ Exec Order 26.4b1 control practices while performing NJ Exec Order 26.4b1 care and 3.) maintain proper NJ Exec Order 26.4b1 control practices during the dining observation. This deficient practice was identified for: 1.) 1 of 3 residents (Resident #645) on NJ Exec Order 26.4b1, 2.) 1 of 2 residents observed for NJ Exec Order 26.4b1 care (Resident #126), and 3.) 1 of 3 dining rooms observed for meals (first floor dining room). This deficient practice was evidenced by the following: 1. On 02/28/2024 at 12:33 PM, Surveyor #1 observed a NJ Exec Order 26.4b1 sign at Resident #645's doorway. Instructions on the sign included, but were not limited to: Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit.	F 880	Element 1: US FOIA (b)(6) who placed food in resident #645 room was in-serviced regarding NJ Exec Order 26.4b1 and hand hygiene. NJ Exec Order 26.4b1 to resident. LPN #2 and CNA #3 who provided/assisted with NJ Exec Order 26.4b1 care to resident #126 were in-serviced regarding NJ Exec Order 26.4b1 control. NJ Exec Order 26.4b1 to resident. Dietary aid #3 who failed to donn a mask was given a clean mask and donned correctly. Dietary aid received in-service regarding infection control and proper use of masks. Since 2/28/24, residents have been offered to clean their hands and perform hand hygiene before receiving food. Element 2: All residents on contact precautions had the potential to be affected by the deficient practice. All residents receiving wound care had the potential to be affected by the deficient practice.	

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F 880	Continued From page 108 On 03/04/2024 at 08:55 AM, Surveyor #1 observed a NJ Exec Order 26.4b1 sign at the doorway of Resident #645's room. The surveyor also observed the U.S. FOIA (b) (6) taking food into Resident 645's room without donning the proper PPE (equipment used to minimize exposure to hazards and illnesses) or performing hand hygiene prior to entering or upon exiting the room. The surveyor interviewed the U.S. FOIA (b) (6) as she exited the room and she stated that it was okay because she just put the tray down and came right out. She further stated that there was no need for hand hygiene or PPE. On 02/28/2024 at 01:36 PM, Surveyor #1 reviewed Resident #645's medical record which revealed physician orders for NJ Exec Order 26.4b1 to be administered NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 and an order for NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 A review of Resident #645's care plan with a focus area that included suspected/actual NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1. Interventions included, but were not limited to NJ Exec Order 26.4b1, apply gown and gloves before every room entry and remove them prior to exit. On 03/04/2024 at 10:00 AM, Surveyor #1 interviewed the U.S. FOIA (b) (6)) who stated that for contact isolation all the PPE was needed. She further stated that if staff was observed entering a room on NJ Exec Order 26.4b1	F 880	All residents had the potential to be affected by the deficient practice of not being offered to perform hand hygiene/ donning masks while serving food. Element 3: Facility Policies “Multiple drug resistant organisms”, “Transmission based precautions”, “Wound Care”, Infection prevention and control”, and “Hand hygiene” were reviewed by facility administration and determined to be in compliance. Facility IP to in-service all staff regarding the following areas: Infection control, donning and doffing, masks, hand hygiene, with the purpose of adherence to infection control practices. Element 4: Infection Preventionist/designee will perform infection control rounds, including observation of entering rooms on precautions, wound care treatments, donning and doffing, offering hand hygiene to residents before meals. Rounds to occur daily x7, then weekly x4, and then monthly. Findings of observations will be presented at Quality Assurance meeting monthly. Responsible party: Infection preventionist/ designee	

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without hand hygiene or PPE, the staff member would be wrong.

2. A review of Resident #126's admission record indicated that Resident #126 was admitted to the facility with diagnosis which included, but was not limited to, NJ Exec Order 26.4b1 [redacted]

A review of the Resident #126's most recent significant change Minimum Data Set (MDS), a comprehensive assessment tool, dated [redacted] indicated Resident #126 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating Resident #126 had NJ Exec Order 26.4b1 [redacted] and an NJ Exec Order 26.4b1 [redacted] which was being treated with [redacted] care, ointments/medications, and had a NJ Exec Order 26.4b1 for the bed and wheelchair.

A review of Residents #126's care plan included, but was not limited to; a care focus area for NJ Exec Order 26.4b1, resident has an [redacted] NJ Exec Order 26.4b1 [redacted].

A review of Resident #126's physician order summary (PO) included an order for [redacted] to be applied NJ Exec Order 26.4b1 [redacted] "

A review of the [redacted] treatment administration record (TAR) indicated the resident's [redacted] care was performed during day

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shift as ordered.

On 02/29/2024 from 2:02 PM to 3:28 PM, Surveyor #2, in the presence of a federal surveyor, observed License Practical Nurse (LPN #2) perform NJ Exec Order care for Resident #126. LPN #2 began the NJ Exec Order care treatment process by bringing the treatment cart containing the needed supplies to the hallway where Resident #126's room was located and placed it along the wall near the resident's room door.

At 2:35 PM, while gathering supplies including NJ Exec Order on a NJ Exec Order 26.4b1, LPN #2 stepped away from the treatment cart to the other side of the resident's room door to obtain clean disposable gloves from the box of gloves placed outside the resident's room door. She proceeded back to the treatment cart and placed the clean gloves under her left armpit while opening the new package of NJ Exec Order 26.4b1. She then donned (put on) the gloves and used them to gather the NJ Exec Order 26.4b1 intended to be used for the NJ Exec Order care treatment.

At 2:44 PM, LPN #2 entered the resident's room with her treatment supplies, along with a container of disinfectant wipes, marker, and spray bottle of antiseptic spray. She placed these three items on the windowsill as she cleaned and disinfected the tray table to place the clean NJ Exec Order care supplies on.

At 3:07 PM, while performing wound care, LPN #2 went to the room doorway and asked a third certified nursing assistant (CNA#3) to put on appropriate personal protective equipment, including but not limited to a disposable gown and gloves, and enter the room to assist with NJ Exec Order

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care. CNA #3 entered the room having donned clean gloves, with her gloved hands in her pants pockets. She then walked towards the [NJ Exec Order] care area and as she walked past the tray table with the clean wound care supplies, she grabbed the table along with the clean [NJ Exec Order 26.4b1] with the [NJ Exec Order] care supplies on it with both gloved hands that were in her pocket, to move it to a side in order to pass by to where she was needed.

At 3:19 PM, once completed with the wound care treatment, LPN #2 gathered the re-usable supplies that she had brought into the room, including a container of disinfectant wipes, a bottle of antiseptic [NJ Exec Order] spray, and a marker, and without disinfecting any of these items brought them back to the clean treatment cart. She placed the antiseptic spray bottle into the cart drawer and the disinfectant wipes and marker on top of the treatment cart.

At 3:28 PM, Surveyor #2 interviewed LPN #2, who confirmed she did not wipe or disinfect these reusable items prior to returning them to the treatment cart, stating "I should have wiped them down." Surveyor #2 inquired about placing the clean gloves under her armpit, to which LPN #2 stated, "I should not have done that."

On 03/01/2024 at 12:59 PM, in the presence of the survey team, Surveyor #2 interviewed the [U.S. FOIA (b) (6)] The [U.S.] stated it is not acceptable for staff to hold clean gloves under their armpit prior to use, or to have their clean gloved hands in their pockets prior to contact with resident care supplies. She stated this could cause risk of '[NJ Exec Order 26.4b1] " She continued to include that returning re-usable supplies from a resident's

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DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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room, particularly after [NJ Exec Order] care treatment, to a treatment cart without disinfecting is also not acceptable, and NJ Exec Order 26.4b1 [redacted]

3. On 02/27/2024 at 9:00 AM, when Surveyor #3 entered the the facility signage was noted on the interior entrance doors that instructed those who entered to "Mask Up in Resident Areas," "Masks should be worn in all resident areas regardless of vaccination status." The receptionist advised all who entered to donn (put on) a mask that were available at the reception desk and perform hand hygiene prior to check-in at the kiosk, where a touchless thermometer was in use.

On 02/27/2024 at 11:59 AM, Surveyor #3 observed dining services in the first floor dining room. Surveyor #3 observed Dietary Aide (DA #3) who failed to donn a mask and wore gloves as she served coffee to the residents. When interviewed, DA #3 stated that she had a mask in her pocket, and had forgotten to put it on prior to meal service. DA #3 declined to answer any further questions. The U.S. FOIA (b) (6) [redacted]) was present, and stated that masks were not required in the kitchen due to social distancing, but were required in the dining room. The [U.S. FOIA] provided DA #3 with a mask to wear at that time. A DA called out to the to the [U.S. FOIA] and asked if hand sanitizer was available to hand out to the residents who were already seated and were being served.

On 02/27/2024 at 12:14 PM, Surveyor #3 observed Resident #25 and an unsampled resident, who were seated at a table together. They both had already begun to eat their meal

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when the [U.S. FOIA (b) (6)] brought it to a [U.S. FOIA] attention that the residents had not received hand wipes. When interviewed, the unsampled resident stated that the facility did not normally provide hand wipes to the residents prior to meal service. The unsampled resident further stated that he/she washed their hands before they went to the dining room. The unsampled resident [NJ Exec Order 26.4b1] with the use of a [NJ Exec Orde] walker which was observed next to the resident's chair.

On 02/27/2024 12:28 PM, Surveyor #3 interviewed the [U.S. FOIA (b) (6)]) who stated that DA #3 was responsible for meal preparation and did not donn a mask prior to the meal service because she did not normally serve the residents. [U.S. FOIA] stated that it was his fault because there was a call out and he was supposed to serve the residents, but was busy speaking with someone in the kitchen.

On 02/28/2024 at 12:51 PM, Surveyor #3 interviewed the [U.S. FOIA (b) (6)]) regarding the facility masking policy. The [U.S.] stated that staff were supposed to wear masks in all patient areas. The [U.S.] stated the minute the dietary staff stepped out of the kitchen they should have had a mask on in order to keep germs to a minimum. The [U.S.] further stated that the facility was remained under [NJ Exec Order 26.4b] status for [NJ Exec Order 26.4b].

At that time, Surveyor #3 asked the [U.S.] to describe her expectation for hand hygiene during meal service. The [U.S.] stated that residents should have been offered to clean their hands before they received their food. The [U.S.] stated if a resident used a [NJ Exec Orde] walker for [NJ Exec Order 26.4b1] hand hygiene was essential to keep germs to a

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minimum. The U.S. stated that staff were required to perform hand hygiene with hand sanitizer or wipes before they served food and before they fed residents. The U.S. stated that gloves should not have been worn in the dining room. The U.S. stated that if gloves were worn, then the staff would have to doff (remove) their gloves and clean their hands, then donn new gloves in between each resident served.

On 03/01/2024 at 11:41 AM, Surveyor #3 interviewed the U.S. FOIA (b) (6)) who stated that all residents should be offered hand hygiene upon entry to the main dining room. The U.S. FOIA (b) stated that if not offered, the resident's ended up eating with dirty hands. The U.S. FOIA (b) further stated that it was an infection control issue if hand hygiene were not offered before the meal.

At that time, the U.S. FOIA (b) stated that it was not appropriate for staff to wear the same gloves when they touched different people's plates of food. The U.S. FOIA (b) stated that everyone should perform hand hygiene between residents. The U.S. FOIA (b) stated that the facility did not encourage anyone to wear gloves when trays were passed to the residents.

On 03/04/2024 at 11:10 AM, Surveyor #3 interviewed the U.S. FOIA (b) (6)) who stated that dining room staff were required to wear masks in resident areas in order to protect the residents. The U.S. FOIA stated that gloves should not be worn during meal service for infection control reasons. The U.S. FOIA stated that staff should wash their hands every two to three residents and use hand sanitizer as well. The U.S. FOIA stated that residents should be offered a towelette on entry

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or at the table as long as it was prior to eating because they could have touched high touch areas and that was an infection control issue. The [U.S. FOIA] stated that masking had been in place since the [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1] occurred and remained in place for [NJ Exec Order 26.4b1] after.

A review of a facility policy titled, " Multiple Drug Resistant Organisms (MDROs)", with revised date of 12/4/2023, indicated "Contact precautions will be implemented for residents with MDROs when secretions, excretions or drainage CANNOT be contained ..."

A review of a facility policy titled, "Transmission Based Precautions", with revised date of 5/18/2023, indicated under Contact Precautions: Number two Upon entering the room of a resident in contact precautions, healthcare personnel and visitors should don a gown and gloves. Number three Prior to leaving the room of a resident in contact precautions, healthcare personnel and visitors should doff personal protective equipment and perform hand hygiene.

Review of the facility's "Wound Care" policy with revised date 10/2022, included but was not limited to, "wipe reusable supplies with alcohol as indicated (I.e., outsides of containers that were touched by unclean hands, scissor blades, etc.) Return reusable supplies to resident's drawer in treatment cart."

Review of the facility's "Infection Prevention and Control" policy with revised date 4/26/2023 included but was not limited to, "this facility follows infection prevention and control policies, procedures, and practices intended to maintain a safe, sanitary, and comfortable environment while

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helping to prevent the development and transmission of communicable diseases and infections. This facility follows standards of practice in regards to infection prevention and control as outlined and recommended by the Centers for Disease Control and Prevention, Occupational Health and Safety Administration, and/or state specific infection prevention and control guidance.

A review of a facility policy titled, Hand Hygiene (Policy No: C-IC-6) (Current Revision Date: 05-18-23) revealed the following: The facility adheres to recommendations by the CDC (Centers for Disease Control) for the practice of hand hygiene in accordance with standard and transmission-based precautions.
Hand Hygiene is performed as [sic.] a minimum at these times: ...Before and after contact with the resident;...Before meals...
Residents are assisted with and/or reminded to perform hand hygiene...before meals, and as needed or requested...

NJAC 8:39-19.4(a); 27.1(a)

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S 000	Initial Comments A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	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 # NJ00171057 Based on interview and review of the Nurse Staffing Report and Payroll Based Journal (PBJ) Staffing Data Report, it was determined that the facility failed to ensure to have sufficient nursing staff on a 24-hour basis to provide nursing care to the residents. This deficient practice was evidenced by following: On 02/28/2024 at 10:30 AM surveyor #2 held a resident council meeting with 10 to 11 residents. Regarding the call bells, all in the group said the wait time was from 2 hours to 4.5 hours waiting for call bell to be answered, especially on evenings and night shift. They further stated, "weekends horrible". 5 of 5 residents stated the delay in call bell response time caused a [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1] episode. On 02/28/2024 at 12:05 PM surveyor #1 met with Resident #171 who stated that s/he constantly hears people calling for help. S/he further stated that s/he hears call bells ringing for long periods	S 560	Element 1: 10 of 11 residents from aforementioned resident council were spoken with regarding call bell response time to receive feedback of current response time. (residents agreed to assist facility with feedback regarding response time) Facility implemented call bell audits (3/1/24?) in order to facilitate faster response time with in reason. Element 2: All residents had potential to be affected by the deficient practice. Element 3: Facility has posted additional advertisements in order to find more CNAs. In addition, facility has offered sign	4/1/24

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

Electronically Signed | 03/19/24

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S 560	Continued From page 1 of time. S/he thinks that NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 at the facility. Resident #171 further stated his opinion is that the staff is NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and that nurses are always doing doubles. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 03/12/2023 to 03/18/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows: -03/12/23 had 11 CNAs for 189 residents on the day shift, required at least 24 CNAs.	S 560	on bonuses, bonuses for picking up additional shifts, and sought assistance from nursing agencies to bring on additional staff. Staff educator to provide education regarding call bell response times, adequate staffing par levels, and notification to US FOIA (b)(6) in the event that staffing levels are not met. Education to also include ensuring resident needs are met. Element 4: The Administrator and DON will audit schedules to ensure direct care staff to resident ratio requirement is met. Audits will be completed weekly x 4 weeks and monthly until compliance is met. The results of these audits will be presented at monthly QAPI. The Administrator and DON are responsible for execution and monitoring of this POC.	

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S 560	Continued From page 2 -03/12/23 had 17 total staff for 189 residents on the evening shift, required at least 19 total staff. -03/13/23 had 13 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/14/23 had 21 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/15/23 had 20 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/16/23 had 23 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/17/23 had 19 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/18/23 had 17 CNAs for 194 residents on the day shift, required at least 24 CNAs. 2. For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 2 of 7 evening shifts, and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -11/12/23 had 9 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/12/23 had 18 total staff for 199 residents on the evening shift, required at least 20 total staff. -11/13/23 had 18 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/14/23 had 21 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/15/23 had 24 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/15/23 had 13 total staff for 199 residents on the overnight shift, required at least 14 total staff. -11/16/23 had 19 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/17/23 had 21 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/18/23 had 18 CNAs for 199 residents on the day shift, required at least 25 CNAs.	S 560		

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-11/18/23 had 18 total staff for 199 residents on the evening shift, required at least 20 total staff.
-11/18/23 had 13 total staff for 199 residents on the overnight shift, required at least 14 total staff.

3. For the week of Complaint staffing from 12/10/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 2 of 7 evening shifts, deficient in CNAs to total staff on 1 of 7 evening shifts, and deficient in total staff for residents on 6 of 7 overnight shifts as follows:

-12/10/23 had 12 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/10/23 had 16 total staff for 198 residents on the evening shift, required at least 20 total staff.
-12/10/23 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.
-12/10/23 had 13 total staff for 198 residents on the overnight shift, required at least 14 total staff.
-12/11/23 had 16 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/12/23 had 15 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/12/23 had 13 total staff for 198 residents on the overnight shift, required at least 14 total staff.
-12/13/23 had 23 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/13/23 had 11 total staff for 198 residents on the overnight shift, required at least 14 total staff.
-12/14/23 had 22 CNAs for 198 residents on the day shift, required at least 25 CNAs.
-12/14/23 had 13 total staff for 198 residents on the overnight shift, required at least 14 total staff.
-12/15/23 had 19 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-12/15/23 had 19 total staff for 199 residents on the evening shift, required at least 20 total staff.
-12/15/23 had 12 total staff for 199 residents on

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the overnight shift, required at least 14 total staff.
-12/16/23 had 18 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-12/16/23 had 11 total staff for 199 residents on the overnight shift, required at least 14 total staff.

4. For the 3 weeks of Complaint staffing from 01/21/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 14 of 21 day shifts, deficient in total staff for residents on 2 of 21 evening shifts, deficient in CNAs to total staff on 1 of 21 evening shifts, and deficient in total staff for residents on 12 of 21 overnight shifts as follows:

-01/21/24 had 12 CNAs for 190 residents on the day shift, required at least 24 CNAs.
-01/21/24 had 13 total staff for 190 residents on the overnight shift, required at least 14 total staff.
-01/22/24 had 11 CNAs for 190 residents on the day shift, required at least 24 CNAs.
-01/22/24 had 9 CNAs to 21 total staff on the evening shift, required at least 10 CNAs.
-01/22/24 had 12 total staff for 190 residents on the overnight shift, required at least 14 total staff.
-01/23/24 had 16 CNAs for 190 residents on the day shift, required at least 24 CNAs.
-01/24/24 had 22 CNAs for 190 residents on the day shift, required at least 24 CNAs.
-01/25/24 had 22 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-01/25/24 had 12 total staff for 192 residents on the overnight shift, required at least 14 total staff.
-01/26/24 had 20 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-01/26/24 had 11 total staff for 189 residents on the overnight shift, required at least 13 total staff.
-01/27/24 had 22 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-01/28/24 had 8 CNAs for 188 residents on the

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day shift, required at least 23 CNAs.
-01/28/24 had 9 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-01/29/24 had 12 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/29/24 had 11 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-01/30/24 had 16 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/30/24 had 11 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-02/01/24 had 13 total staff for 192 residents on the overnight shift, required at least 14 total staff.
-02/03/24 had 19 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-02/03/24 had 11 total staff for 192 residents on the overnight shift, required at least 14 total staff.
-02/04/24 had 12 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-02/04/24 had 17 total staff for 192 residents on the evening shift, required at least 19 total staff.
-02/04/24 had 11 total staff for 192 residents on the overnight shift, required at least 14 total staff.
-02/05/24 had 16 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-02/06/24 had 18 CNAs for 191 residents on the day shift, required at least 24 CNAs.
-02/08/24 had 16 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-02/09/24 had 17 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-02/09/24 had 12 total staff for 189 residents on the overnight shift, required at least 13 total staff.
-02/10/24 had 12 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-02/10/24 had 18 total staff for 189 residents on the evening shift, required at least 19 total staff.
-02/10/24 had 10 total staff for 189 residents on the overnight shift, required at least 13 total staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060804	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEA	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

(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 6	S 560		

5. For the 2 weeks of staffing prior to survey from 02/11/2024 to 02/24/24, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 3 of 14 evening shifts, deficient in CNAs to total staff on 2 of 14 evening shifts, and deficient in total staff for residents on 12 of 14 overnight shifts as follows:

02/11/24 had 14 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-02/11/24 had 18 total staff for 189 residents on the evening shift, required at least 19 total staff.
-02/11/24 had 10 total staff for 189 residents on the overnight shift, required at least 13 total staff.
-02/12/24 had 15 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-02/13/24 had 22 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-02/13/24 had 12 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-02/14/24 had 22 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-02/15/24 had 19 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-02/15/24 had 12 total staff for 188 residents on the overnight shift, required at least 13 total staff.
-02/16/24 had 21 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/16/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/17/24 had 15 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/17/24 had 11 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/18/24 had 12 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/18/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/19/24 had 18 CNAs for 195 residents on the

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	060804	A. BUILDING: _____ B. WING _____	C 03/05/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 7	S 560		

day shift, required at least 24 CNAs.
-02/19/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/20/24 had 13 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/20/24 had 10 total staff for 195 residents on the day shift, required at least 14 total staff.
-02/21/24 had 19 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/21/24 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs.
-02/21/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/22/24 had 20 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-02/22/24 had 18 total staff for 195 residents on the evening shift, required at least 19 total staff.
-02/22/24 had 12 total staff for 195 residents on the overnight shift, required at least 14 total staff.
-02/23/24 had 19 CNAs for 207 residents on the day shift, required at least 26 CNAs.
-02/23/24 had 10 CNAs to 22 total staff on the evening shift, required at least 11 CNAs.
-02/23/24 had 11 total staff for 207 residents on the overnight shift, required at least 15 total staff.
-02/24/24 had 11 CNAs for 207 residents on the day shift, required at least 26 CNAs.
-02/24/24 had 19 total staff for 207 residents on the evening shift, required at least 21 total staff.
-02/24/24 had 9 total staff doe 207 residents on the overnight shift, required at least 15 total staff.

On 03/04/24 at 10:47 AM surveyor #1 interviewed staffing coordinator who stated the CNA ratios of 1 to 8 on day shift, 1 to 10 on evening shift, and 1 to 14 on night shift. She also stated that one LPN on each hall is ideal for 7-3 and 3-11 shifts. She also stated the facility has a 3-11 supervisor Monday through Friday and that day shift has Unit Managers also Monday through Friday. She

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S 560	Continued From page 8 stated that on the 11-7 shift they staff four nurses (2 upstairs and 2 downstairs) and a RN supervisor. On 03/05/24 at 09:28 AM surveyor #1 interviewed DON regarding minimum staffing. She stated that the facility is separated into 4 units, 1A/1B, 1C/1D, 2A/2B, and 2C/2D. During the day shift Monday through Friday there should be eight to nine nurses in addition to four unit managers, on the evening shift eight nurses plus one supervisor, and on the night shift four nurses plus one supervisor. On the weekend day shift there should be eight nurses and one supervisor. She also stated that there should be four CNAs on each unit on each shift. She also stated that the shortage is all over and the management staff come in when needed to fill in; however, payroll will not show that expectations are met and will show staffing below the minimum required. Review of policy "Staffing Hours" revised 04/2023, provided by facility on 03/04/2024 includes: 1. Our facility maintains adequate staffing on each shift to ensure that our residents needs and services are met. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outline on the resident's comprehensive care plan. NJAC 8:39-5.1(a), 25.2 (b), 27.1 (a)	S 560		
S 830	8:39-9.3(b) Mandatory Administration (b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental	S 830		4/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 830	Continued From page 9 health, emotionally stable, of good moral character, and are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to obtain reference checks for 10 of 10 new employee records reviewed. This deficient practice was evidenced by the following: The surveyor reviewed human resource (HR) files for ten new employees on NJ Exec Order 26.4b1. Employee 1's date of hire was NJ Exec Order 26.4b1 Employee 2's date of hire was NJ Exec Order 26.4b1 Employee 3's date of hire was NJNJ Exec Order 26.4b1 Employee 4's date of hire was NJ Exec Order 26.4b1 Employee 5's date of hire was NJ Exec Order 26.4b1	S 830	Element 1: 10 of 10 employees whose references were not checked and are still employed by the facility had their references checked between NJ Exec Order 26.4b1 (who were the employees, place into files) Element 2: All residents had potential to be affected by deficient practice. Element 3: Education to be provided by regional administrator to Human Resources	

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S 830	Continued From page 10 Employee 6's date of hire was NJ Exec Order 26.4b1 Employee 7's date of hire was NJ Exec Order 26.4b1 Employee 8's date of hire was NJ Exec Order 26.4b1 Employee 9's date of hire was NJ Exec Order 26.4b1 Employee 10's date of hire was NJ Exec Order 26.4b1 No reference checks were found in any of the above employee files. On 03/04/2024 at 10:24 AM the surveyor interviewed Human Resources who stated that she hasn't seen any references. The Licensed Nursing Home Administrator (LNHA) came into the interview and stated, "we do reference checks". He further stated he would get them for surveyor review. On 03/04/2024 at 02:32 PM the surveyor reminded the LNHA about the reference checks. He stated that he checked with Human Resources about reference checks and will get back to the surveyor. No further information was provided to the surveyor. N.J.A.C. 8:39-9.3(b)	S 830	regarding obtaining reference checks before hire. Element 4: Reference check was added to the list of requirements for HR to have before an employee begins working at the facility. Audit to be conducted weekly x4 of all new hires in that week to ensure reference checks were completed. Afterwards, audit to be conducted monthly- on going. Findings of audit to be presented at monthly QAPI. Responsible Party: HR/Designee	

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)
315174	A. Building B. Wing	4/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0004 Reg. # 483.73(a) LSC	Correction Completed 04/01/2024	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 3/5/2024	☐ 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)
315174	A. Building B. Wing	4/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 04/01/2024	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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/5/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315174 Y1	A. Building B. Wing Y2	4/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0577	Correction	ID Prefix F0583	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(10)(11)	Completed	Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024
ID Prefix F0584	Correction	ID Prefix F0585	Correction	ID Prefix F0645	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.20(k)(1)-(3)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024
ID Prefix F0656	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024
ID Prefix F0688	Correction	ID Prefix F0690	Correction	ID Prefix F0695	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024
ID Prefix F0725	Correction	ID Prefix F0728	Correction	ID Prefix F0755	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.35(d)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315174 Y1	A. Building B. Wing Y2	4/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0761	Correction	ID Prefix F0803	Correction	ID Prefix F0804	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(c)(1)-(7)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024
ID Prefix F0806	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.60(d)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/01/2024	LSC	04/01/2024	LSC	04/01/2024

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/5/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060804	A. Building B. Wing	4/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/01/2024	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
3/5/2024

☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060804 Y1	A. Building B. Wing Y2	4/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/01/2024	ID Prefix S0830 Reg. # 8:39-9.3(b) LSC	Correction Completed 04/01/2024	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

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FOLLOWUP TO SURVEY COMPLETED ON	
3/5/2024	☐ 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
	315174	A. BUILDING **01** B. WING _____	C **03/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	**1511 CLEMENTS BRIDGE RD** **DEPTFORD, NJ 08096**

(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 02/27/2024 and 02/28/2024 Deptford Center for Rehabilitation and Healthcare 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. Deptford Center for Rehabilitation and Healthcare is a two story, the origional building was built in January 1978 of Type I Fire Resistant construction. The building had an addition to the existing building in 1983 withType I Fire Resistant construction. The facility is divided into 12 smoke zones. The facility has a 85 KW Natural Gas Emergency Generatot.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 02/27/2024 and 02/28/2024, in the presence of facility management it was determined that the facility	K 281	Element 1: Maintenance director installed lighting fixtures to place by the three exit discharge doors which did not have	4/1/24

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

Electronically Signed | 03/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING **01** B. WING _____	C **03/05/2024**

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K 281	Continued From page 1 failed to ensure that all means of egress were provided with continuous lighting with two lamps for 3 of 10 exit discharge doors in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. This deficient practice was evidenced by the following: On 02/27/2024 (day one of survey) during the survey entrance at approximately 9:27 AM, a request was made to the U.S. 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 two-story (2) building with ten (10) designated exit discharge doors (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 9:39 AM on 02/27/2024 and continued on 02/28/2024, in the presence of the facility's U.S. FOI the surveyor inspected outside of the building of 10 designated exit discharge doors for continuous emergency lighting and observed the following, On 02/28/2024: 1) At approximately 10:35 AM, the surveyor observed outside of the designated (illuminated exit sign) first floor "A-Wing" stairwell discharge door a one single bulb light fixture. There was no supplemental light to ensure area is illuminated should the single bulb or single bulb light fixture failed.	K 281	continuous lighting with two lamps: First floor A wing stairwell discharge door, first floor center stairwell exit, and at the stairwell that leads into the residents outside smoking area. Lighting was installed on 3/14/2024. Element 2: All residents had potential to be affected by this deficient practice. Element 3: US FOIA (b)(6) in-serviced on NFPA-101 (National Fire Protection Association) pertaining to illumination of means of egress. Routine maintenance rounds to be conducted weekly-focused on fire safety. Element 4: Facility Director of Maintenance will audit illumination by means of egress for exit discharge doors daily x7, then weekly x4, and then monthly x3. Findings of Audit to be presented at Quality Assurance meeting monthly. Responsible Party: Director of Maintenance/designee	

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K 281	Continued From page 2 2) At approximately 11:04 AM, the surveyor observed outside of the designated (illuminated exit sign) first floor "Center" stairwell exit discharge door a one single bulb light fixture. There was no supplemental light to ensure area is illuminated should the single bulb or single bulb light fixture failed. 3) At approximately 11:44 AM, the surveyor observed outside of the designated (illuminated exit sign) stairwell that leads into the Residents outside smoking area had no evidence of emergency lighting. At that time the surveyor asked the [redacted] do you see any lights outside of the door. The [redacted] looked and said, no. There was no supplemental light to ensure area is illuminated. The [redacted] confirmed the findings at the times of observations. The [redacted] was informed of the Life Safety Code deficiency during the survey exit on 02/28/2024 at approximately 1:48 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281		
K 311 SS=D	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	K 311		4/1/24

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K 311	Continued From page 3 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 02/27/2024 and 02/28/2024, in the presence of facility Management it was determined that the facility failed to ensure that 1 of 14 exit access stairwell doors tested, were capable of maintaining the 2 hour fire rated construction. This is evidenced by the following, On 02/27/2024 (day one of survey) during the survey entrance at approximately 9:27 AM, a request was made to the U.S. 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 two-story (2) building. There are six (6) exit stairwells 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 9:39 AM on 02/27/2024, and continued on 02/28/2024, in the presence of the facility's U.S. FOI a tour of the building was conducted. Along the two (2) day tour, the surveyor inspected and conducted closure test of fourteen (14) exit access doors leading into exit stairwells with the following results,	K 311	Element 1: A new 2-hour fire rated door was installed at the stairwell door in the basement. Element 2: All residents had potential to be affected by the deficient practice. Element 3: US FOIA (b)(6) in-serviced on NFPA-101 (National Fire Protection Association) pertaining to vertical openings-enclosures and fire ratings. Routine maintenance rounds conduced weekly-focused on fire safety. Element 4: Facility Director of Maintenance will audit fire rated door daily x7, then weekly x4, then monthly x3. Findings of Audit to be presented at Quality Assurance meeting monthly. Responsible Party: Director of Maintenance/designee	

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K 311	Continued From page 4 On 02/27/2024: 1) At approximately 9:45 AM, when the surveyor tested the Basement level center stairwell door (near the Housekeeping Manager's office), the surveyor observed that the wooden veneer of the door (on both sides) were breaking apart form the frame, exposing the inside material and did not maintain the fire rating of the door. 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 facility U.S. FO confirmed the finding at the time of the observation. The U.S. FOIA (b) (6) was informed of the Life Safety Code deficiency during the survey exit on 02/28/2024 at approximately 1:48 PM. Fire Safety Hazard. Life Safety Code 101, 2012 Edition NJAC 8:39- 31.2(e)	K 311		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K 321		4/1/24

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K 321	Continued From page 5 Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 02/27/2024 and 02/28/2024, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 02/27/2024 (day one of survey) during the survey entrance at approximately 9:27 AM, a request was made to the U.S. FOIA (b) (6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.	K 321	Element 1: Director of Maintenance fixed the 1/4 inch gap in the corridor fire rated double doors which did not meet the edge. Element 2: All residents had potential to be affected by the deficient practice. Element 3: US FOIA (b)(6) [redacted] in-serviced on NFPA-101 (National Fire Protection Association) pertaining to hazardous areas-enclosures. Routine maintenance rounds conduced weekly-focused on fire safety. Element 4: Facility Director of Maintenance will audit fire rated doors to hazardous areas to ensure hazardous areas were separated	

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K 321	Continued From page 6 A review of the facility provided lay-out identified the facility is a two-story (2) building with a basement. Starting at approximately 9:39 AM on 02/27/2024 and continued on 02/28/2024, in the presence of the facility's U.S. FOI an inspection tour of the building was conducted. During the two (2) day building tour the surveyor observed the following hazardous area that failed to have smoke resisting doors, On 02/27/2024: 1) At approximately 10:02 AM, during an inspection of the basement level commercial laundry room when the corridor double doors were opened to a 90 degree opening and allowed to self-close into the frame, one door did not close into its frame. The surveyor observed and recorded a 1/4" gap between the meeting edges. This closure test was repeated two additional times with the same results. With this corridor doors not smoke resistant, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The Commercial Laundry room was larger than 100 square feet. A review of an emergency evacuation diagram posted on the corridor wall identified to pass the commercial laundry room is the primary and/ or secondary exit access to reach an exit. The facility U.S. FO confirmed the finding at the time of the observation. The U.S. FOIA (b) (6) was informed of the Life Safety Code deficiency during the survey exit on	K 321	by smoke resisting partitions in accordance with NFPA-101 National Fire Protection Association) daily x7, then weekly x4, then monthly x3. Findings of Audit to be presented at Quality Assurance meeting monthly. Responsible Party: Director of Maintenance/designee.	

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K 321	Continued From page 7 02/28/2024 at approximately 1:48 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		4/1/24

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K 363	Continued From page 8 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 02/27/2024 and 02/28/2024, in the presence of facility management, it was determined that the facility failed to ensure that 5 of 38 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was evidenced by the following, On 02/27/2024 (day one of survey) during the survey entrance at approximately 9:27 AM, a request was made to the U.S. 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 two-story (2) building with a basement. There are 120 Resident sleeping rooms and common areas that Residents and Visitors could use. Starting at approximately 9:39 AM on 02/27/2024 and continued on 02/28/2024, in the presence of the facility's U.S. FOI an inspection tour of the building was conducted. During the two (2) day tour of the facility the	K 363	Element 1: Director of Maintenance fixed edges of the five corridor doors which did not resist the passage of smoke. Door 1: Housekeeping managers office 1-1/4 inch gap Door 2: Basement level storage room 1-1/4 inch gap Door 3: Basement level men's bathroom door 3/8 inch gap Door 4: Basement level hose room 2-1/2 inch gap Door 5: First floor resident dining room double corridor doors 1/4 inch gap Element 2: All residents had potential to be affected by the deficient practice. Element 3: US FOIA (b)(6) in-serviced on NFPA-101 (National Fire Protection Association) pertaining to doors resisting fire/gaps in edges	

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K 363	Continued From page 9 surveyor performed closure tests of the thirty-eight (38) doors in the corridors with the following results, On 02/27/2024: 1) At approximately 9:41 AM, during a closure test of the Basement level Housekeeping Manager's office door the surveyor observed, measured and recorded a 1-1/4 inch gap along the door's bottom edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 9:44 AM, during a closure test of the Basement level storage room (next to the Housekeeping Manager's office) door the surveyor observed, measured and recorded a 1-1/4 inch gap along the door's bottom edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 3) At approximately 9:56 AM, during a closure test of the Basement level Men's bathroom door the surveyor observed, measured and recorded a 3/8 inch gap along the door's top edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 4) At approximately 10:17 AM, a closure test of the Basement level "Hose Room" door was performed. The door did not positive latch into its frame and opened. The surveyor observed, measured and recorded a 2-1/2 inch gap between the door and the door's frame. This test was repeated two additional times with	K 363	Routine maintenance rounds conduced weekly-focused on fire safety. Element 4: Facility Director of Maintenance will audit fire rated doors ensure there are no gaps in edges which would allow for fire/smoke, in accordance with NFPA-101 National Fire Protection Association) daily x7, then weekly x4, then monthly x3. Findings of Audit to be presented at Quality Assurance meeting monthly. Responsible Party: Director of Maintenance/designee	

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K 363	Continued From page 10 the same results. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an Emergency Evacuation diagram posted in the corridor identified to pass these room would be the primary and /or secondary exit access route to reach an exit. On 02/28/2024: 5) At approximately 11:32 AM, during a closure test of the first floor Resident Dining room double corridor doors, the surveyor observed, measured and recorded a 1/4 opening between the double doors meeting edges. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an Emergency Evacuation diagram posted in the corridor identified to pass the dining room is the primary and /or secondary exit access route to reach an exit. The facility [U.S. FC] confirmed the findings at the time of the observations. The [NJ Ex Order 26.4b1] was informed of the Life Safety Code deficiency during the survey exit on 02/28/2024 at approximately 1:48 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 374		4/1/24

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K 374	Continued From page 11 Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 02/27/2024 and 02/28/2024, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire and smoke protection. This deficient practice was identified for 1 of 10 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 02/27/2024 (day one of survey) during the survey entrance at approximately 9:27 AM, a request was made to the U.S. FOIA (b) (6) to provide a copy of the facility lay-out which	K 374	Element 1: Director of Maintenance installed a sweep on the bottom of the A-wing unit doors in order to maintain smoke barrier and not allow for the transfer of smoke when completely closed. Element 2: All residents had potential to be affected by the deficient practice Element 3: US FOIA (b)(6) in-serviced on NFPA-101 (National Fire Protection Association) pertaining to Subdivision of building space- smoke barrier doors Routine maintenance rounds conduced weekly-focused on fire safety. Element 4:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING **01** B. WING _____	C **03/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	**1511 CLEMENTS BRIDGE RD** **DEPTFORD, NJ 08096**

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K 374	Continued From page 12 identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with 6 smoke zones on the first floor and 6 smoke zones on the second floor. There are 120 Resident sleeping rooms and common areas that Residents and Visitors could use. Starting at approximately 9:39 AM on 02/27/2024 and continued on 02/28/2024, in the presence of the facility's U.S. FOI an inspection tour of the building was conducted. During the two (2) day tour of the facility the surveyor performed closure tests of the twelve (12) sets of double smoke doors in the corridors with the following results, On 02/28/2024: 1) At approximately 10:29 AM, during a closure test of the double smoke doors leading into the "A-Wing Unit" , when the doors were release from the magnetic hold open device and allowed to self close into their frame. The surveyor observed and measure a one (1) inch gap along the doors bottom edge. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The U.S. FO confirmed the findings at the time of observation. The U.S. FOIA (b) (6) was informed of the Life Safety Code deficiency during the survey exit on	K 374	Facility Director of Maintenance will audit fire rated doors to ensure there are no gaps which would allow for fire/smoke, in accordance with NFPA-101 National Fire Protection Association) daily x7, then weekly x4, then monthly x3. Findings of Audit to be presented at Quality Assurance meeting monthly. Responsible Party: Director of Maintenance/designee	

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	315174	A. BUILDING **01** B. WING _____	C **03/05/2024**

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K 374	Continued From page 13 02/28/2024 at approximately 1:48 PM. Life Safety Code 101, 2012 Edition. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of facility provided documentation on 02/27/2024 and 02/28/2024, in the presence of facility management it was determined that the facility failed to: 1) Maintain emergency communications in proper working condition for 2 of 2 elevators tested, in accordance with ASME/ANSI A17.3. and 2) Test and inspect the elevator's annually with the New Jersey	K 531	Element 1: Director of Maintenance contacted elevator vendor who fixed the phone lines in elevators #1 and #2. All invoices paid to the State for inspection re-certifications. State re-inspection scheduling in progress, with confirmation from State representative, for elevator inspection recertification.	4/1/24

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K 531	Continued From page 14 Department of Community Affairs Division of Codes and Standards Elevator Safety Division and/or AHJ. This deficient practice was evidenced by the following: On 02/27/2024 (day one of survey) during the survey entrance at approximately 9:27 AM, a request was made to the facility's U.S. FOIA (b) (6) how many elevators are in the building. The U.S. FO told the surveyor that there are two (2) elevators. The surveyor also requested to have all mandatory inspections from 01/01/2022 through 02/26/2024 for review later. Starting at approximately 9:39 AM on 02/27/2024 and continued on 02/28/2024, in the presence of the facility's U.S. FOI an inspection tour of the building was conducted. During the two day building tour the surveyor observed the following: On 02/27/2024 at approximately 10:27 AM,, a test of elevator #1 emergency communication telephone was performed. When the surveyor pressed the button for the emergency communication phone it did not function properly, the emergency communication phone did not have a pre-recorded message and the person who had answered the phone did not respond when the surveyor asked "Do you know where I am at." The person and hung up. This test was repeated two additional times with the same results. Later at approximately 12:20 PM, a second test of elevator #1 emergency communication telephone was performed. When the surveyor pressed the	K 531	Element 2: All residents had potential to be affected by the deficient practice. Element 3: US FOIA (b)(6) in-serviced on NFPA-101 (National Fire Protection Association) pertaining to elevators-maintaining emergency communications in proper working condition, and testing and inspecting the elevator annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division and/or AHJ. Routine maintenance rounds conduced weekly- elevator safety. Element 4: Facility Director of Maintenance will audit the elevators to ensure emergency communication is functioning properly, in accordance with NFPA-101 National Fire Protection Association) daily x7, then weekly x4, then monthly x3. Findings of Audit to be presented at Quality Assurance meeting monthly. Facility Director of Maintenance will audit the elevators to ensure inspection certificates are up to date and available. Audits to occur quarterly and presented at Quality Assurance meeting quarterly. Responsible Party: Director of maintenance/designee	

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	315174	A. BUILDING **01** B. WING _____	C **03/05/2024**

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K 531	Continued From page 15 button for the emergency communication phone it did not function properly, there was no answer to the call. At approximately 12:50 PM, a review of the facility's elevator inspection certificate's, revealed that 2 of 2 elevator devices #1 and #2, were last inspected 01/10/2022 and were good for use until 09/30/2022. The annual elevator inspection was conducted by the authority having jurisdiction (AHJ) and was greater than 1 year 5 months overdue. On 02/28/2024 at approximately 1:10 PM, a test of elevator #2 emergency communication telephone was performed. When the surveyor pressed the button for the emergency communication phone it did not function properly, the emergency communication phone did not dial to anyone. The facility U.S. FO confirmed the findings at the time of the observations. The U.S. FOIA (b) (6) was informed of the Life Safety Code deficiency during the survey exit on 02/28/2024 at approximately 1:48 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3 NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that	K 911		4/1/24

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K 911	Continued From page 16 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 02/27/2024 and 02/28/2024, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 14 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, 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	K 911	Element 1: Director of Maintenance had the outlet on the 2nd floor D-wing residents shower room, removed. Element 2: All residents had potential to be affected by the deficient practice. Element 3: US FOIA (b)(6) in-serviced on NFPA-101 (National Fire Protection Association) pertaining to electrical systems- electrical outlets located next to a water source (within 6 feet) requiring a Ground-fault circuit interrupter protection. Routine maintenance rounds conduced weekly-focused electric systems. Element 4: Facility Director of Maintenance will audit electrical outlets located near water sources(within 6 feet), to ensure they are equipped with Ground-fault circuit interrupter protection in accordance with NFPA-101 National Fire Protection Association) daily x7, then weekly x4, then monthly x3. Findings of Audit to be presented at	

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K 911	Continued From page 17 1.8 M (6 feet) of the outside of a sink. On 02/27/2024 (day one of survey) during the survey entrance at approximately 9:27 AM, a request was made to the U.S. FOIA (b) (6) [redacted] 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 two-story (2) building. There are 120 Resident sleeping rooms and common areas that Residents and Visitors could use. Starting at approximately 9:39 AM on 02/27/2024 and continued on 02/28/2024, in the presence of the facility's U.S. FOI [redacted] a tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested fourteen (14) electrical outlets in wet (with-in 6 feet of a sink) locations with one (1)electrical outlet that failed to de-energize when tested in the following location, On 02/27/2024: 1. At approximately 11:46 AM, the surveyor observed, measured and recorded in the 2nd floor "D-Wing" Residents shower room, one (1) Duplex electrical outlet located 5 feet 8 inches to the left of the sink 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 U.S. FO [redacted] confirmed the finding at the time of the observation.	K 911	Quality Assurance meeting monthly. Audits to occur quarterly and presented at Quality Assurance meetings. Responsible Party: Director of Maintenance/designee	

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K 911	Continued From page 18 The U.S. FOIA (b) (6) was informed of the Life Safety Code deficiency during the survey exit on 02/28/2024 at approximately 1:48 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315174 Y1	A. Building 01 - GREENBRIAR EAST HCC B. Wing Y2	4/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	04/01/2024	LSC K0311	04/01/2024	LSC K0321	04/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	04/01/2024	LSC K0374	04/01/2024	LSC K0531	04/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	04/01/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO