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WATERS EDGE HEALTHCARE & REHAB	512 UNION STREET TRENTON, NJ 08611

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F 000	INITIAL COMMENTS Survey Date: 4/14/22 Census: 132 Sample: 27 + 3 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		5/16/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/29/2022

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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to a.) inform and offer educational material regarding advance directives (written instruction including but not limited to living will, medication restrictions, and treatment restriction for the provision of healthcare when an individual is incapacitated) with a resident's legal representative, and b.) ensure life-sustaining treatment wishes were reviewed with the residents or their representatives and documented consistently within the medical record. This deficient practice was identified for 2 of 2 residents (Resident #96 and #62) reviewed for advance care planning and directives and was evidenced by the following: On 4/5/22 at 9:12 AM, the surveyor observed Resident #96 in a recliner chair in the 3rd unit day room. The surveyor attempted to talk to the resident, but the resident did not respond.	F 578	1. In reference to Resident #96: Social Services contacted the Guardian and reconfirmed the Full Code status of the resident. Information regarding the resident wishes was updated on the resident Care Plan. In reference to resident #62: Social Services confirmed resident capacity to perform an Advanced Directive. An Advanced Directive was completed with the resident and discussed with the Residents P.O.A. Resident confirmed his full code status as per the new Advanced Directive. Information regarding was updated on the Resident Care Plan. 2.All Residents have the potential to be negatively affected if they are not educated or offered the rights to accept or refuse medical or surgical treatment and,	

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F 578	Continued From page 2 The surveyor reviewed the medical record for Resident #96. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] The Admission Record indicated Resident #96 had a guardian and under "[redacted]", the resident was listed as a full code. A review of the Judgement of Incapacity and Appointment of Guardian of Person and Estate filed 9/6/18 included the Guardian shall ascertain and consider characteristics which define uniqueness and individuality; encourage the incapacitated person to express preferences and participate in decision-making; and promote the incapacitated person's right to privacy, dignity, respect, and self-determination. The document further indicated any advance directive for healthcare previously executed by [Resident #96] was voided, but the Guardian shall consider the preferences expressed in such advance directive. A review of the resident's individualized care plan focus area, did not include the resident's life sustaining treatment wishes or code status. A review of the "Acknowledgement of Receipt Resident Rights Advance Directives" packet of information, included but was not limited to a page for the resident or responsible party to sign with a facility representative. The acknowledgment page included acknowledging	F 578	at the resident option, formulate an Advanced Directive. 3.A whole house review of the current status of residents and their current Advanced Directive was performed. Competency of Residents without Advanced Directives was reviewed. Those capable of making the decision on Advanced Directives were educated and offered the ability to complete an Advanced Directive. Any changes or updates regarding Residents Advanced Directives was placed on the Residents Care Plan. The facility Admission Agreement was updated to provide improved education and offering to Residents/Family regarding Advanced Directives and the process for completing upon admission. Social Services will audit 20 residents per quarter for education, competency, and completion of Advanced Directives. This will also include review of Resident Care Plans to assure information is documented. Re-education to the Nursing Management and Social Services staff regarding Advanced Directives and requirements to offer and complete if appropriate was completed. 4. Above audits on Advanced Directives and	

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F 578	Continued From page 3 receipt of a copy of the resident rights, informed of rights under the Federal and State law to execute an Advance Directive, have an Advance Directive on file, or do not have an Advance Directive and do not want to execute one. There was no opportunity offered on the acknowledgement page to have the Advance Directive education discussed, explained or offered. The packet included that if the resident was unable to make decisions, they directed loved ones and healthcare providers to follow my (resident) instructions as set forth below. (Initial all those that apply.) The packet contained six options and the opportunity to check only a.) direct that life-sustaining treatment which would serve only to artificially prolong dying be withheld or ended. Also, all medically appropriate treatment and care necessary to make me comfortable and to relieve pain. b.) direct that life-sustaining treatment be continued if medically appropriate. The packet covered the definition of brain death and to initial only if applies to declare death on the basis of the whole brain death standard would violate personal religious believes. Therefore, with my death to be declared only when my heartbeat and breathing have irreversibly stopped. The packet concluded with signatures witnessed by two people or notarized. On 4/6/22 at 9:46 AM, the surveyor interviewed the Social Worker (SW) who stated she had worked at the facility for nine years. The SW stated when a resident was admitted that the medical records department would let her know about POLST (New Jersey Practitioner Orders for Life-Sustaining Treatment) and code status. If there were "no advance directive", we (the facility) asked during the initial assessment. If a resident was confused, the family member was contacted.	F 578	Care Plans will be provided to the Administrator and DON on a Monthly basis for 6 months. If continued issues with Advanced Directives and documentation continues following 6 months, audits will continue until compliance is achieved for a minimum of three month. A quarterly report summarizing the education and initiation of Advanced Directives with Residents and appropriate documentation in care plans will be provided to the team at the Quarterly Quality meetings by the Social Services Department.	

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The SW went on to state that a family member was not able to establish advance directives except if they were the legal guardian. The SW stated that advance directives would be discussed every three months during the care plan meeting.

On 4/6/22 at 12:55 PM, the surveyor re-interviewed the SW who stated "I do believe when we do our care plan meeting" we documented that we asked the resident if they were interested (in an advance directive). When asked what a POLST was, the SW replied "family being able to make a short term" decision what they would like done. The SW acknowledged that a POLST and advance directive were different; that an advance directive was 'the patient and/or family are letting us know" what the resident desired. The SW further stated if the resident or family stated they were not interested in advance directives, "I do not have a next step to give" to provide anything. She stated in resident council, the facility informed the residents they were doing an annual resident rights review and advance directive review meaning we provided or sent out the advance directive to the residents and families. The SW stated there would be a paper for the resident if able or family to sign.

On 4/6/22 at 1:21 PM, the surveyor interviewed the Director of Social Services (DSS) who provided and reviewed the form that was given to residents and/or their family on an annual basis. She stated that the form did not cover such things as DNH (Do Not Hospitalize) because that would be part of the POLST. She further acknowledged that the form was a form and packet were given to check off the information but there were no educational pieces that would be provided with

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the form.

On 4/6/22 at 1:29 PM, the surveyor interviewed the SW who stated she discussed with those (residents) and asked the residents if they were interested in advance directives. The SW stated the discussion was in regard to if the resident wanted to be DNR (do not resuscitate), intubate, have a feeding tube, kept comfortable, and going to hospital. The SW stated she could not say she followed up if a family had not returned the forms and that the importance of the advance directive was to let the family and facility know the resident wishes.

On 4/7/22 at 9:26 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated if there were no advance directives on admission, the facility would offer them. She stated that the SW discussed the advance directives quarterly, but she was unaware if any education was provided. The ADON stated she was not aware of documentation about education or additional information if no advance directives were on the chart.

On 4/7/22 at 9:39 AM, the surveyor interviewed the DSS who stated she could not provide information on advance directives for Resident #96 because his/her resident representative stated they wanted the resident to be a Full Code. The DSS stated that SW documented nothing about advanced directives education, only noted about code status. The DSS stated she needed to look further into it Resident #96's advance directives because the Social Services Department had focused on code status and POLST. The DSS further stated that Resident #96 was incapacitated and only a resident could

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make their advance directives not the family.

On 4/7/22 at 10:25 AM, the surveyor called Resident #96's resident representative who was the legal guardian, but there was no answer and no message availability.

On 4/14/22 at 9:28 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), ADON, and survey team acknowledged that Resident #96 did not have an advance directive and there was no documentation the resident representative was educated.

2. On 3/31/22 at 10:00 AM, the surveyor observed Resident #62 EX Order 26 § 4b1 [redacted] to the Nurse's Station. The resident asked the nurse to read the lunch menu.

The surveyor reviewed the medical records for Resident #62.

A review of the Admission Record reflected the resident was admitted to the facility with diagnoses which included EX Order 26 § 4b1 EX Order 26 § 4b1 The record indicated the resident had a Power of Attorney responsible for their care. The section for Advance Directive reflected there was no advanced directive, resident was a full code

A review of the electronic Medical Record included under the resident's profile, a section to enter the resident's life sustaining treatment wishes EX Order 26 § 4b1 [redacted]

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A review of the current physician's orders revealed an order dated 3/31/22 for no advanced directives- full code.

A review of the resident's individualized care plan did not include the resident's life sustaining treatment wishes or code status.

On 4/6/22 at 11:13 AM, the surveyor interviewed Resident #62's Licensed Practical Nurse/Unit Manager (LPN/UM) who stated the facility does use a POLST form that can be found on the resident's chart. LPN/UM stated if there was no POLST in the chart it was assumed the resident was a full code. She further stated the code status information was reviewed with the residents quarterly at the Interdisciplinary team (IDT) meetings.

On 4/6/22 at 1:09 PM, the surveyor interviewed the DSS who stated every year the facility sent out notices to all resident and their families that provided instructions for forming an advanced directive. The DSS could not provide evidence that either Resident #62 or his/her family had been given the education to complete an advanced directive.

On 4/11/22 at 11:55 AM, the surveyor interviewed the DON who stated if we do not have an advanced directive or a POLST, then we considered the resident a full code. The SW addressed on the quarterly IDT meeting document that advanced directives were discussed and should be able to discuss the process of forming an advanced directive and provided the education for forming one. The DON stated she was unsure if Resident #62 had a POLST form and acknowledged code status was

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not the same as an advanced directive.

A review of the facility provided policy and procedure, "Advance Directives" dated January 2021, included Purpose: the staff ..will assist the residents and their families/friends in understanding and being sensitive to end-of-life decisions. Procedure: upon admission the admitting nurse will question the existence of an advance directive; if the resident does not have an advance directive, the social services director or designee will provide information concerning the right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. In accordance with current OBRA (Omnibus Budget Reconciliation Act) definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include but are not limited to:
Living Will- preferences about measure used to prolong life when there is a terminal prognosis...
Do Not Resuscitate- indicates in a case of respiratory or cardiac failure, no cardiopulmonary resuscitation or other life-saving methods are to be used.
Do Not Intubate- indicates a resident will not have a tracheal intubation performed for ventilator or manual respiratory support if in respiratory failure.
Do Not Hospitalize- indicates the resident is not to be hospitalized even if the medical condition that would usually require hospitalization.
Organ Donation- indicates the resident wishes his/her organs be available for transplantation upon his/her death.
Autopsy Request- indicates an autopsy be performed upon death.
Feeding Restrictions- indicates wishes to be fed

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F 578	Continued From page 9 by artificial means if he/she is not able to be nourished by oral means. Medication Restrictions- indicates a wish to not receive life-sustaining medications. Other Treatment Restrictions- indicates other wishes for the resident to not receive certain medical treatments. The interdisciplinary team will review the resident's advance directives to ensure that the directives are still the wishes of the resident. These reviews will be done quarterly and with significant changes as defined by the MDS (Minimum Data Set). The attending Physician will be informed of advance directives, or changes to an existing directive, so that appropriate orders can be documented in the resident's medical record and plan of care. Written information on advance directives will be provided and will include, a summary of the state law outlining the rights of residents to formulate advance directives. NJAC 8:39-4.1(a)(3)(4); 9.6(a)	F 578		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those	F 582		5/16/22

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services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of

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F 582	Continued From page 11 these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to issue the required Notice to Medicare Provider Non-coverage (NOMNC) for 2 of 3 residents (Resident #382 and #383) reviewed for change notifications. This deficient practice was evidenced by the following: On 4/5/22 at 9:00 AM, the surveyor reviewed three residents (Resident #79, #382, and #383) who were discharged from the Medicare Part A stay with benefit days remaining within the past six months and should have received Beneficiary Notices. Resident #382 was admitted to the facility in December 2021. The last documented covered day of Medicare Part A service coverage was 2/12/22 from a voluntary discharge when benefit days were not exhausted. The facility did not present the resident with the required NOMNC form to notify them their right to an expedited review of a service termination. Resident #383 was admitted to the facility in December of 2021. The last documented covered day of Medicare Part A service coverage was 2/3/22 from a facility initiated discharge when benefit days were not exhausted. The facility did not present the resident with the required NOMNC form to notify them their right to an expedited review of service termination. On 4/7/22 at 1:05 PM, the surveyor interviewed the Social Worker (SW) who stated that the NOMNC form was given to the resident or their	F 582	1. Resident # 382 and #383 were already discharged from the facility when the deficient practice error was discovered. Immediate in servicing was given by the Administrator to the Social Services and MDS team regarding proper notification of Advance Beneficiary Notice and Notice of Medicare Non-Coverage forms prior to discharge. 2.All residents can be affected if proper notifications of eligibility are not provided timely at discharge or change of service. 3.The MDS Director will work with Social Services to review all possible weekly resident discharges or expected changes in coverage to assure proper notifications are distributed timely. The MDS Director or Designee will provide the Administrator copies of signed notices on a weekly basis based on weekly review performed above. The MDS Director or Designee will track all notifications provided to utilize for audit purposes to assure ongoing compliance on proper notification and document completion. 4.The MDS Director will provide information on the above audit to the Administrator on a monthly basis for a minimum of six months. If concerns continue after six months, audits shall continue until compliance is achieved for	

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F 582	Continued From page 12 representative to inform them their last day of Medicare Part A coverage and their right to appeal. The SW stated that the Minimum Data Set (MDS) Coordinator who was out of the facility for the survey was in charge of providing the NOMNC forms for Resident #382 and #383. On 4/7/22 at 1:36 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the MDS Coordinator was in charge of the NOMNC forms for Resident #382 and #383, and they were out of the facility for the survey so he could not speak to why the forms were not provided. The LNHA confirmed that both residents should have received a NOMNC form. NJAC 8:39-5.4(b)(c)	F 582	a minimum of three consecutive months. The MDS Director shall provide quarterly reports of audits on a quarterly basis at the Quarterly Q. A. meetings.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		5/16/22

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	315324	A. BUILDING _____ B. WING _____	04/14/2022

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F 656	Continued From page 13 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other documentation, it was determined that the facility failed to implement a Care Plan (CP) intervention for a resident with an actual [redacted] This deficient practice was identified for 1 of 4 residents (Resident #96) reviewed for [redacted] and was evidenced by the following: On 4/5/22 at 9:12 AM, the surveyor observed Resident #96 in a recliner chair in the 3rd floor day room. The surveyor attempted to interview the resident, but the resident did not respond. On 4/6/22 at 8:52 AM, the surveyor observed	F 656	1. The [redacted] Care Plan on resident #96 was reviewed and all interventions were to continue, including the floor matts. These matts were re-instituted immediately. The Nurse Aide Kardex was updated to reflect this intervention. 2.All residents with and intervention of floor matts have the potential to be affected by this deficiency. 3.An audit on all the residents with a falls care plan was completed. Implementation for all interventions related to [redacted] were	

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F 656	Continued From page 14 Resident #96 awake lying in bed. The bed was in the low position, there was a foot cushion at the foot board, a perimeter cover (a mattress cover used for EX Ord prevention) on the mattress, but no floor mats. The surveyor noted there were no floor mats in the room. On 4/11/22 at 8:15 AM, the surveyor observed Resident #96 awake and calm lying in bed. The bed was in the low position and there were no floor mats down by either side of the bed or in the room at all. The surveyor reviewed the medical record for Resident #96. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility in EX Order 26 § 4b1 with diagnoses which included EX Order 26 § 4b1 [redacted], EX Order 26 § 4b1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 2/15/22, reflected a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated Ex.Order 26.4(b)(1) . The MDS section G. Functional Status reflected for Balance During Transitions and Walking, the resident was not steady with surface-to-surface transfers. The MDS further reflected in Section J. Health Conditions that the resident had a EX Ord with no injury, since admission/entry or reentry or prior assessment. The MDS reflected under Section O. Therapies, that the resident had ended Occupational Therapy on 10/21/2020.	F 656	checked for entry. Entry on the Residents Kardex used for nurse aide communication was also confirmed. Education on the following: The Director of Nursing gave in-services to the Nurse Managers on Care Plan Policy and documentation entry onto the nurse aide Kardex. The Nurse managers gave in-service education to the professional Nursing staff on the Care Plan Policy and review of the resident care plan. The Nurse managers gave in-service education to the Nurse Aides on the purpose and use of the resident's Kardex. Audits on the following: Every 2 weeks random audits will be done on a minimum of 6 residents that had sustained a EX Ord to verify Care plan interventions are implemented. Every 2 weeks random audits will be done on the nurse aide Kardex for a minimum of 6 residents that had a EX Ord to verify entry of the Care Plan interventions. The audits will be reviewed by the DON/ADON for compliance. 4. These audits will be conducted for 6 months unless full compliance is not reached for a minimum of 3 consecutive months. The audits will continue until this goal is reached The Director of Nursing will report the audit findings at the Quarterly Quality Meetings.	

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A review of the Order Summary Report revealed a physician's order dated 2/16/22 for B/L (bilateral) floor mats.

A review of the facility provided "Resident Accident/Incident Report" revealed Resident #96 was found on the EX Order 26 § 4b1 on 2/3/22 at 3:00 PM. The EX Ord was deemed unwitnessed and no injuries to the resident were noted. The report further indicated that the resident was a risk for EX Order due to poor safety awareness and a history of intentionally putting his/herself EX Order 26 § 4b1.

A review of the resident's individualized CP included a focus area initiated on 8/20/2020 and last revised on 8/26/2020, that the resident was at risk for EX Order 26 § 4b1 The goal initiated on 5/23/17 with a target date of 5/16/22 included the resident would suffer no EX Ord related injuries over the next 90 days. There was a new intervention date initiated 2/16/22, for bilateral floor mats. The "Position" noted to monitor the intervention was the Registered Nurse (RN) and Licensed Practical Nurse (LPN).

A review of the facility provided resident care Kardex (a care plan for CNAs [Certified Nursing Assistant] to refer to), did not include the bilateral floor mats.

A review of the facility provided, EX Order 2 Assessment" dated 2/3/22, revealed Resident #96 scored a EX Or which indicated a EX Order 26 § 4b1.

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F 656	Continued From page 16	F 656		

A review of the facility provided, EX Order 2 Assessment" dated 2/15/22, revealed Resident #96 scored a EX Or which indicated a EX Order 26 § 4b1.

On 4/5/22 at 11:02 AM, the surveyor interviewed the resident's CNA who stated she had worked at the facility for five years and was familiar with the resident. The CNA stated the resident was total care for Activities of Daily Living (ADL), used a reclining chair, spoke mainly Spanish but a little English, and required a special lift device to transfer. The CNA stated if there was anything new with the resident, the nurses would let her know what to do. The CNA further stated Resident #96 had no EX Orde she was aware of but was a EX Or risk so the staff would use the perimeter cover on the bed.

On 4/11/22 at 9:18 AM, the surveyor interviewed the resident's LPN who stated she had worked at the facility for 25 years and normally worked on the 3rd floor unit. The LPN stated the process after a EX Or would be to do an incident report, call the physician and family, and document on the 24-hour report to monitor the resident. The LPN stated the Unit Manager (UM) would be responsible to update the CP. The LPN further stated she looked through the CPs only "when needed" and would find out about a new EX Or mat order from the UM. The LPN stated the UM would put the floor mat in place. The LPN stated she would monitor to see that floor mats were down.

At this time, the LPN and surveyor walked down the low hall and observed various resident's rooms with floor mats. The LPN stated she knew Resident #96 fell in the past few months and that the only intervention was the "scoop" [perimeter] mattress and to keep the bed in the low position.

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The LPN and surveyor went to Resident #96's room and the LPN acknowledged there were no floor mats in the room at all.

On 4/11/22 at 9:26 AM, the surveyor interviewed the 3rd floor RN/UM who stated Resident #96 was at risk for [redacted] with an actual [redacted] at the facility. She stated the [redacted] was on 2/3/22 and interventions put in place were to keep the resident out of bed on Tuesday, Thursday, and Saturday; to do frequent checks when the resident was in their room; to keep the bed in the low position; and to anticipate the resident needs. She stated the CP would be updated and would show any new interventions. The surveyor and the RN/UM reviewed the CP. The RN/UM stated Resident #96 had a special mattress as a new intervention. When inquired, the RN/UM confirmed the resident should have floor mats and the RN/UM verified this by looking in the physician orders.

At this time, the RN/UM and surveyor went to Resident #96's room where the RN/UM acknowledged there were no floor mats. The RN/UM stated the staff nurse, and "I" (RN/UM) should monitor floor mats. The RN/UM stated there would be no log and no documentation but that it was "just done". The RN/UM further stated that new interventions were on the CP and would be reported to the staff. She stated she obtained the floor mats from housekeeping. The RN/UM stated the floor mats were important to prevent injury in case of a [redacted] The RN/UM stated if the floor mats were taken off the resident's floor, they should be still be in the resident's room.

On 4/12/22 at 9:04 AM, the surveyor interviewed the Director of Housekeeping who stated he had

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F 656	Continued From page 18	F 656		

worked at the facility for 10 years. He stated if the nurses needed a floor mat, we (housekeeping) would go to storage and bring them to the nurses. He stated the facility always had floor mats in stock and currently had two full cases. The Director of Housekeeping stated that housekeeping would deliver the floor mats immediately but that he did not keep a record of who received a floor mat or when they were requested. He stated that yesterday he was asked to deliver floor mats to Resident #96's room. He further stated that he remembered the floor mats there before but not sure when he had seen them last in the resident's room.

On 4/12/22 at 11:17 AM, the surveyor interviewed the Director of Nursing (DON) who stated any resident [redacted] would have an assessment done and that once a resident had a [redacted] the facility would look at the cause and decided which interventions to put in place. She stated the facility checked if anything were clinically wrong like an infection. The DON stated the team would meet every morning of every [redacted]. The team would take the information from the clinical meeting to the department director meeting, and [redacted] would be reviewed when they happen and quarterly. She stated if a resident was a frequent [redacted], the team would take a look at the time of day and location to determine factors. The DON stated if a resident were issued a [redacted] mat, the clinical UM would order it from housekeeping and the UM would make sure the staff was aware of the intervention. She stated the intervention would be on CP and CNA Kardex. The DON further stated that the [redacted] mats should be audited by the UM and if missing, should be noticed because the UM made rounds daily.

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F 656	Continued From page 19 A review of the facility provided policy and procedure, "Policy on Resident Care Planning" dated revised July 2021, included... plan of the resident's care is based on clinical, psychosocial, teaching/learning, spiritual, behavioral, and cultural needs and identified individual needs... the care plan will be reviewed and updated by the unit manager and other departments as changes in the resident occur... the care plan is updated as warranted by the resident's changes and preferences. NJAC 8:39- 11.2(e)(1)(2); 27.1(a)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		5/16/22

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F 657	Continued From page 20 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to update and revise the Care Plan (CP) for 1 of 4 residents (Resident #112) reviewed for [redacted] and 1 of 1 resident (Resident #31) reviewed for Ex.Order 26.4(b)(1) [redacted]. This deficient practice was evidenced by the following: 1. On 3/31/22 at 10:20 AM, the surveyor observed Resident #112 in his/her room in bed with the head of the bed elevated and knees bent with call bell within reach. The surveyor attempted to interview the resident, and the resident shook their head "yes" to surveyor, however resident did not respond verbally to the surveyor's questions. On 4/1/22 at 12:17 PM, the surveyor observed the resident in bed, dressed in socks on their feet, head of bed elevated and knees bent. Again, the surveyor attempted to interview the resident, but the resident did not respond to surveyor's greetings, only shook their head. The surveyor observed a high back [redacted] in the room with non-slip cushion on the seat. On 4/4/22 at 11:32 AM, surveyor interviewed the resident's family member who was waiting outside the resident's room. The family member stated they were waiting for the resident to be dressed because the family was taking the	F 657	1. The Care Plan on resident #112 was updated to note the interventions recommended on the [redacted] Incident report were present on the Care Plan. Resident #31, who was treated for a Ex.Order 26.4(b)(1), had their Care Plan updated to note the recognition of the [redacted], treatment of the [redacted] and completion of the [redacted] treatment. 2. All residents who have an incident or new treatment ordered have the potential to be affected. An audit on all residents care plans was completed by the Assistant Director of Nursing and the Nurse Managers. All interventions were assessed for implementation and for notice on the Residents Kardex used for nurse aide communication was also confirmed. 3. Education on the following: The Director of Nursing provided education to the Nurse Managers on Care Plan Policy and entry documentation onto the nurse aide Kardex. The Nurse Managers provided education to the Professional Nursing staff on the Care Plan Policy and review of the resident care plan. The Nurse Managers gave education to the Nurse Aides on the purpose and use	

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F 657	Continued From page 21 resident out of the facility. The family member further stated the last time the resident sustained a [EX Orde] was last year, which resulted in a minor [EX Order 26 § 4b1], but had not [EX Order 26] since. The family member stated that the resident required help getting into their [EX Order 26 § 4b1] and could not operate the [EX Order 26 § 4b1] on their own. On 4/7/22 at 1:19 PM, the surveyor interviewed Certified Nursing Aide (CNA #1) who stated she cared for the resident occasionally, but not recently. CNA #1 explained the resident used the sit to stand machine for transfers and demonstrated that the staff placed a belt around the resident while in the [EX Order 26 § 4b1] and the resident was assisted up by the machine. CNA #1 stated if the resident was in bed, the resident was assisted to the side of the bed and then the belt was placed around the resident's waist and the machine assisted the resident to stand and then sit into the [EX Order 26 § 4b1]. On 4/7/22 at 01:33 PM, the surveyor interviewed CNA #2 who stated she had been taking care of the resident for about three years. CNA #2 stated the resident had a lot of anxiety, could be confused, and did not speak English. CNA #2 also stated the resident relied on her for care, could not walk and required a stand-up lift to transfer into a [EX Order 26 § 4b1]. CNA #2 stated she was unsure if the resident had any recent [EX Order 2]. On 4/7/22 at 1:42 PM, the surveyor interviewed Resident #112's Licensed Practical Nurse Unit Manager (LPN/UM) who stated the resident had been a long-term care resident for a while and the resident liked familiarity, and would get anxious otherwise, and had some [EX Order 2] as a result, but not lately. The previous [EX Orde] were during transfer	F 657	of the residents Kardex. Audits to confirm entry of the incident or new clinical diagnosis and the interventions that were initiated are as follows: Every 2 weeks random audits will be done on a minimum of 10 residents that confirm new Care plan interventions are entered. The audits are done by the Director of Nursing and the Nurse Managers. Every 2 weeks random audits will be done on the nurse aide Kardex for a minimum of 10 residents that had a [EX Orde] to verify entry of the Care Plan interventions. The audits are done by the Nurse Managers. The audits will be reviewed by the DON/ADON for compliance. 4. These audits will be conducted for 6 months unless full compliance is not reached for a minimum of 3 consecutive months. The audits will continue until this goal is reached. The Director of Nursing will report the audit findings at the Quarterly Quality Meetings	

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when the resident would get nervous and would have to be lowered to the floor. The LPN/UM stated a [redacted] was "anytime the butt hits the floor." After a [redacted] there would be an investigation and an incident report would be completed, if we put new interventions into place, we would update the care plan. A [redacted] would be a reason to update the care plan with interventions, but not every [redacted] required an intervention, and the facility did not account for all [redacted] in the care plan.

A review of the facility provided Resident Accident/ Incident Report for Resident #112 dated 2/26/22, revealed at 12:20 PM there was a witnessed [redacted]. Staff reported the resident was assisted to the floor during transfer from bed to [redacted] with no reported injury. The investigation report revealed the immediate interventions implemented were "to continue with safe transfers, call another staff member for help if any prior signs of any increased confusion or agitation. Inform the nurse of any changes if noted prior to care to follow with physician"

The surveyor reviewed the medical record for Resident #112.

A review of the Admission Record (an admission summary) revealed Resident #112 was admitted to the facility with diagnoses that included but were not limited to [redacted].

A review of the annual Minimum Data Set (MDS), an assessment tool dated 2/20/22, reflected in Section J Health Conditions, that the resident experienced a [redacted] since admission without injury. The MDS also reflected that the resident had

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Ex.Order 26.4(b)(1) and required extensive to total dependence with activities of daily living (ADLs).

Further review of the MDS in Section G Functional Status, reflected the resident required extensive one-person assistance with bed mobility, total dependence and two-person assistance to transfer between surfaces including to and from bed, chair, EX Order 26 § 4b1 and standing position and also required a EX Order 26 § 4b1 as a mobility device.

A review of the resident's individualized comprehensive CP included a focused area initiated 2/20/19 and last revised 11/26/21, that the resident was a risk for EX Order due to multiple EX Order at home in which last EX Order resulted in fractured left hip; [he/she] now has ambulatory dysfunction (changes in normal walking); fearful when attempt to stand; remains at risk for EX Order due to poor safety awareness, [he/she] scoops self downward in [his/her] high-back EX Order 26 § 4b1 and fear of EX Order 26 §; shown increased anxiety when [his/her] routine aide has days off. The goal initiated on 2/20/19 with a target date of 5/20/22 included that the resident will have no EX Ord related injuries for ninety days. The interventions included to provide with an electric low bed kept in the lowest position when in bed; to transfer to EX Order 26 § 4b1 with use of sit/stand lift; and to make sure the resident is wearing the proper footwear to include non-skid socks during all transfers. The CP was not updated to include the new interventions from the most recent EX Ord on 2/26/22.

On 4/11/22 at 12:13 PM, the surveyor interviewed the Director of Nursing (DON) who stated the definition of a fall would be anytime you change

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F 657	Continued From page 24 plane. The DON stated some residents placed themselves on the fall and we processed that as a fall as well. The DON continued that the cause of Resident #112's Ex.Order on 2/26/22 was their anxiety when using the sit to stand machine and that there had not been subsequent falls, and there was no fall history. The DON also added the review team did not feel Resident #112 needed to change their type of transfer, the current sit to stand method of transfer was deemed appropriate. The DON stated she did not believe the CP was updated after the Ex.Order on 2/26/22, that the team had discussed the Ex.Orde, but there was nothing else to do. On 4/14/22 at 9:28 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant DON, and survey team, acknowledge that the resident's CP had not been updated and should have been updated after the fall on 2/26/22. A review of the facility's "Policy Resident Care Planning) dated revised July 2021, included ... The care plan will be reviewed and updated by the unit manager and other departments as changes in the resident occur ... 2. On 3/31/22 at 11:06 AM, the surveyor observed Resident #31 resting in bed in their room. The surveyor observed that the resident's room had a	F 657		

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F 657	Continued From page 25 EX Order 26 § 4b1 -EX Order 26 § 4b1 sign by the room's entrance which indicated enhanced barrier precautions and a door mounted storage container containing personal protective equipment (PPE) including disposable isolation gowns, gloves, and hand sanitizer dispenser. On 4/1/22 at 11:00 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated this resident was on Ex.Order 2 for a diagnosis of Ex.Order 26.4(b)(1)) and had received two rounds of antibiotics with a physician's order for repeat labs to confirm if the Ex.Order had been resolved scheduled on 4/4/22. On 4/5/22 at 10:15 AM, the LPN/UM informed the surveyor that the resident's care was a collaboration with the Primary Care Physician as well as the Infectious Disease Physician, and the facility was still awaiting the lab results from the most recent culture and sensitivity urine analysis to determine what the next course of treatment or action was. The LPN/UM stated until then, the resident remained on Ex.Order 2, but was no longer symptomatic. The surveyor reviewed the medical record for Resident #31. A review of the Admission Record reflected the resident was admitted to the facility in November of 2020 with diagnoses that included EX Order 26 § 4b1 [redacted]	F 657		

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A review of the most recent quarterly MDS dated 1/4/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated a Ex.Order 26.4(b)(1) [redacted]. A further review of Section H. Bladder and Bowel reflected that the resident did not have an indwelling urinary catheter in place and was always EX Order 26 § 4b1 [redacted].

A review of the resident's individualized comprehensive CP sheet initiated 6/15/21 and last revised 2/3/22, did not include the resident's current Ex.Order or Ex.Order 2.

On 4/12/22 at 11:46 AM, the surveyor interviewed the LPN/UM who stated that CP can be initiated and updated by the DON, Assistant Director of Nursing (ADON), Infection Preventionist nurse (IP), or Unit Managers (UM). The LPN/UM and surveyor reviewed the resident's current CP and the LPN/UM confirmed that the CP did not include the current Ex.Order or Ex.Order 2. The LPN/UM stated Ex.Order's should be care planned and this one "should have been captured, but just got missed."

On 4/14/22 at 9:25 AM, the DON in the presence of the ADON, LNHA, and the survey team, confirmed that Resident #31 did not have an updated CP to include care for their most recent Ex.Order and Ex.Order 2.

A review of the facility's "Policy on Resident Care Planning" dated revised 7/2021, included ... the care plan will be reviewed and updated by the unit manager and other departments as changes in the resident occur...

NJAC 8:39-11.2(i)

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F 755	Continued From page 27	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure EX Order 26 § 4b1	F 755	1.Resident #39 did not incur injury from this deficient practice. The resident medication pass was reviewed, and the	5/16/22

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F 755	Continued From page 28 EX Order 26 § 4b1) was administered and documented in accordance with professional standards of practice. This deficient practice was identified for 1 of 27 (Resident #39) sampled residents reviewed for medication management and was evidenced by the following: On 4/1/22 at 9:58 AM, the surveyor observed Resident #39 lying in bed asleep. At that time, the surveyor observed a graduated unit dose cup (used to administer medications) containing a light blue liquid on the resident's bedside table. At that time, the surveyor was unable to locate the nurse assigned to Resident #39. On 4/1/22 at 10:02 AM, the surveyor observed an ancillary staff walk through the hallway who informed the surveyor that she would call the unit manager (UM) to the resident's room. At that time, the Registered Nurse/Unit Manager (RN/UM) walked into Resident #39's room and stated she was unable to identify the light blue liquid in the graduated unit dose cup but would look at the electronic Medication Administration Record (eMAR) to identify the liquid. She further stated the medication administration nurse for the resident was on break. The RN/UM reviewed the eMAR and identified that the light blue liquid in the unit dose cup was EX Order 26 § 4b1 [redacted] She further stated that the mouthwash was a prescribed medication by the doctor and the dentist for his/her diagnosis. The RN/UM acknowledged medications must be administered to the resident in the presence of the medication nurse. On 4/1/22 at 10:09 AM, the surveyor interviewed Resident #39 who stated, "I did not request for	F 755	involved medication nurses were immediately in-serviced on Medication Pass protocol by the Director of Nursing. 2. All residents have a potential to be affected by this practice. 3. The nurses that left the mouthwash at the bedside had a Medication Administration observation done by the facility Pharmacy Consultant. The Consultant reviewed the conclusions of the Medication administration observation on these two nurses with the Director of Nursing. Education on Medication Administration Policy will be given to all staff nurses by the pharmacy consultant and the Nurse Managers. Education to general staff will be given by the Nurse Managers and Department Directors on #1- to be observant if medications are left at a residents bedside and #2- to inform a nurse of this finding. The pharmacy Consultant will perform at minimum 2 random Medication Administration pass observations per month. The results of these observations will be reviewed with the DON/ADON. 4. The Pharmacy Consultants monthly reports will reflect the results of all nurse Medication Administration observations. The results of the Medication Administration audits are reviewed with the Director of Nursing or Assistant Director prior to the Quarterly meeting.	

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F 755	Continued From page 29 the medication to be left." On 4/1/22 at 12:29 PM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who acknowledged that she poured the resident's EX Order 26 § 4b and left it with the resident but had not observed the resident take it. LPN #1 confirmed that she signed that the EX Order 26 § 4b was administered with the rest of the resident's medications that morning on the eMAR, even though she had not observed the resident take the EX Order 26 § 4b. LPN #1 further stated Resident #39 was able to perform his/her own mouth hygiene and on that day the resident wanted to use the prescribed mouthwash after he/she brushed his/her teeth. LPN #1 emphasized she does not always leave medications at the bedside. On 4/1/22 at 12:38 PM, the surveyor and LPN #1 reviewed the active Order Summary Report (OSR) for April 2022 which reflected the following: EX Order 26 § 4b1 At that time, LPN #1 removed the prescribed bottle from the medication cart and identified the light blue liquid to be EX Order 26 § 4b for Resident #39. The surveyor reviewed the medical record for Resident #39. A review of the Admission Record (an admission summary) reflected the resident was admitted to the facility in May of 2021 with diagnoses which included EX Order 26 § 4b1	F 755	These reports will be presented and reviewed at the Quarterly Quality Committee meeting by the Pharmacy Consultant.	

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EX Order 26 § 4b1 [redacted].

A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated 12/30/21, reflected a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated a Ex.Order 26.4(b)(1).

A review of the individualized Care Plan initiated 2/1/18 and revised on 7/14/21, included a focus area on presentation of decrease motor control left upper extremity (LUE)/left lower extremity related to her Ex.Order 26.4(b)(1) [redacted]

On 4/4/22 at 9:28 AM, the surveyor observed Resident #39 lying in bed asleep. At that time, the surveyor observed a graduated unit dose cup containing light blue liquid on the resident's bedside table.

On 4/4/22 at 9:52 AM, the surveyor observed the speech therapist (ST) enter the resident's room walked right back out. The ST stated she would return later once the resident was awake. The graduated dosing cup containing the light blue liquid was still on the resident's bedside table.

On 4/4/22 at 9:59 AM, the surveyor observed the Certified Nursing Aide (CNA) enter Resident #39's room and closed the door.

On 4/4/22 at 10:37 AM, the surveyor observed the CNA exit Resident #39's room. At that time, the surveyor interviewed the CNA who stated she provided morning care for the resident which

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included bathing, dressing, transferring the resident into his/her motorized [redacted], hair care and set up for oral hygiene. The CNA acknowledged she moved the resident's bedside table but did not recall seeing the light blue liquid and confirmed she did not touch or give the liquid to the resident.

On 4/4/22 at 10:45 AM, the surveyor and CNA reviewed the contents of the resident's bedside table and observed the light blue liquid in a graduated dosing cup still there. The CNA stated, "I do not know what that is. I will ask the nurse."

On 4/4/22 at 10:46 AM, the surveyor accompanied by the CNA approached LPN #2 who was on the medication cart. LPN #2 identified the blue liquid in the graduated unit dose cup was the resident's mouthwash. LPN #2 stated the resident was alert and oriented to person, place, and time and they requested for the medication to be left on the bedside table. LPN #2 acknowledged medications should not be left unattended because the resident could swallow the medication if the resident "had not known to swish and spit." In addition, LPN #2 confirmed she signed the eMAR without observing the resident used the medication appropriately. She further stated, "technically swish and spit should occur in front of the nurse." LPN #2 stated that signing the eMAR meant "the medication was administered even for mouthwash", but she had not observed the resident use the [redacted]

On 4/4/22 at 10:53 AM, the surveyor observed LPN #2 retrieve the light blue liquid in the graduated medication cup from Resident #39's room and poured it into a drug disposal bottle.

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F 755	Continued From page 32 LPN #2 stated that she would administer the [redacted] to the resident after tracheal care. On 4/4/22 at 12:34 PM, the surveyor re-interviewed Resident #39 who stated he/she had not asked the staff to leave the mouthwash on his/her bedside table and used it after brushing his/her teeth. On 4/5/22 at 11:42 AM, the Director of Nursing (DON) in the presence of the survey team acknowledged that nurses conducting the medication pass were expected to follow their facility protocol, which was to pour the medication, observe the resident take the medication as ordered, and assessed for efficacy. The DON confirmed that medications should not be left unattended and signed for as administered. Review of the facility's "Medication Administration Policy and Protocol" dated 1/2022, included that .... The medication nurse will immediately document the administration of each resident's medication after administration before going onto the next resident...the medication nurse must document any medication not given and the reason why and if refused by the resident must notify the physician as appropriate depending on the medication... all pharmacy cautionaries will be followed... no medications will ever be pre-poured. No medications will ever be left in a resident's room or on the medication cart unattended.	F 755		
F 810 SS=D	NJAC 8:39-29.2(a)(d) Assistive Devices - Eating Equipment/Utensils	F 810		5/16/22

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F 810	Continued From page 33 CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure an adaptive cup was provided to a resident during meal service. This deficient practice was identified for 1 of 4 residents (Resident #62) reviewed for nutrition and the evidence was as follows: On 3/31/22 at 10:00 AM, the surveyor observed Resident #62 seated in a EX Order 26 § 4b1 using their feet to propel themselves to the Nurse's Station. The resident then asked the nurse at the Nurse's Station to change their lunch meal to pork roll, French fries, and ginger ale. The surveyor observed both of the resident's hands appeared to be contracted. On 3/31/22 at 12:17 PM, the surveyor observed Resident #62 in their room with their lunch tray. The resident's pork roll and French fries were on a scoop dish (adaptive dish with raised sides to aide in feeding) and the resident was using a standard fork and knife to cut the pork roll. There was also a can of ginger ale, a foam cup of coffee, a foam cup of iced tea, and a small carton of milk. There was no observed adaptive equipment for liquids. The surveyor reviewed the medical record for	F 810	1. Resident #62 had a Kennedy cup provided immediately 2. All residents that have an order for Kennedