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	315094	A. BUILDING _____ B. WING _____	C 10/16/2023

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COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

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F 000	INITIAL COMMENTS Complaint NJ #: 152855; 154988; 159452; 161368 STANDARD SURVEY: 10/16/2023 CENSUS: 107 SAMPLE SIZE: 21 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		11/30/23

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

Electronically Signed | 11/07/2023

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F 584	Continued From page 1 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 NJ: #159452 Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to maintain a clean, comfortable, homelike environment. This deficient practice was identified in 2 of 50 resident rooms, for 1 of 1 resident, (Resident #44) reviewed for cleanliness of their [NJ Exec Ord redacted], and on 2 of 2 nursing units. The deficient practice was evidenced by the following: 1.) On 10/04/23 at 11:36 AM, the surveyor entered room [NJ Ex] and observed black scuff marks throughout the floor which resembled wheels from a wheelchair. The surveyor further	F 584	1. Room [NJ Ex] was immediately deep cleaned. Black scuff marks were removed. Heating / cooling unit was cleaned and window sill was wiped down. Overbed tables were swapped out for new ones. Trash were cleaned and liners properly replaced. Wall near shower room cleaned immediately. NJ Exec Order 26.4b1 were cleaned. And wall spackle was smoothed out. 2. All residents have the potential to be affected by this deficient practice. All rooms checked and were found that these issues did not exist in the other rooms 3. All housekeeping staff were educated on what and how to clean the floors, which items to clean and the proper placement of garbage can liners. the in services will be ongoing. The	

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F 584	Continued From page 2 observed that the heating and air conditioner unit in the room, had a perforated vent cover which was covered with a caked on brownish grey material. At that time, the surveyor observed a dead fly on the windowsill. There was brownish-grey colored debris observed throughout the windowsill. The room contained four beds and four overbed tables. The surveyor observed that the edges of the overbed tables were lighter brown in color with indentations, scratches, peeling material, and broken pieces throughout. In addition, all 4 tables had an unknown residue on top of them and the bottoms of the overbed tables had caked on brown, white, and grey residue. There were three garbage cans observed in the room without a liner (garbage bag). All the three garbage cans were filled with debris and food. On 10/04/23 at 11:45 AM, the surveyor entered the bathroom for room [redacted] and observed a garbage can without a liner. Paper towels and other garbage was observed in the garbage can. The surveyor observed scratches and indentations throughout the walls in the resident's bathroom. The bottom of the wall across from the toilet was missing, exposing a large, deep open area. On 10/05/23 at 12:04 PM, the surveyor re-entered room [redacted] and observed that the black scuff marks on the tile in the resident's room appeared lighter in color, not as prominent, but still existed. The surveyor further observed the first bed to the right of the bathroom had black scuff marks in between the resident's dresser and refrigerator in the room. The liner inside on of the garbage cans was not correctly placed in the garbage can, leaving the sides of the garbage can exposed.	F 584	housekeeping director will review randow rooms to ensure proper cleaning. 4. The Housekeeping Director or designee will audit 10 random rooms per week for a month and then 10 rooms a month for the next 4 months. the findings of these audits will be given to the adminstrator at the quaterly QAPI meeting. 5. The facility will in compliane by 11/30/2023	

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The liner was observed scrunched up in the bottom of the garbage can. The tiles in front of the heating and air conditioner unit were observed to be indented into the floor with black coating in between the flooring in the resident's room. The heating and air conditioner unit in the room was observed in the same condition as the previous observation, with the caked on brownish - grey material and scratches throughout. The tops of the residents over bed tables had been wiped clean but remained in same tattered condition as prior observation. The bottom portion of the over bed tables legs and base supporting the structure were observed to have caked on debris on all 4 tables.

On 10/05/23 at 12:16 PM, the surveyor observed that the wall between the shower room and room 35 had black vertical markings which extended throughout the center of the wall.

On 10/05/23 at 12:31 PM and on 10/11/23 at 10:41 AM, the surveyor entered room [redacted] and observed spackle to the left of the window on the wall. The spackle was white in color and the wall behind the spackle was green. The spackle was upraised and bumpy, indicating that it had not been sanded. The surveyor further observed above the resident's window, that there were three holes in the wall which resembled past evidence of a curtain rods prior existence. Grey, flaky debris was observed over top of the window. To the left of the resident's window, the surveyor observed that the green paint on the wall was peeling, exposing white paint underneath.

On 10/11/23 at 11:13 AM, the surveyor observed in between the medical supply room and room 11, yellow caked on material above the plastic

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molding attached to the bottom of the floor. The surveyor further observed that there was an orange-reddish colored stain on the wall.

On 10/11/23 at 11:16 AM, the surveyor observed behind the South wing nurses' station, where the wheelchair scale and Hoyer lifts were stored, black horizontal scratches throughout the bottom portion of the wall.

On 10/12/23 at 09:49 AM, the surveyor interviewed the Housekeeping Director (HD) who stated that he was responsible for the oversite of the housekeeping staff members in the facility. The HD explained the housekeeping staff were responsible for cleaning common areas which included bathrooms, resident rooms, and day rooms. He told the surveyor the protocol for cleaning resident rooms was top to bottom. The housekeeping staff were to start by dusting the room, sweeping the rooms, and would mop the floors last. The HD further stated that his expectation would be for the staff to put a liner in the garbage can, take out the trash and put a new liner in the garbage can when the garbage can was full of garbage. He stated that the expectation for the housekeeping staff was for them to dust the corners in the resident's rooms, the windows sills, and window frames.

On 10/12/23 at 09:56 AM, the surveyor interviewed the Maintenance Supervisor (MS) who stated that his job was basically to keep the building, "up and running" by making sure that things such as toilets and air conditioners were fixed. The MS further stated he was responsible for fixing holes in walls, spackling, and painting. The MS told the surveyor that fixing the scratches and indentations on the walls depended on how

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bad they were. He stated that the facility tried to fix the walls, but some residents would bang into the walls with their wheelchairs which caused the indentations and created the scratches throughout the walls. The MS told the surveyor that the Maintenance and Housekeeping department would work together to maintain the cleanliness of the building.

On 10/12/23 at 11:07 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he met with the HD and MS and asked them if anything was preventing them from doing their jobs, such as staffing. The LNHA further stated that the facility prioritized the cleanliness of the building based off what they observed and resident concerns.

On 10/16/23 at 09:46 AM, the surveyor conducted an additional interview with the facility's LNHA who stated that he and the HD re-educated the staff regarding the room cleaning and dirty Tube Feeding poles. The LNHA stated that the housekeeping staff had not yet cleaned room [redacted] when the surveyor made the observations on 10/04/23 at 11:36 AM. The LNHA did not speak to cleaning the bottom of the overbed tables in the room.

2.) On 10/04/23 at 12:16 PM, and 10/05/23 at 11:13 AM, on the [redacted], the surveyor observed in Resident #44's room, next to their bed, a [redacted]. There were several areas of [redacted] and the floor, which was consistent with the [redacted] that was used for

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the resident's [redacted]. The resident was not in their room.

On 10/06/23 at 09:23 AM, the surveyor observed Resident #44 in their bed asleep. The resident was observed with a [redacted] attached to a [redacted] There were several areas of [redacted] and the floor, which was consistent with the [redacted] that was used for the resident's [redacted]

Review of Resident #44's Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted]

Review of Resident #44's Admission Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted], revealed that the resident's brief interview of mental status (BIMs) score was [redacted] which indicated the resident [redacted] The MDS also revealed that the resident was dependent for all activities of daily living and [redacted].

Review of Resident #44's Order Summary Report revealed a physician order dated [redacted] for [redacted]

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NJ Exec Order 26.4b1

Review of Resident #44's NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected the above physician's order and was documented as administered.

On 10/06/23 at 10:17 AM, the surveyor interviewed the Registered Nurse (RN) caring for Resident #44, in the resident's room. The RN stated the resident received NJ Exec Order 26.4b1 and that all NJ Exec Order 26.4b1 The RN stated that she thought it was the housekeeper's responsibility to NJ Exec Order 26.4b and NJ Exec Order 2 but that she was not sure. Together, the surveyor and the RN observed the NJ Exec Order 26.4b1 and NJ Exec Order 26. The RN acknowledged the NJ Exec Order 26.4b1 and stated it was NJ Exec Order 26.4b1 " and that it should not have been there. The RN stated that if she saw the debris that she would have cleaned it and that it was important to keep resident equipment clean for infection control.

On 10/06/23 at 10:30 AM, the surveyor interviewed the housekeeper/porter (HK/P) who stated his role was to clean the unit's floors, take the linen out, take the trash out, and to clean mechanical lifts, wheelchairs, oxygen condensers, IV poles and feeding pumps. The HK/P stated that he would clean the NJ Exec Order 26. and NJ Exec Order 26.4b1 once they were no longer needed when the nurse placed them on the cart across from the utility room, which indicated they were dirty.

On 10/06/23 at 10:35 AM, the surveyor interviewed the Housekeeping Director (HD) who stated that it was the housekeeper's responsibility

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to clean the resident's NJ Exec Order 2 and NJ Exec Order 26.4b1 daily and once it was no longer used that it was cleaned and bagged. The surveyor informed the HD of the HK/P interview and he stated that he was a porter and that the housekeeper was responsible to clean the NJ Exec Order 2 and NJ Exec Order 26 daily. The surveyor escorted the HD to Resident #44's bedside to observe the NJ Exec Order 2 and NJ Exec Order 26.4b1. The HD stated he did not know what the NJ Exec Order 26.4b1 was and that it should not have been there. The HD further stated that for disinfection, to prevent bacterial growth, and for infection control, that the equipment should have been cleaned.

On 10/06/23 at 10:43 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) of the NJ Exec Order 26.4b1 who stated that the HK was responsible for cleaning any resident's NJ Exec Order 2 and NJ Exec Order 26.4b1 and that the nurse should have been cognizant to report dirty equipment to the LPN/UM or HK so it could have been cleaned. The surveyor showed the LPN/UM photographs of Resident #44's IV NJ Exec Order 26.4b1 that was observed on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 The LPN/UM acknowledged the NJ Exec Order 26.4b1 and stated that it appeared to be NJ Exec Order 26.4b1 and that it should not have been on the NJ Exec Order 26.4b1. The LPN/UM stated that for infection control that she would have cleaned the equipment and then also informed the HK to make sure the equipment was cleaned.

On 10/06/23 at 10:56 AM, in the presence of the Director of Clinical Services/RN, the surveyor interviewed the Director of Nursing (DON) who stated that cleaning the NJ Exec Order 26.4b1 was the nurse's responsibility for immediate needs such as a spill but that the HK was

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responsible for cleaning them. The surveyor showed the DON photographs of Resident #44's NJ Exec Order 26.4b1 that was observed on NJ Exec Order 26.4b NJ Exec Order 26.4b, and NJ Exec Order 26.4b. The DON acknowledged the debris and stated that the debris was probably from NJ Exec Order 26.4b1 and that it should not have been there. The DON further stated that it was important to maintain overall cleanliness for the residents.

On 10/12/23 at 12:45 PM the surveyors met with the administrative team who were made aware of Resident #44's dirty NJ Exec Order 26.4b1.

Review of Maintenance Supervisor Education, dated 11/12/2023, indicated, "It is the maintenance supervisor's responsibility to complete all maintenance - related tasks in their entirety. This includes: filling all repaired holes and sanding rough edges. Painting any repaired areas with the correct colors."

Review of the facility's undated Routine Cleaning and Disinfection policy revealed, "Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Definitions: "Cleaning" refers to the removal of visible soil from objects and surfaces ...Policy Explanation and Compliance Guidelines: 1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms ...4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visible soiled surfaces and high touch areas to include, but not limited to: h. Monitor control panels, touch screens and cables,

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j. IV poles."

Review of the facility's undated Medical equipment cleaning Policy and Procedure indicated that it was the housekeeping staffs responsibility to check and clean rooms daily. The facility's Medical equipment cleaning Policy and Procedure further indicated, "During daily cleaning of resident rooms all equipment should be cleaned and sanitized using appropriate disinfectant .... Feeding poles, pumps, concentrators, and nebulizers should be cleaned daily."

Review of the facility's undated Daily room cleaning details Policy and Procedure indicated that room cleaning was done daily. Further review of the policy indicated, "What to Clean: High dusting and cleaning of window sills, Heating/cooling units, over bed lights, medical equipment, nightstands, dressers, closets, Bedrails, floor mats, Spot clean walls, Door frames, Doors, Bathroom lights, toilets, Sink, Mirrors, ect. Sweep and mop entire floor in room and bathroom to include corners, edges under and behind furniture and equipment."

Review of the Job Title: Light Housekeeper dated 1/01/2000, indicated, "The Light Housekeeper performs a variety of tasks, such as dust mopping floors, cleaning and sanitizing bathrooms including sinks, tubs, and commodes. They are responsible for the daily cleaning and sanitizing of patient room furniture, as well as sitting room and dining room furniture. Light Housekeepers also do discharge cleaning and may also be called on for utility work in any area of the building."

Review of the undated Housekeeping Director's

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F 584	Continued From page 11 Job Description indicated that the HD was responsible for, "Manages and supervises the environmental service staff at a single site according to policies and procedures, and state/federal requirements." Review of the Maintenance Manager Job Position dated January 2023, indicated, "The primary purpose of the job position is to plan, organize, develop, and direct the general and preventative maintenance of physical plant and grounds as directed by the Administrator, to assure that out facility is maintained according to policy." NJAC 8:39-31.4(a)(f)	F 584		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced	F 644		11/30/23

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F 644	Continued From page 12 by: Based on observation, interview, and record review it was determined that the facility failed to conduct a new Preadmission Screening and Resident Review (PASRR) Level I assessment after a resident was newly diagnosed [redacted] This deficient practice was identified in 1 of 1 resident reviewed for PASRR (Resident #70) and was evidenced by the following: On 10/05/23 at 10:09 AM, the surveyor observed Resident #70 lying in bed talking on the phone. According to the Admission Record, Resident #70 had diagnoses which included: [redacted] Review of the admission Minimum Data Set (MDS), an assessment tool utilized to facilitate care, dated [redacted], revealed under Section I: Active Diagnoses did not reflect an active diagnosis of [redacted] Review of the quarterly MDS, dated [redacted], included a Brief Interview for Mental Status (BIMS) score [redacted] out of 15, which indicated a [redacted]. A further review of the MDS Section I: Active Diagnoses included an active diagnosis of [redacted] A review of the resident's Preadmission Screening and Resident Review (PASRR) Level I (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) dated [redacted], indicated the resident did not have [redacted]	F 644	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENT FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident # 70 was determined to have a diagnosis of [redacted] after admission. Upon addition of the diagnosis the level PASRR level 2 was not initiated. No negative effects were found from this deficient practice. PASRR updated and Level 2 evaluation will be/ completed to fax to the DHMAS. Will include Date 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Complete Care Mercerville will continue to audit each PASRR in the facility to ensure that PASRR's are current for proper determination by Nov 30, 2023. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Education will be provided to the social services director. PASRR will be checked upon admission and reviewed during each quarterly care conference for accuracy. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Social	

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F 644	Continued From page 13 NJ Exec Order 26.4b1 [redacted] A review of the Psychiatric Evaluation, dated NJ Exec Order 26.4b [redacted] revealed the resident had a diagnosis of NJ Exec Order 26.4b1 [redacted] On 10/05/23 at 12:28 PM, the surveyor interviewed the Director of Social Services (DSS), who stated the process for the Preadmission Screening and Resident Review (PASRR) Level I screen was that if the resident came from the hospital, then the PASRR was completed prior to the admission and that the Social Worker (SW) reviewed them to ensure it was completed and accurate. The DSS stated that if the PASRR was not completed correctly then the SW would update it accordingly. She stated that sometimes the PASRR could be a false negative and then she would have to resubmit it. She further stated that the SW was responsible for ensuring the PASRRs were accurate. The surveyor and the DSS reviewed the PASRR level 1 for Resident #70 in the electronic medical record (EMR) together. At that time, the surveyor asked if Section II - Mental Illness Screen question one should be checked as yes or no since the resident had a diagnosis (dx) of NJ Exec Order 26.4b1 [redacted] The DSS stated that for Section II question one with an active dx of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted]." The DSS then stated that the resident was diagnosed on NJ Exec Order 26.4b [redacted] which was after the PASRR level 1 was completed. She then stated that typically a new one should have been	F 644	Services will complete random audit of 6 PASRR then monthly x 2 months. Then again quarterly during scheduled care conferences. Results of the audits will be reported to the Administrator at the quarterly QA meeting. 5. The facility will be in compliance by 11/30/2023	

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F 644	Continued From page 14	F 644		

completed. The DSS confirmed that a new PASRR should have been completed for Resident #70 after the first PASRR since the resident was diagnosed with [redacted] after the resident was admitted.

On 10/05/23 at 12:44 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the SW was responsible for completing the PASRR but that she was not too familiar with it. She stated that the SW was responsible for checking if the resident had any [redacted] and if the PASRR was completed accurately. The DON stated that if the PASRR was not accurate then the SW would reach out to the corporate office to be directed on how to complete a whole new PASRR form. The DON stated that if a resident had a new dx of [redacted] then she believed that they would need a new PASRR Level I completed.

On 10/16/23 at 09:33 AM, the DSS in the presence of the survey team stated that it was identified the end of last year/the beginning of this year that the PASRR Level I was not being completed accurately upon admission. She stated that a QAPI (Quality Assurance Performance Improvement) was started and that the PASRRs were not all done correctly. The surveyor inquired if a resident was diagnosed with a [redacted] after admission whether a new PASRR Level I should have been completed. The DSS stated that if a resident had [redacted] then a new PASRR should have been completed. At that time, the DSS acknowledged that Resident #70 should have had a new PASRR Level I completed prior to surveyor inquiry.

A review of the Social Worker Job Description,

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F 644	Continued From page 15 included "Perform administrative requirements, such as completing necessary forms, reports, etc. and submitting such as required." A review of the QAPI Plan for 01/03/23, 04/05/23, and 07/05/23, all reflected the following: -PASRR are not 100% updated. -Upon admission and ongoing nursing and social services staff will identify any new and/or updated diagnoses r/t [related to] Mental Illness and/or Development Delay/Intellectual Disability by physician and/or psychiatry and update the PASRR as appropriate. A review of the facility's Coordination - Pre-Admission Screening and Resident Review (PASRR) program, revised January 2023, included the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations. 1. The facility will coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. NJAC 8:39-5.1(a);27.1 (a)	F 644		
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	F 658		11/30/23

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F 658	Continued From page 16 by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) obtain a Physician's Order (PO) for a treatment after removal of a NJ Exec Order 26.4b1 [redacted] and b.) re-apply the [redacted] after it was removed by the physician. This deficient practice was identified for 1 of 23 residents, (Resident #71) reviewed for professional standards of nursing practice and was evidenced by the flowing: 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." Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions " b. 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 regimens as prescribe by a licensed or otherwise legally authorized physician or dentist.	F 658	1. The NJ Exec Order 26.4b1 treatment was put in proper placement on Resident #71. The LPN assigned to resident #71 was educated on the facility policy regarding NJ Exec Order [redacted] care visits and the timely replacement of NJ Exec Order 26.4b1 treatment on the resident. 2. All residents have the potential to be affected by this practice. A full audit was completed on any facility resident with an order for a wound vac treatment with no further non-compliance noted. 3. All licensed nursing staff were educated on the facility policy regarding wound care visits and the timely replacement of wound vac treatment on the residents. Nurses will be provided with an updated wound care visit list each week by the Unit Manager to ensure timely treatment post-wound care visits. 4. The Director of Nursing or designee will audit all residents with wound vacs to ensure the facility policy is properly being adhered to. This audit will be completed weekly x 4 weeks and then monthly for 4 months. The results of the findings will be reported to the administrator at the quarterly QAPI meeting. 5. The facility will be in compliance by 11/30/23	

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Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem.

On 10/04/23 at 01:02 PM, the surveyor observed Resident #71 in their room seated on his/her bed looking out the window. The surveyor observed a yellow sock on the resident's left foot with a [NJ Exec Ord] [redacted] peeking out from the sides of the sock. The resident told the surveyor that he/she was at the facility receiving NJ Exec Order 26.4b1 [redacted] related to a NJ Exec Order 26.4b1. At that time, the surveyor observed a [NJ Exec Order 26.4b1] by the resident's bed which was not attached to the residents [NJ Exe] [redacted]. The resident told the surveyor that the [NJ Exec Order 26.4b1] [redacted] physician had come to the facility that morning, removed the [NJ Exec Order 26.4b1], saw the resident's [NJ Exec Order], '[NJ Exec Order 26.4b1]" and he/she was waiting for the nurse to re-apply his/her [NJ Exec Order 26.4b1] [redacted].

On 10/05/23 at 01:22 PM, the surveyor saw the resident in their room. At the time of the observation, the [NJ Exec Order 26.4b1] was not attached to the resident's [NJ Exec Order 26] [redacted]. The resident told the surveyor that the nursing staff had not re-applied the [NJ Exec Order 26.4b1] [redacted].

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On 10/05/23 at 01:48 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was NJ Exec Order 26.4b1 [redacted]. The CNA told the surveyor that the resident did not have a NJ Exec Order 26.4b1 and she was not responsible for the care of the NJ Exec Order 26.4b1 because the resident's primary nurse would be.

On 10/05/23 at 02:10 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated she saw the resident during her AM medication pass, and noticed that the NJ Exec Order 26.4b1 was not functioning and was not attached to the resident's NJ Exec O[redacted]. The LPN stated that the resident told her that the NJ Exec Order 26.4b1 was supposed to be changed every Monday, Wednesday, and Friday and the 3:00 PM - 11:00 PM nurse the night before never attached the NJ Exec Order 26.4b1 after the doctor saw him/her yesterday. The LPN stated that she had to finish her morning medication pass and was going to change the residents NJ Exec Order 26.4b1 now. The LPN further stated that she had no idea why the NJ Exec Order 26.4b1 was not attached to the resident, but it should have been. The LPN told the surveyor that the resident told her that, 'NJ Exec Order 26.4b1 [redacted]. The surveyor's interview with the LPN corroborated the surveyor's interview with Resident #71.

On 10/05/23 at 02:22 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who stated that the resident was NJ Exec Order 26.4b1 [redacted] and when the resident was admitted to the facility, they came with PO for the NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1.

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The LPN/UM stated that the [redacted] care physician) came to the facility at 8:30 AM - 9:00 AM the day prior, saw the resident, removed the [redacted] to assess the [redacted], and applied a [redacted] to the [redacted]. The LPN/UM told the surveyor that the 3:00 PM - 11:00 PM nurse reapplied the [redacted] on [redacted]. At the time of the interview, the LPN/UM never mentioned that she had assisted the 3:00 PM - 11:00 PM nurse with the application of the [redacted] The LPN/UM explained that the resident did not have a PO for a [redacted] to be applied because, "that was just the way he [the physician] does it". The LPN/UM further stated that technically if a different treatment was applied to the resident, there should be a PO that reflected the treatment. The LPN/UM could not speak to why the [redacted] was not currently attached to the residents [redacted] and made no metion that she assisted the 3:00 PM - 11:00 PM nurse in the application of the [redacted] the day prior.

On 10/05/23 at 02:36 PM, the surveyor interviewed the Director of Nursing (DON) who stated that she did not know why the [redacted] would not have reapplied the [redacted] to the resident after he assessed the [redacted], and the [redacted] should have been immediately reapplied after the physician's assessment. The DON told the surveyor that the LPN/UM who made rounds with the physician could have also immediately reapplied the [redacted] after it was removed. The DON told the surveyor that if the resident had a [redacted] applied to their [redacted], there should have been a physician's order for the treatment.

The surveyor reviewed the medical record for

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F 658	Continued From page 20 Resident #71. Review of the resident's Admission Record (an Admission Summary) indicated that the resident had diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] Review of the resident's NJ Exec Order 26.4b1 Order Summary Report (OSR) reflected a PO, dated NJ Exec Order 26.4b, to NJ Exec Order 26.4b1 pat dry, apply NJ Exec Order 26.4b1 to the NJ Exec Order 2 NJ Exec Order 26.4b1 [redacted]), continuous pressure on evening shifts every Monday, Wednesday, and Friday for NJ Exec Order care. A further review of the resident's NJ Exec Order 26.4 OSR did not reflect a PO for a NJ Exec Order 26.4b1 if the NJ Exec Order 26.4b1 was not functioning. Review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15 which indicated the resident was NJ Exec Order 26.4b1 A further review of the resident's MDS, Section M - NJ Exec Order 26.4b1 revealed that the resident had an NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1. Section M - NJ Exec Order 26.4b1 further indicated that the resident was receiving NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 Review of the NJ Exec Order 26.4b1 Treatment	F 658		

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Administration Record (TAR) revealed a PO, dated [redacted], to [redacted], pat dry, apply [redacted] to the [redacted] continuous pressure on evening shifts every Monday, Wednesday, and Friday for [redacted] care. A further review of the [redacted] TAR reflected that the nurses had signed that the [redacted] was applied to the resident's [redacted] on Monday, [redacted] and Wednesday, [redacted] during the evening shift hours. This indicated that the resident did not have their [redacted] applied during the day shift on [redacted]

A further review of the resident's [redacted] TAR did not reveal a PO for the treatment and care of the [redacted] on the resident's [redacted] after the [redacted] was removed by the [redacted] physician.

Review of the resident's Progress Notes (PN), dated [redacted] and timed at 22:36 (10:36 PM), indicated that the resident had been [redacted] with [redacted] was educated not to remove the [redacted] on their own and was further educated to ask the nurse for assistance. A further review of the resident's PN did not reveal documentation that the resident was removing their [redacted] on [redacted] or [redacted].

On 10/16/23 at 09:57 AM, the surveyor conducted a follow-up interview with the DON who stated that she investigated the [redacted] for the resident and the resident stated that he/she only liked the LPN/UM to apply the [redacted] The DON told the surveyor that she had interviewed the 3:00 PM - 11:00 PM nurse who was responsible for applying the [redacted] to the

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F 658	Continued From page 22 resident on [NJ Exec Order 26.4b] and the nurse told her that the resident wanted the LPN/UM to apply the [NJ Exec Order 26.4b1] not her. So, the LPN/UM applied the [NJ Exec Order 26.4b1] to the resident, the resident did not like the way it was applied, so he/she removed it. The DON stated that she educated the nurses that after the doctor removed a [NJ Exec Order 26.4b1], it needed to be re-applied. The DON could not speak to why the nurses had not documented in the PN that the resident removed the [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b] or [NJ Exec Order 26.4b] Review of the facility's Negative Pressure Wound Therapy Policy and Procedure, dated 2023, indicated, "To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The Negative Pressure Wound Therapy Policy further indicated, "Negative pressure wound therapy will be provided in accordance to physician orders, including the desired pressure setting, continuous or intermittent therapy, and frequency of dressing change. Clean technique shall be utilized unless otherwise specified by the physician." NJAC 8:39-27.1(a)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint NJ: #161368	F 677	-Please accept the following as the	11/30/23

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F 677	Continued From page 23 Based on observation, interview and review of the medical record, it was determined that the facility failed to provide care in a manner to maintain the grooming needs of a resident who was dependent on staff for activities of daily living and grooming. This deficient practice was identified for 1 of 23 residents reviewed, (Resident #76), and was evidenced by: According to the Admission Record, Resident #76 was admitted to the facility with the diagnoses which included but was not limited to: NJ Exec Order 26. [redacted] The quarterly Minimum Data Set (MDS-an assessment tool utilized to facilitate care) dated NJ Exec Order 26.4b1 indicated that the resident had NJ Exec Order 26.4b1 [redacted] and required total care with all aspects of activities of daily living (ADLs). On 10/05/23 at 11:09 AM, the surveyor observed Resident #76 lying in bed with the head of bed up and NJ Exec Order 26.4b1 [redacted] The surveyor was not able to interview the resident due to NJ Exec Order 26.4b1 [redacted]. While the surveyor was present in the resident's room, two nurses came in and changed the resident's position in bed. The surveyor observed that the resident NJ Exec Order 26.4b1 [redacted] The surveyor observed the resident's hair to be uncombed with small braids and with matted hair in the back. The surveyor interviewed the Licensed Practical Nurse Unit Manger (LPN/UM) at this time who stated that the residents were showered two (2) times a week and the shower list was documented on the daily assignment schedule with residents highlighted who took a shower.	F 677	facility's plan -Resident #76, hair was washed and combed to the resident's preference. -All residents have the potential to be affected by the cited deficient practices - All residents were assessed to ensure proper hair hygiene was being rendered. Any resident identified to refuse their hair to be washed per their preference was care planned properly. All nursing staff have been re-educated on proper grooming policies and procedures, with a special focus on hair washing. New staff members not present will be trained prior to their scheduled shifts. - To help ensure the plan of correction is effective and the specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements, beginning 10/23/23, the facility Director of Nursing Services or designee will complete shower day audits three times weekly for four weeks. Thereafter, audits will be completed twice weekly for four weeks, then once a week for four weeks. The findings from the audit will be discussed in weekly meetings with the Administrator and Administrative Nursing Staff. Results will be discussed and addressed during the facility's monthly Quality Assessment and Performance Improvement (QAPI) meeting. The date of completion will be 11/30/23	

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The LPN/UM provided the surveyor with the NJ Exec Ord [redacted] shower schedule which indicated that Resident # 76 received showers on the 7:00 AM-3:00 PM shift on Wednesdays and Saturdays.

On 10/05/23 at 11:20 AM, the surveyor reviewed the Point of Care (POC) area of Resident #76's electronic medical record (EMR). The LPN/UM explained to the surveyor that the POC section of the EMR was where the Certified Nursing Assistants (CNAs) documented an ADL was performed.

On 10/05/23 at 11:32 AM, the surveyor interviewed the CNA who stated that she had been employed in the facility for NJ Exec Order 26 [redacted]. She stated that resident's that were scheduled for a shower were written by the nurse on the daily assignment sheet and were highlighted to indicate the importance of performing the shower. She continued to explain that the nurse was responsible to write the resident showers on the daily assignment sheet. She stated that the facility process for showers were that all residents received showers or bed baths two times a week. She stated that the CNAs were responsible to document showers that were performed on the POC. She stated that if a resident refused a shower, the CNAs would offer the shower "a little later" and then if the resident continued to refuse the shower, the CNA would notify the nurse and the nurse would document it. She stated, "We try to make a couple attempts." The CNA then explained that if the CNA documented in the POC "not applicable" then the CNA was not able to perform the shower, however the CNA would have to document if a bed bath was performed if the resident could not take a shower. She added

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that the CNA was responsible to wash, dress and brush the resident's hair during care. The CNA stated that all resident's hair should be brushed daily and that it was important to make sure that the resident's hair was not matted to the residents head because the resident could get a headache.

On 10/05/23 at 12:07 PM, the LPN/UM accompanied the surveyor to Resident # 76's room. The surveyor asked the LPN/UM how often the resident's hair was washed and brushed. The LPN/UM stated that the resident's hair should be brushed daily with care and that the resident's hair should be washed in bed during shower days. The LPN/UM and the surveyor observed that the resident had matted hair on the back of his/her head. The LPN/UM confirmed that the resident's hair was matted on the back of his/her head and that it should not look like that.

On 10/05/23 at 12:12 PM, the surveyor interviewed the CNA who stated that yesterday (10/04/23) was the first time that she had worked in the facility in at [redacted] year. She stated that when a CNA performed ADL care it consisted of washing the resident, brushing the resident's teeth, brushing the resident's hair, changing the resident's clothes and toileting and providing incontinent care. She stated that she fixed the front of the Resident #76's hair today, but not the back of the resident's hair. She stated that she didn't know that the resident had his/her hair matted on the back of the head that she should have checked it. She admitted that she did not brush the back and the resident's hair during AM care.

On 10/05/23 at 01:40 PM, the surveyor attempted

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F 677	Continued From page 26 to telephone interview the resident's son, however the phone was out of service. The surveyor also called the resident's daughter and she stated that she was not sure what type of care her mother needed because she lived in a different country. The surveyor reviewed Resident #76's Care Plan (CP) which indicated that the resident was totally dependent on staff for ADL's and staff was to provide a bath twice weekly. The CP also indicated that the resident would be bathed NJ Exec Orde [redacted] There was no documentation on the CP regarding hair care or refusals of hair care. The facility policy titled "Activities of daily living," with a revised date of 2013, indicated that based on the comprehensive assessment of the patient and consistent with the patient's needs and choices, the center must provide the necessary care and services to ensure that a patient's ability in activities of daily living do not diminish unless circumstances of the individuals clinical condition demonstrate that such diminution was unavoidable. The policy also indicated that ADL care was to be documented every shift by the nursing assistant on the ADL flow sheet. The policy also indicated that a patient who is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene. NJAC 8:39- 27.2 (g)	F 677		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life	F 678		11/30/23

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F 678	Continued From page 27 support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to honor a resident's preference for NJ Exec Order 26.4b1, as directed on the New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form, by performing NJ Exec Order 26.4b1 when the resident was found [redacted] for 1 of 1 resident (Resident #102) reviewed for [redacted]. This deficient practice was evidenced by the following: According to the Admission Record, Resident #102 was admitted to the facility with diagnoses which included, but were not limited to: [redacted] The resident [redacted] NJ Exec Order 26.4b1. The surveyor reviewed the resident's closed paper medical record which included two copies of the same POLST form in the front of the record. The POLST form, dated [redacted], was signed by the resident and Physician/Advanced Nurse Practitioner/Physician's Assistant, and indicated the following under the section titled, Cardiopulmonary Resuscitation (CPR): If the person has no pulse and/or is not breathing, '[redacted]	F 678	Please accept the following plan of correction for the facility . Resident #59 [redacted] -All residents are potentially at risk of the same deficient practice. - All clinical staff were in-serviced on the facility policy Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS). All staff were in-serviced on where to locate the CODE Status for each resident in the event of an emergency. All Licensed Nurses were educated on the facility policy on medical record review in reference to POLST forms and advance directives. All licensed staff were educated in properly identifying the correct code status and ensuring the proper order was reflected in the residents medical records. Any new staff will be educated prior to their scheduled shift. -The DON/designee will complete an investigation immediately, upon notification, for any death or code blue event to determine if the facility policy was followed regarding Advanced Directives for 6 months. The DON/Designee will randomly audit 2 new admission medical records times 4 weeks, and then one new admission medical record for 4 weeks to ensure a proper code status order and identification process is being followed.	

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F 678	Continued From page 28 NJ Exec Order 26.4b1 and, NJ Exec Orde " The surveyor reviewed the resident's Electronic Medical Record (EMR): Review of the Admission Assessment, dated NJ Exec Order 26.4b, revealed the resident was NJ Exec Order 26.4b Review of the Care Plan, initiated NJ Exec Order 26.4b, included a focus that "[Resident #59] has advance directive," with a goal of, "[Resident #59's] wishes will be followed thru next review," and an intervention of, "NJ Exec O." Review of the Order Summary Report (OSR), as of NJ Exec Order 26.4b, revealed the resident's profile included the resident's name, location, admission date, gender, date of birth, physician, pharmacy, allergies, and diagnoses. The profile did not include the resident's code status. Further review of the OSR did not include a physician's order for the resident's code status. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for NJ Exec Order 26.4b1 included a section at the top for "Advance Directive," but there was no code status indicated. Further review of the MAR and TAR did not include a physician's order for the resident's code status. Review of a Progress Note, dated NJ Exec Order 26.4b at 7:21 AM, included, "Pt [patient] found NJ Exec Order 26.4b1 5:30 AM. Code Emergency activated, NJ Exec C initiated, 911 called. EMT responded to the unit. NJ Exec Order 26.4b1 at 5:48 AM."	F 678	The DON/designee will present a summary of the investigation to the Quality Assurance committee monthly for 6 months. Thereafter, it will be determined by the Quality Assurance Committee if further monitoring should continue and for what period of time. - the facility will be in compliance by 11/30/23	

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During an interview with the surveyor on 10/11/23 at 10:50 AM, Certified Nursing Assistant (CNA) #1 stated that she was an agency CNA and that if she found a resident [NJ Exec Order 26.4b1], she would call for help. When asked how the CNA would know a resident's code status, she stated she was not sure where to look to find out the code status. The CNA further stated that it was important to follow a resident's code status "in case of an emergency."

During an interview with the surveyor on 10/11/23 at 10:55 AM, CNA #2 stated that if she found a resident [NJ Exec Order 26.4b1], she would immediately notify the nurse. When asked how the CNA would know a resident's code status, she stated that if the resident had a purple sticker next to their name on the doorway, it meant they were a [NJ Exec O], but if there was no sticker on the door, then that meant the resident was [NJ Exec Order 26.] and to perform [NJ Exec Or]. The CNA further stated it was important to follow the resident's code status to honor their rights.

During an interview with the surveyor on 10/11/23 at 11:04 AM, the Licensed Practical Nurse (LPN) explained that the POLST form is like an advance directive and tells the staff the resident's code status. The LPN further stated that if a resident came from the hospital with a POLST form, the POLST would be confirmed with the resident and placed in the front of the resident's chart. The LPN then stated that the resident's code status should also be documented in the resident's EMR under the resident's profile, there should be a physician's order, and it should be at the top of the MAR. The LPN added that it was important to follow a resident's code status in order to honor

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the resident's wishes.

During an interview with the surveyor on 10/11/23 at 11:12 AM, the Registered Nurse (RN) explained that a POLST form was a document that stated the wishes of the resident in terms of NJ Exec Order 26.4b1. She further stated that when a resident was transferred from one facility to another, their POLST form traveled with them, but was unsure what happened when a resident was admitted to the facility with a POLST form already completed. The RN stated that a resident's code status was documented in their medical record with the POLST form in the paper chart, the physician's order in the EMR, and in the profile at the top of the MAR. When asked what the RN does when a resident is NJ Exec Order 26.4b1, the RN stated she would look in the EMR at the resident's orders or at the POLST in the paper chart to find out the resident's code status.The RN further stated that if the resident was NJ Exec Order 26.4b, she would call a code and perform NJ Exec Ord The RN stated the importance of following a resident's code status was to honor the resident's wishes.

During an interview with the surveyor on 10/11/23 at 11:18 AM, the LPN/Unit Manager (LPN/UM) stated that a resident's POLST form was filed under Advance Directives in the resident's paper chart and that if a resident was admitted with a POLST form completed, the staff should follow the instructions on the POLST form. The LPN/UM further stated that residents were automatically a NJ Exec Order 26.4 when they were admitted, but the physician's order would have changed based on the POLST form. The LPN/UM explained that the resident's code status should have been in the resident's profile in the

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EMR and at the top of the MAR. The LPN/UM also explained that if a resident was [NJ Exec O], they would have a purple sticker next to their name at their doorway and also on their paper chart. The LPN/UM added that it was important to follow a resident's code status because that was the resident's wishes. When asked about Resident #59, the LPN/UM stated she thought the resident was a [NJ Exec O] and was unsure if staff performed [NJ Exec O] on the resident. She further stated that if the resident was [NJ Exec O], the staff should not have performed [NJ Exec Ord], and there should have been a physician's order to indicate [NJ Exec Ord] in the EMR.

During an interview with the surveyor on 10/11/23 at 11:32 AM, the Director of Nursing (DON) stated that all residents were a [NJ Exec Order 26.] when they were admitted to the facility unless they had a POLST, or something else in writing, that stated differently. The DON explained that if a resident was admitted to the facility with a POLST, the physician's orders in the EMR should have been updated according to the POLST, then the POLST form was placed in the paper chart. The DON also stated that the resident's code status was an ancillary physician's order that shows up across the top of the MAR. The DON explained that the POLST form gives the resident the option of how to proceed in the event of an emergency, such as [NJ Exec Order 26.4b1], and let the resident make their wishes known. The DON stated that if a resident was found [NJ Exec Order 26.4b1], the nurse should have gone into the EMR and looked for the resident's code status in order to honor the resident's wishes. When asked about Resident #59, the DON was unsure of the resident's code status, but believed the staff performed [NJ Exec Ord] when the resident was found [NJ Exec Order 26.4b1]. The surveyor informed the

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DON of the resident's POLST form which indicated [NJ Exec C] and the DON confirmed that the staff should not have performed [NJ Exec C] according to the resident's POLST. The DON stated that once the POLST was obtained from the hospital, the nurse should have notified the physician and obtained a physician's order for the [NJ Exec C] code status.

Review of the facility's Advance Directives policy, updated 01/2019, included, "The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive," and, "Do Not Resuscitate indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life sustaining treatments or methods are to be used."

Review of the New Jersey Department of Health, "Practitioner Orders for Life-Sustaining Treatment (POLST)" guidelines, reviewed 01/31/2022, included, "The Practitioner Orders for Life Sustaining Treatment (POLST) form enables patients to indicate their preferences regarding life-sustaining treatment. This form, signed by a patient's attending physician, advanced practice nurse or physician's assistant, provides instructions for health care personnel to follow for a range of life-prolonging interventions. This form becomes part of a patient's medical records, following the patient from one healthcare setting to another, including hospital, nursing home or hospice."

NJAC 8:39-27.1(a)

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that an [NJ Exec Order 26.4b1] was accurately set according to the resident's weight for 1 of 1 resident (Resident #59) reviewed for [NJ Exec Order 26.4b1] This deficient practice was evidenced by the following: On 10/04/23 at 12:25 PM, 10/05/23 at 11:02 AM, and 10/06/23 at 9:42 AM, the surveyor observed Resident #59 lying in bed. The resident had an [NJ Exec Order 26.4b1] and the weight setting on the control unit was set to [NJ Exec Order 26.4b1] which was the highest setting. When interviewed, the resident stated he/she had a [NJ Exec Order] that received daily [NJ Exec Order] care. According to the Admission Record, Resident #59 had diagnoses which included, but were not	F 686	1. The nurse assigned to resident #59 immediately changed the weight setting for this resident's [NJ Exec Order 26.4b1] to match the resident's current weight. The nurse was educated on how to set the weight on the [NJ Exec O] and the importance of appropriate weight settings. 2. All residents have the potential to be affected by this practice. A full facility audit was completed on all other residents with a current order for LAL mattresses with no further non-compliance noted. 3. All nurses were re-educated on how to ensure the weight setting on the LAL mattress matches the weight of the resident. The nurses will receive a weekly list of those residents who have a LAL mattress and ensure that the weight setting is accurate. 4. The Director of Nursing or designee will	11/30/23

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F 686	Continued From page 34 limited to NJ Exec Order 26.4b1 [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status score of [redacted] out of 15, which indicated the resident's NJ Exec Order 26.4b1 [redacted]. Further review of the MDS included the resident had NJ Exec Order 26.4b1 that was not present on the resident's admission to the facility. Review of the resident's weights listed in the Electronic Medical Record, revealed the resident weighed [redacted] on [redacted] Review of the Care Plan included a focus, revised [redacted], of NJ Exec Order 26.4b1," with an intervention of NJ Exec Order 26.4b1 on bed for protection and comfort." Review of the Order Summary Report, as of [redacted], included a physician's order for [redacted] on bed, check functioning every shift (facility owned) every shift for prevention," with an order date of [redacted] Review of the Progress Note (PN), dated [redacted], indicated the resident was observed with a NJ Exec Order 26.4b1 [redacted]. Further review of the PN included, "maintained on [redacted]" Review of the NJ Exec Order 26.4b1 dated [redacted], included the resident had a [redacted] that was resolved, an	F 686	audit all LAL for accurate weight settings weekly x 4 weeks and then monthly for 4 months. The results of the findings will be reported to the administrator at the quarterly QAPI meeting. 5. The facility will be in compliance by 11/30/23	

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existing NJ Exec Order 26.4b1 and a new NJ Exec Order 26.4b1. Further review of the NJ Exec Order included under a section titled Off-Loading, NJ Exec Order 26.4b1 in place with correct settings."

During an interview with the surveyor on 10/06/23 at 12:00 PM, the Certified Nursing Assistant (CNA) stated Resident #59 was NJ Exec O and NJ Exec Order 26.4b and had a NJ Exec Order 26.4b1. The CNA further stated the resident had an NJ E and the nursing staff was responsible for ensuring the NJ Exec Order 26.4b1 was set correctly. The CNA added that it was important for the air mattress to be set correctly in order to prevent NJ Exec Order 26.4b1

During an interview with the surveyor on 10/06/23 at 12:04 PM, the Licensed Practical Nurse (LPN) explained that when a resident needed an NJ E, maintenance would have set up the mattress in the room and the nursing staff would have adjusted the weight setting on the control unit. The LPN further stated that the NJ Exec Order 26.4b1 settings should have been correct to help NJ Exec O. When asked about Resident #59, the LPN stated the resident had a NJ Exec Order 26.4b and used an NJ Exec Order 26.4b1. The surveyor then accompanied the LPN to the resident's room. The LPN confirmed the NJ Exec Order 26.4b1 was set to NJ Exec Order 2 and the surveyor informed the LPN that the resident's most recent weight was listed as NJ Exec Order 26.4b. The LPN then adjusted the weight setting on the control unit to just below the NJ Exec setting and stated the nurses should have been checking to ensure the NJ Exec Order 26.4b1 is set correctly.

During an interview with the surveyor on 10/06/23

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at 12:10 PM, the LPN/Unit Manager (LPN/UM) stated that when a resident needed an [redacted], the facility would either provide one in-house or obtain a rental. The LPN/UM further stated that maintenance would have put the [redacted] on the bed frame and set the [redacted] to the highest setting to NJ Exec Order 26.4b1. The LPN/UM added that it was the nursing staff's responsibility to adjust the weight setting according to the resident's weight and ensure the [redacted] was set correctly. When asked about the importance of the weight setting, the LPN/UM stated that if the [redacted] was set too high, it would make the [redacted] harder, and if it was set too low, it will not have enough air flow. The LPN/UM further stated that Resident #59's NJ Exec Order 26.4b1 have been set to the resident's correct weight.

During an interview with the surveyor on 10/06/23 at 12:20 PM, the Director of Nursing (DON) stated when a resident needed an [redacted], maintenance would have installed it and the nurse would have adjusted the settings. The DON further stated that the nurses were responsible for ensuring the [redacted] was set correctly. The DON also stated that it was important to set the [redacted] correctly because otherwise it could cause more issues with skin integrity. The DON explained that the [redacted] setting was to distribute the air flow according to the resident's weight. When the surveyor informed the DON that Resident #59's [redacted] was set to [redacted] and the resident weighed [redacted] the DON stated the [redacted] settings should have been adjusted to the resident's weight and that the nurses should have been checking the [redacted] settings every shift.

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F 686	Continued From page 37 Review of the facility's Prevention of Pressure Ulcers/Injuries policy, updated 10/2022, included under the section, "Support Surfaces and Pressure Redistribution," to "Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors." Review of the air mattress Operation Manual, undated, included under the section titled Pressure-adjust Knob, "Determine the patient's weight and set the control knob to that weight setting on the control unit."	F 686		
F 698 SS=E	NJAC 8:39-27.1(a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to a.) document the appropriate NJ Exec Order 26.4b1 [redacted] maintain ongoing consistent complete communication notes between the facility and the NJ Exec Order 26.4b1 and c.) document post NJ Exec Order 26.4b1 as per standards of practice. This deficient practice was identified for 1 of 1 resident reviewed for NJ Exec Order 26 [redacted], (Resident #8), and was evidenced by the following:	F 698	1. All documentation for resident # 8 was immediately updated to include the appropriate NJ Exec Order 26.4b1 site, complete communication notes between the facility and the NJ Exec Order 26.4b1, and the NJ Exec Order 26.4b1 weight. 2. All residents have the potential to be affected by this practice. A full facility audit was completed for all residents on dialysis treatment. All documentation was found to	11/30/23

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F 698	Continued From page 38 According to the Admission Record, Resident #8 was admitted to the facility with the diagnoses which included but was not limited to: NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the quarterly Minimum Data Set (MDS-an assessment tool utilized to facilitate care) dated NJ Exec Order 26.4b1, which indicated that Resident #8 was NJ Exec Order 26.4b1 and required extensive to total care with activities of daily living (ADLs). The MDS also indicated that the resident received NJ Exec Order 26.4b1 On 10/06/23 at 09:16 AM, the surveyor interviewed Resident #8 who stated that NJ Exec Order [redacted] He/she stated that they NJ Exec Order 26.4b1 [redacted]. The resident stated that he/she had a new NJ Exec Order 26.4b1 [redacted] He/she stated that they ha NJ Exec Order 26.4b1 [redacted] He/she stated that the nursing staff took NJ Exec Order 26.4b1 [redacted] in the NJ Exec Order 26.4b1, but not the NJ Exec [redacted] due to the NJ Exec Order 26.4b1 On 10/06/23 at 09:22 AM, the surveyor interviewed the Registered Nurse (RN #1) who stated that she had been employed in the facility for approximately NJ Exec Order 26.4 [redacted]. RN #1 stated that Resident #8 required total care with ADLs. She stated that the resident had some NJ Exec Order 26.4b1 [redacted] however was able to NJ Exec Order 26.4b1 [redacted]. She stated that the family made decisions for the resident. RN #1 stated that the	F 698	be in compliance. 3. All nursing staff were re-educated on proper communication between the dialysis center and the facility. Including, but not limited to, documenting proper blood pressure sites, completing documentation between the two facilities, and ensuring that the resident returns from dialysis with the post-dialysis weight documented. If it is not documented, the nurse is instructed to call the dialysis center to retrieve the weight. 4. The Director of Nursing or designee will audit the dialysis communication documents weekly x 4 weeks and then monthly for 4 months. The results of the findings will be reported to the administrator at the quarterly QAPI meeting. 5. The facility will be in compliance by 11/30/23	

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resident was a [NJ Exec Order 26], received [NJ Exec Order 2] and had a [NJ Exec Order]. She stated that the resident's [NJ Exec] was taken in the [NJ Exec Order 26.4b], due to a [NJ Exec Order 26.4b] that was positioned in the [NJ Exec Order 26]. The surveyor reviewed the Medication Administration Record (MAR) with the RN who explained to the surveyor that when she documented the resident's [NJ Exec] on the MAR on [NJ Exec Order 26.4b1] at 16:05, she made a mistake and documented that she took the [NJ Exec] in the [NJ Exec Order 2]. The RN indicated that this was a documentation error. RN #1 acknowledged that she had to be careful documenting accurately because the resident was only to have [NJ Exec Or] taken on the resident's [NJ Exec Order 26.4b], not the [NJ Exec]

The surveyor reviewed the physician "Order Summary Sheet," dated [NJ Exec Order 26.4b1], which reflected a physician's order (PO) "[NJ Exec Order 26.4b1]

The surveyor reviewed the documented [NJ Exec O] for Resident #8 in [NJ Exec Order 26.4b1] In 12 out of 31 days, the nurses documented that they took Resident #8's [NJ Exec] in the [NJ Exec Order 26] instead of the [NJ Exec Order 26.4b]. These are the following dates and times: [NJ Exec Order 26.4b] at 17:23 (05:23 PM), [NJ Exec Order 26.4b] at 16:37 at (04:37 PM) [NJ Exec Order 26.4b] at 17:30 (05:30 PM), [NJ Exec Order 26.4b] at 16:18 (04:18 PM), [NJ Exec Order 26.4] at 17:27 (05:27 PM), [NJ Exec Order 26.4] at 18:16 (06:16 PM), [NJ Exec Order 26.4b] at 16:08 (04:08 PM), [NJ Exec Order 26.4b] at 16:18 (04:18 PM), [NJ Ex.Order 26.4(b)(at 16:12 (04:12 PM), [NJ Exec Order 26.4b] At 17:26 (05:26 PM), [NJ Exec Order 26.4] at 16:40 (04:40 PM).

The surveyor reviewed the documented [NJ Exec O] for Resident #8 in [NJ Exec Order 26.4b1] In 17 out of 30 days, the nurses documented that they took Resident #8's [NJ Exec] in the [NJ Exec Order 2] instead of the [NJ Exec Order 26.4]. These are the following dates and

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times: NJ Exec Order 26.4b at 17:14 (05:14 PM), NJ Exec Order 26.4b at 16:14 (04:14 PM), NJ Exec Order 26.4b 3 at 16:26 (04:26 PM), NJ Exec Order 26.4b at 16:04 (04:04PM), NJ Exec Order 26.4b at 17:10 (05:10 PM), NJ Exec Order 26.4b at 16:48 (04:48 PM), NJ Exec Order 26.4b at 16:00 (04:00 PM), NJ Exec Order 26.4b at 16:10 (04:10 PM), NJ Exec Order 26.4b at 08:33 AM, NJ Exec Order 26.4b at 08:58, NJ Exec Order 26.4b at 14:48 (02:48 PM), NJ Exec Order 26.4b at 15:49 (03:49 PM), NJ Exec Order 26.4b at 08:55 AM, NJ Exec Order 26.4b at 08:45 AM, NJ Exec Order 26.4b at 15:31 (03:31 PM), NJ Exec Order 26.4b at 16:17 (04:17 PM), and NJ Exec Order 26.4b at 16:39 (04:39 PM).

The surveyor reviewed the documented NJ Exec O for Resident #8 in NJ Exec Order 26.4b1. In 3 out of 11 days, the nurses documented that they took Resident #8's NJ Exec in the NJ Exec Order 26 instead of the NJ Exec Order 26.4b. These are the following dates: NJ Exec Order 26.4 at 20:08 (08:08 PM), NJ Exec Order 26.4b at 16:05 (04:05 PM), and NJ Exec Order 26.4 at 08:02 AM.

The surveyor reviewed Resident #8's medical record and there was no documentation or indication that the resident had any complications associated with the NJ Exec Order 26.4b1.

On 10/06/23 at 09:53 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) for the NJ Exec Order 26.4b1 who stated that Resident #8 had the NJ Exec Order 26.4b put in the NJ Exe on NJ Exec Order 26.4. She stated that the nurses should not be documenting in the EMR that they are taking the resident's NJ Exec Order 26.4b1 readings on the NJ Exec Order 26. She stated that she re-wrote a separate physician's order not to take the residents NJ Exec Order 26.4b1 in the NJ Exec Order 26.

On 10/06/23 at 10:00 AM, the surveyor reviewed the NJ Exec Order 26.4b1 book which contained the NJ Exec Order 26.4b1

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communication sheets. The surveyor observed that the communication sheets dated [NJ Exec Order 26.4b], [NJ Exec Order 26.4b], [NJ Exec Order 26.4b], [NJ Exec Order 26.4], [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b] were not filled out completely and the bottom section of the sheets were blank.

On 10/06/23 at 10:08 AM, the surveyor interviewed the LPN/UM for the [NJ Exec Order 26.4b1] who stated that sometimes the [NJ Exec Order 26.4b1] did not always send the communication sheet back with the resident from [NJ Exec Order 26] or did not always complete their section of the form to include the resident's [NJ Exec Order 26.4b1] weight or vital signs ([NJ Exec Order 26.4b1]). She stated that she had never personally called the [NJ Exec Order 26.4b1] to inquire as to why the [NJ Exec Order 26] communication sheets were not filled out by [NJ Exec Order 26.4b1] or why the communication sheets were not returned to the facility, but she had heard other nurses call the [NJ Exec Order 26.4b1] to inquire why the information was not completed on the form. The LPN/UM stated that she did not know if the Director of Nursing (DON) was aware of the issue with the [NJ Exec Order 26.4b1] not returning the communication sheets or why the [NJ Exec Order 26] did not consistently complete the communication forms.

On 10/06/23 at 10:39 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurses should not be documenting in the electronic medical record (EMR) that they were taking Resident #8's [NJ Exec] in the [NJ Exec Order 26] when the physician order indicated "[NJ Exec Order 26.4b]". The DON reviewed the resident's [NJ Exec Order 26] communication book in the presence of the surveyor. The surveyor asked the DON what the bottom section of the [NJ Exec Order 26] communication sheet was. The DON explained

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that the bottom section was to be completed by the [NJ Exec Order 26.4b1]. The surveyor asked why some of the communication sheets were blank or not filled out. The DON stated that the [NJ Exec Order 26] was to complete was this section with the communication sheets and confirmed that the communication sheets dated [NJ Exec Order 26.4], [NJ Exec Order 26.4b], [NJ Exec Order 26.4], [NJ Exec Order 26.4b], [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4] were blank or not competed entirely. The DON stated that she was not aware that the [NJ Exec Order 26] was not completing their section of the form. She stated that it would be important for the [NJ Exec Order 26.4b1] to complete their section to include the residents' weights and VS because the facility utilized that information for their documentation. She stated that she was not notified that this was not being done. She also stated that she usually audited the communication books for the [NJ Exec Order 26] residents but must have missed Resident #8's.

On 10/06/23 at 12:17 PM, the surveyor reviewed the physician order sheet. There was an physician's order written on [NJ Exec Order 26.4b1] for the staff to enter Resident #8's [NJ Exec Order 26.4b1] in EMR every Tuesday, Thursday and Saturday every evening shift. The LPN/UM was interviewed at this time and stated that the nurses obtain the [NJ Exec Order 26.4b1] after the resident returns from [NJ Exec Order 26]. She stated that the [NJ Exec Order 26] weighed the resident and documented the weight on the [NJ Exec Order 26] communication sheet. The nurses in the facility then would take that [NJ Exec Order 26.4b1] weight and document it on the Medication Administration Record (MAR). The surveyor asked the LPN/UM what if the resident did not come back from [NJ Exec Order 26] with the communication sheet or the communication sheet was blank when the resident returned from

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NJ Exec Order 26 The LPN/UM explained that the nurse should have called the NJ Exec Order 26.4b1 to find out the information and then documented in the progress notes what had happened. The LPN/UM reviewed the NJ Exec Order 26.4b1 communication sheet with the surveyor and confirmed that the communication sheet post NJ Exec Order 26 was not consistently filled out by the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b1, and NJ Exec Order 26.4b.

The LPN/UM stated that the nurse would not be able to document in the MAR that the NJ Exec O weight was done if it was not documented on the NJ Exec Order 26 communication sheet. The LPN/UM reviewed the MAR in the presence of the surveyor and confirmed that on NJ Exec Order 26.4b the nurse documented that they had received and documented the resident's NJ Exec Order 26.4b1 weight however there was no NJ Exec Order 26.4b1 weights documented on the communication from the NJ Exec Order 26 center. The LPN/UM stated that when there was a check mark and signature on the MAR, it meant that the nurse received and documented the NJ Exec Order 26.4b1 weight on the EMR however on NJ Exec Order 26.4b there was no weight documented in the EMR.

On 10/10/23 at 10:51 AM, the surveyor reviewed additional information that the DON had provided the surveyor and according to the MAR dated NJ Exec Order 26.4b1, the nurse signed in the signature spot on the MAR that she obtained a NJ Exec Order 26.4b1 weight and that she documented the weight in the EMR. When the surveyor reviewed the weight section in the resident's EMR dated NJ Exec Order 26.4b1, there was no NJ Exec Order 26.4b1 weight documented. The surveyor also reviewed the NJ Exec Order 26 communication sheet and there were

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no NJ Exec Order 26.4b1 weights documented on the NJ Exec Order 26 communication sheet. The DON confirmed that the nurse failed to document the NJ Exec Order 26.4b1 weight in the EMR.

On 10/11/23 at 09:24 AM, the surveyor interviewed RN #2 who stated that she had been employed in the facility been since NJ Exec Or. RN#2 explained the process for monitoring NJ Exec Order 26.4b1 residents that resided in the facility. She explained that prior to a resident going to the NJ Exec Order 26 provider, the nurses would have completed the top section of the NJ Exec Order 26 communication sheet that included monitoring of the NJ Exec Order 26.4b1 The NJ Exec Order 26 provider would then have been responsible to complete the bottom section of the sheet which would have included VS, NJ Exec O weight and any medications that were provided in NJ Exec Order 26. She stated that if the NJ Exec Order 26 facility did not complete their section that the nurse would have called the NJ Exec Order 26.4b1 and requested the missing information or that the NJ Exec Order 26 provider would have faxed their completed NJ Exec Order 26 communication section back to the facility. RN #2 stated that if a resident had an NJ Exec Order 26.4b that the NJ Exec Order 26.4b1 would have been taken on the arm that did not have the NJ Exec Ord to avoid complications with the site. She stated that it would be important to document the correct site that you took the resident's NJ Exec Ord to ensure accurate documentation. She added that it would be important to document the correct arm especially if a resident had NJ Exec Orde

On 10/12/23 at 09:49 AM, the DON provided the surveyor with three (3) statements from LPN #1, RN #3 and RN #4, all who documented that they

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 45 took Resident #8's NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 when they shouldn't have. The DON explained that all three nurses stated that they had made errors in documentation and that they all took the NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 but made a mistake and documented the NJ Exec Order 26.4b1. A review of the facility policy titled "Dialysis Patients" with a revised date of 11/2022, indicated that whether residents were receiving hemodialysis, were transported out of the center or were receiving in house, communication was essential for the continuity of care. Communication between the dialysis provider and the center staff should include written communication to include medication list, changes in condition and mood, evaluation of the access site. The policy also indicated that blood pressures should be done prn (as needed) or as ordered by the physician and that blood pressures should not be taken in the arm that the fistula was in. A review of the facility policy titled, "Charting and Documentation" with a revised date of 2017, indicated that documentation in the medical record would be objective, complete and accurate. NJAC 8:39-27.1(a)	F 698		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		11/30/23

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F 732	Continued From page 46 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to ensure that the daily posted nurse staffing information was current and completed in its entirety.	F 732	The correct date for nurse staffing was immediately posted in a prominent place readily accessible to residents and visitors. -All residents have the potential to be affected by this deficient practice.	

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F 732	Continued From page 47 This deficient practice was evidence by the following: On 10/04/23 at 9:05 AM, when the survey team entered the facility, the surveyor observed the facility's Nursing Home Resident Care Staffing Report posted at the receptionist desk was dated 09/22/23 Day Shift and did not include Certified Nurse Aides (CNA) information, such as the total number of hours worked. The Staffing Report was inside of a plastic frame and there was no other Staffing Report visible at the receptionist desk. On 10/05/23 at 12:20 PM, the surveyor observed there was a staffing schedule posted at the receptionist desk in a plastic frame, but was unable to locate the nurse staffing information that included the total number of hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. There was a second plastic frame at the receptionist desk which contained the sign announcing the recertification survey. When the surveyor asked the receptionist where the current Staffing Report was posted, the receptionist stated she would have to call the Scheduler. At 12:25 PM, the Scheduler arrived at the receptionist's desk. When asked where the current Staffing Report was posted, the Scheduler was unsure what the surveyor was talking about and stated she would have to ask the Licensed Nursing Home Administrator (LNHA). At 12:28 PM, the surveyor accompanied the Scheduler to the LNHA's office to ask about the Staffing Report. The LNHA stated that the facility	F 732	-Education was provided to the scheduler to ensure there was a process to maintain current daily staffing postings with all three nursing disciplines at the start of the shift, seven days a week. Education was provided to the scheduler on the facility policy to maintain daily staffing records for a period of 18 months. -DON or designee will ensure nurse staffing posting is correct daily 5 times a week for 4 weeks, 3 times a week for 8 weeks, and weekly for 12 weeks. DON or designee will report any findings of audits to the monthly Quality Assurance meeting. - the facility will be in compliance by 11/30/23	

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was currently between Schedulers, as the previous Scheduler was terminated, and the new Scheduler was recently hired. The LNHA further stated that the previous Scheduler was responsible for posting the daily Staffing Report for each shift until she was terminated and then the Director of Concierge (DOC) was responsible until the new Scheduler could be trained on the process. When asked who the surveyor should speak to regarding the Staffing Reports, the LNHA stated that "maybe" the Director of Nursing (DON) was posting the Staffing Report while between Schedulers and that he would get the DON for the surveyor.

At 12:32 PM, the surveyor observed the DON and the Scheduler at the receptionist desk together holding the current Staffing Report. The DON stated that the current Staffing Report was placed behind the sign announcing the recertification survey at the receptionist desk.

At 12:34 PM, the surveyor interviewed the DON and the Scheduler. The DON stated the Scheduler was responsible for completing the Staffing Report every shift. The DON further stated the prior Scheduler was terminated on [redacted] and had completed the Staffing Reports through 09/24/23, and afterwards, the DOC completed the Staffing Reports starting 09/25/23. The DON also stated that the Staffing Reports should not be hidden behind other signs at the receptionist desk.

At 12:40 PM, the Scheduler stated she started at the facility on [redacted] and was responsible for completing the Staffing Reports accurately and in their entirety. The Scheduler further stated that she posted the Day Shift report in the morning

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and then posted the Evening and Night Shift reports on the 3:00 - 11:00 PM shift. The Scheduler added that on the weekends, the Staffing Reports were printed for the Supervisors to post, and that the Staffing Reports were posted at the receptionist desk. The Scheduler then stated that the 09/22/23 Day Shift Staffing Report had been posted by the previous Scheduler and that it should have included CNA information. When asked about the Staffing Reports from 09/22/23 Evening Shift to 10/04/23 Night Shift, the Scheduler stated she does not maintain copies of the Staffing Report since she can go online to print them.

At 12:56 PM, the surveyor accompanied the Scheduler to the receptionist desk to print the Staffing Reports for 09/22/23 Dayshift through 10/05/23 Day Shift. The surveyor reviewed the Staffing Reports in the presence of the Scheduler who verified the following:
-The 09/22/23 Day Shift was missing CNA information.
-The 09/22/23 Evening Shift was missing CNA information.
-The 09/23/23 Day Shift had no shift information available.
-The 09/23/23 Evening Shift had no shift information available.
-The 09/23/23 Night Shift had no shift information available.
-The 09/24/23 Day Shift had no shift information available.
-The 09/24/23 Evening Shift had no shift information available.
-The 09/24/23 Night Shift had no shift information available.
-The 09/25/23 Day Shift had no shift information available.

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-The 09/25/23 Evening Shift had no shift information available.
-The 09/25/23 Night Shift had no shift information available.
-The 09/28/23 Day Shift had no shift information available.

At 1:25 PM, the surveyor interviewed the DOC who stated the previous Scheduler was responsible for the Staffing Reports for Friday 09/22/23 through Monday 09/25/23, and should have printed them to be given to the weekend Supervisor to post 09/23/23 through 09/24/23. When asked who was responsible for posting the 09/25/23 Staffing Report, the DOC stated they were between Schedulers at that time, so he was unsure who was responsible. The DOC further stated that starting on 09/26/23, the new Scheduler was responsible for posting the Staffing Reports. When asked about the Staffing Reports that were missing CNA information or the entire shift information, the DOC stated they should have been completed in their entirety. The DOC also stated that the current Staffing Report should have been posted at the receptionist desk.

Review of the facility's Nurse Staffing Posting Information policy, revised 01/2023, included, "The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: ... Certified Nurse Aides," and, "The facility will post the Nurse Staffing Sheet at the beginning of each shift. The information posted will be: ... In a prominent place readily accessible to residents and visitors." Further review of the policy included, "Nursing schedules and posting information will be maintained in the Human Resources Department for review for a minimum

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F 732	Continued From page 51 of 18 months or as required by State law, whichever is greater. NJAC 8:39-41.2 (a)	F 732		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of facility documentation it was determined that the facility failed to: a.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination and b.) maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and	F 812	I. Corrective actions accomplished for residents found to have been affected by the deficient practice: 1. 2 pots identified with liquid on drying rack were rewashed and let dry properly. All dietary staff were educated/in-serviced on proper pot washing policy/processes. 2. All cutting boards were replaced immediately.	12/15/23

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F 812	Continued From page 52 evidenced by the following: On 10/04/23 at 09:45 AM, the surveyor started the kitchen tour in the presence of the cook, while awaiting the arrival of the Director of Dining Services (DDS). At 09:52 AM, the surveyor was met by the Food Services Director (FSD) of a sister facility and continued the tour. The surveyor observed the following: 1. On the metal dried storage rack, there were two 6-inch-deep pans with clear liquid between them. The FSD acknowledged the liquid and stated that it should not have been wet nested because it could have caused bacterial growth. 2. Under the cook service area in a rack on the lower metal shelf, there were several cutting boards. There was a large yellow cutting board with black scratches on both sides of the board. The FSD acknowledged the scratches and stated that that was what happened when they were used for cutting and that she did not think the scratches should have been there. The FSD stated that it was important to make sure food surfaces were clean. The FSD removed the yellow cutting board to the three-compartment sink area for rewashing and stated that if the scratches did not come off the cutting board, that it would be replaced. 3. The large standing mixer was covered with a clear plastic bag. The FSD stated that once equipment was cleaned and sanitized that they were covered. The FSD removed the plastic bag and there was white debris noted on the base leg and dried brown smudged debris on the outside	F 812	3. Large mixer was re washed properly. All dietary staff were educated/in-serviced on proper ware washing and equipment storage policy/processes. 4. Employee was coached immediately on proper hairnet application, and she corrected her hairnet on the spot. All dietary staff were educated/in-serviced on proper hairnet application policy/process. Date of Completion: 11/01/2023 II. All residents can be affected by this defcient practice III. Measures put into place or systemic changes to ensure that the deficient practice will not reoccur: 1. All dietary staff were educated/in-serviced on proper pot washing policy/processes. 2. FSD was educated on cutting board standard. 3. All dietary staff were educated/in-serviced on proper ware washing and equipment storage policy/processes. 4. All dietary staff were educated/in-serviced on hairnet application policy/processes. 5. Manager□s weekly audit form put in place to monitor proper execution of corrective actions. Findings will be presented at the QAPI meeting Date of Completion: 11/01/2023 III. Monitoring of corrective actions:	

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F 812	Continued From page 53 of the mixing bowl. The FSD wiped the white debris with her finger then scraped at the brown debris with her fingernail. The FSD stated the brown debris was "chocolate" and that it was a small mark, but the inside of the bowl was clean. When the surveyor inquired as to whether the debris should have been on the mixer, the FSD stated, "It's just a small mark, they did a pretty good job (of cleaning the mixer)." The FSD stated that it was important to keep equipment clean to prevent contamination. On 10/05/23 at 10:52 AM, the surveyor toured the kitchen in the presence of the DDS and observed the following: 4. At the dishwasher dirty side, there was a dish washer (DW) observed cleaning off the dishes and placing them into the dishwasher. The DW was wearing a hairnet on the back of her head with her long bangs on her forehead exposed and not contained in the hairnet. The DW stated that everyone who entered the kitchen was to wear a hairnet and acknowledged that she was not wearing the hairnet correctly. She stated that her hairnet should have been pulled down and motioned to her bangs. The DW stated it was important to keep all hair covered by the hairnet, so no hair went into the food. The DDS witnessed the interaction between the surveyor and the DW and apologized. The DDS stated that before entering the kitchen that all hair was to be covered by a hairnet or beard net and that the DW was not wearing her hairnet correctly. The DDS further stated that it was important to make sure all hair was covered with a hairnet to prevent hair from contaminating the food or the kitchen equipment.	F 812	1. The monitoring of Pot Washing will be completed by the FSD/Designee using Weekly Audit form for 3 months or until concerns are corrected. 1. Pot washing audits findings will be reported to the Administrator weekly. 2. Cutting board inspections will be completed by the FSD/Designee using Weekly Audit form for 3 months or until concerns are corrected. 1. Cutting board audit findings will be reported to the Administrator weekly. 3. The monitoring of execution ware washing standards and equipment storage will be completed by the FSD/Designee using Weekly Audit form for 3 months or until concerns are corrected. 1. Ware washing audits findings will be reported to the Administrator weekly. 4. The monitoring of execution of proper hairnet application policy/processes will be completed by the FSD/Designee using Weekly Audit form for 3 months or until concerns are corrected. 1. Hairnet policy/processes audits findings will be reported to the Administrator weekly. the findings will be presented at the QAPI meeting. Date of Completion: 12/15/2023	

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F 812	Continued From page 54 A review of the facility documentation, "Dietary Department Inservice," dated 8/29/2022, revealed there was a review of the hairnet policy which the DW signed in attendance. A review of the undated facility policy, "Staff Attire," revealed Policy Statement: All employees wear approved attire for the performance of their duties. Procedures: 1. All staff members will have their hair off the shoulders, confined in a hair net ... A review of the facility policy, "Warewashing," with a revision date of 9/2017, revealed Procedures: 4. All dishware will be air dried and properly stored. A review of the facility policy, "Equipment," with a revision date of 9/2017, revealed Policy Statement: All foodservice equipment will be clean, sanitary, and in proper working order. Procedures: 3. All food contact equipment will be cleaned and sanitized after every use. 4. All non-food contact equipment will be clean and free of debris. NJAC 8:39-17.2(g)	F 812		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey. This deficient practiced was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. Inadequate number of Certified Nursing Assistants 2.All the residents may be affected by the short staff as required by NJ DOH 3.• The Administrator will in-service the new Staffing Coordinator in reference to the state guideline S560. • The Director of Human Resources will continue to post the vacancies on all 3 shifts. • The Director of Human Resources will schedule the Open House. • The Administrator will boost the rate when there is an emergency staffing coverage.	11/30/23

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

Electronically Signed | 11/07/23

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COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: 1. For the week of Complaint staffing from 02/27/2022 to 03/05/2022, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -02/27/22 had 7 CNAs for 79 residents on the day shift, required at least 10 CNAs. -02/28/22 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -03/01/22 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -03/04/22 had 8 CNAs for 69 residents on the day shift, required at least 9 CNAs. -03/05/22 had 7 CNAs for 69 residents on the day shift, required at least 9 CNAs. 2. For the week of Complaint staffing from	S 560	• The staffing agency will block a schedule for the open position to cover the vacancies. • The Administrator just hired a new Staffing Coordinator 4.• The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 3 months. • The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee 5. The facility will be in compliance by 11/30/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061106	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

(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 2 05/22/2022 to 05/28/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -05/22/22 had 6 CNAs for 81 residents on the day shift, required at least 10 CNAs. -05/23/22 had 7 CNAs for 81 residents on the day shift, required at least 10 CNAs. -05/24/22 had 7 CNAs for 81 residents on the day shift, required at least 10 CNAs. -05/25/22 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs. -05/26/22 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs. -05/27/22 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs. -05/28/22 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs. 3. For the week of Complaint staffing for residents on 7 of 7 day shifts as follows: -11/13/22 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -11/14/22 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -11/15/22 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -11/16/22 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -11/17/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/18/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/19/22 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. 4. For the 2 weeks of staffing prior to survey from 09/17/2023 to 09/30/2023, the facility was deficient in CNA staffing for residents on 14 of 14	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

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S 560	Continued From page 3	S 560		

day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows:

-09/17/23 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs.
-09/18/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs.
-09/19/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-09/20/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-09/21/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-09/22/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-09/23/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-09/23/23 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff.

-09/24/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-09/24/23 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff.
-09/25/23 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-09/26/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-09/27/23 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-09/28/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs.
-09/29/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs.
-09/30/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs.

On 10/05/23 at 12:53 PM, the surveyor interviewed the Scheduler who stated that the

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S 560	Continued From page 4 state minimum requirements for staffing were one (1) CNA for eight (8) residents on the 7 AM to 3 PM day shift, 1 CNA to 10 residents on the 3 PM to 11 PM evening shift, and 1 CNA for 14 residents on the 11 PM to 7 AM shift. On 10/12/23 at 10:34 AM, the surveyor interviewed the Director of Nursing (DON) who stated the higher the facility census, the more staff that was needed. She further stated the facility handled callouts by using on-call staff and posting the availability for other staff and agencies. The DON stated that the residents, the staff, and families have brought workload concerns to her more so since COVID, but that the facility was "really not short staffed." She explained that they used agency staff daily, but tried to used facility staff as much as possible for continuity of care. On 10/12/23 at 10:55 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the state minimum requirements for staffing were one (1) CNA for eight (8) residents on the 7 AM to 3 PM day shift, 1 CNA to 10 residents on the 3 PM to 11 PM evening shift, and 1 CNA for 14 residents on the 11 PM to 7 AM shift.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315094	A. Building B. Wing	12/21/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 11/30/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
10/16/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061106		12/21/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

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

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/30/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
10/16/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315094	A. BUILDING **01** B. WING _____	**10/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD** **MERCERVILLE, NJ 08619**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 10/11/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/11/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Complete Care at Mercerville is a two-story building with a partial basement that was built in the 1950's. It is composed of Type V protected construction. The facility is divided into eight - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 110 of 114. .	K 000		
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or	K 232		10/31/25

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

Electronically Signed | 11/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 232	Continued From page 1 unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the corridor width on the second floor was at least 44 inches in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 19.2.3.4. This deficient practice had the potential to affect 110 residents. Findings include: An observation on 10/11/23 at 12:33 PM revealed the corridors on the second floor were 36 inches and 41 inches respectfully. At the time of observation, the Maintenance Director and the Regional Maintenance Director were present and confirmed the corridors on the second floor were not 44 inches in width. NJAC 8:39-31.2(e) .	K 232	1. The corridor on our second floor measured less than the required 44 inches which is not in compliance with NFPA 101 Life Safety Code 2. The deficient practice does not affect any residents. Because its upstairs and the door is locked 3. We are requesting a time- limited waiver (TLW). This TLW is needed because the facility will need more time to correct this issue. The facility will be widening the corridor to the proper width. The residents and visitors will be safe, because the door is locked preventing them from accessing the upstairs. We have implemented additional life safety measures for the staff, which go above and beyond the minimum requirements, including but not limited to , the maintenance director or designee doing bi yearly fire drills in these specific corridors followed by in -services on safety measures in these corridors for the staff. We will also make sure the corridors are kept clutter free and we will change the combination number quarterly. The Maintenance Director or designee will monitor safety and project milestones monthly until completion.	

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K 232	Continued From page 2	K 232	We will secure an engineer for the project by January 31,2024. We will submit the plans to the DCA for approval by May 31, 2024. We hope to get their approval by August 31,2024. We hope to have all approvals from local, county and state by 12/31/2024. We anticipate the project will take approximately 6-9 months and will completed by October 31,25 4. The findings of the monitoring will be presented to the administrator at the quarterly QAPI meetings. 5. The anticipate the completion of the project by 10/31/2025	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101	K 311	1. The fire door hardware identified on the two stairway exit doors, located on the first and second floors and adjacent to the main entrance, was replaced with the correct fire-rated door assemblies in	11/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 311	Continued From page 3 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect 110 residents. Findings include: An observation on 10/11/23 at 12:33 PM revealed two of two stairway exit doors, located on the first and second floors and adjacent to the main entrance, were equipped with panic hardware which violated the listing of the rated fire door assembly. During an interview at the time of observation, the Maintenance Director and the Regional Maintenance Director confirmed the stairway exit doors were equipped with panic hardware. NJAC 8:39-31.2(e) NFPA 80 .	K 311	accordance with NFPA. 2. All residents have the potential to be affected by this deficient practice. The remainder of the facility fire doors were assessed to ensure proper hardware was in place with no further non-compliance noted. 3. The Maintenance Director was educated on correct fire-rated door assemblies with approved fire exit hardware to ensure any further corrections to facility fire doors receive proper hardware. 4. The administrator or designee will audit all facility fire doors to ensure the correct fire-rated door assemblies with approved fire exit hardware are in place weekly for four weeks, then monthly for two months. All findings will be reported at the facility's monthly QAPI meeting. 5. the facility will be in compliance by 11/15/23	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on document review, observation and	K 345	1. The smoke detector sensitivity test for the facility was completed with	11/15/23

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K 345	Continued From page 4 interview, the facility failed to ensure smoke detection sensitivity testing of the smoke detectors was completed every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 110 residents. Findings include: A document review of the facility binder for the calendar year 2023, provided by the Maintenance Director, revealed the fire alarm "Inspection and Testing Reports" dated 07/07/23 had no reference to a smoke detection sensitivity test. An observation of the facility smoke detectors on 10/11/23 from 12:30 PM to 02:30 PM revealed smoke detectors were in the corridors at the smoke barriers, in all sleeping rooms, and other concealed areas throughout the building. During an interview at the time of observation, the Maintenance Director and Regional Maintenance Director confirmed that the smoke sensitivity testing was not completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	documentation provided. 2. All residents have the potential to be affected by this deficient practice. 3. The Maintenance Director was educated on the requirement to have the smoke detectors tested for sensitivity every year. The Maintenance Director has included this task in the center's work schedule calendar. 4. The Administrator or designee will audit the Maintenance director calendar each month for six months to ensure that the test results are documented and that no further facility-required tests are missed. the audit will also ensure that the requests are made for the next scheduled sensitivity test in a timely manner. Results of the findings will be presented at the quaterly QAPI meeting. 5. The facility will be in compliance by 11/15/23.	
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	K 363		11/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 5 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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure corridor doors closed and latched	K 363	1. Doors to room 29 and room 32 were immediately corrected to ensure that they both now latch properly to prevent any	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD** **MERCERVILLE, NJ 08619**

(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 363	Continued From page 6 in their frames and there were no impediments to the closing of the doors in accordance with NFPA 101 Life Safety Code (2012 edition) Section 19.3.6.3 This deficient practice had the potential to affect 25 residents. Findings include: An observation on 10/11/23 at 12:47 PM revealed the door to Room 29 failed to latch when closed and the door to Room 32 was catching on the threshold on the floor. During an interview at the time of the observation, the Maintenance Director confirmed the door to Room 32 was catching on the threshold and the door to Room 29 failed to latch when closed. NJAC 8:39-31.1(c), 31.2(e) .	K 363	impediment. 2. All residents have the potential to be affected by this deficient practice. All facility doors were assessed, and they all latched properly when closed with no impediment. 3. The Maintenance Director was educated on the need for all resident room doors to properly close and latch. All staff were educated to inform the Maintenance Director immediately if any notation of door concerns is noted. 4. The Administrator or designee will conduct audits on random resident room doors to ensure they close and latch properly. These audits will be 4 random doors per week for 4 weeks and then 5 random doors per month for 3 months. The findings will be brought to the quarterly QAPI meeting 5. The facility will be in compliance by 11/1/23.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.	K 761		11/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315094	A. BUILDING **01** B. WING _____	**10/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD** **MERCERVILLE, NJ 08619**

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K 761	Continued From page 7 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 110 residents. Findings include: An observation of the facility's fire doors on 10/11/23 from 12:30 PM to 2:30 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of the observation, the Maintenance Director and Regional Maintenance Director confirmed the fire doors were not inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 761	1. Fire door checklist was obtained, and all checks were done on all fire doors in accordance with NFPA 101 Life Safety Code Section 7.2.1.15. 2. This deficient practice has the potetial to affect all residents. 3. 3. The Maintenance Director was educated on the process of following the checklist for fire doors. Audits will be preformed to to ensure that the fire doors are always tagged with the proper tags. 4. The administrator or designee will audit all facility fire doors to ensure the doors are still up to the code as per the checklist. the audits will be done weekly for four weeks, then monthly for two months. All findings will be reported at the facility's monthly QAPI meeting. 5. the facility will be in compliance by 11/15/23	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		11/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315094	A. BUILDING **01** B. WING _____	**10/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD** **MERCERVILLE, NJ 08619**

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K 918	Continued From page 8 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to ensure the three-year load bank test was completed on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had the potential to affect all 110 residents.	K 918	1. The 4 hour load test of the generator was completed by our generator company, GenServe in accordance with NFPA 110. 2. All residents have the potential to be affected by this deficient practice.	

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	315094	A. BUILDING **01** B. WING _____	**10/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD** **MERCERVILLE, NJ 08619**

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K 918	Continued From page 9 Findings include: A document review of the generator reports for 2022 and 2023, provided by the Maintenance Director, revealed a three-year load bank test had not been completed for the emergency generator. During an interview at 2:55 PM on 10/11/23 the Maintenance Director confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110 .	K 918	3. The Maintenance Director was educated on this section of the code that the generator needs to be tested for 4 hours continuously in accordance with NFPA 110. The Maintenace Director has included this task in the center's work schedule calendar. 4. The administrator or designee will audit the Maintenance director calendar each month for six months to ensure no further facility-required tests are missed and timely requests are made for the next generator test. All findings will be reported at the facility's quaterly QAPI meeting. 5. the facility will be in compliance by 11/15/23	

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	315094	A. BUILDING **01** B. WING _____	R **02/27/2024**

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{E 000}	Initial Comments	{E 000}		
{K 000}	INITIAL COMMENTS The facility is requesting a time-limited waiver for K232. SA reviewed the POC and recommends approval. Infromation has been sent to CMS for final determination on 11/22/2023. All other tags have been accepted and approved.	{K 000}		

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315094 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/27/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

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 K0232	11/15/2023	LSC K0311	11/15/2023	LSC K0345	11/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	11/01/2023	LSC K0761	11/15/2023	LSC K0918	11/15/2023
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	
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	
10/16/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO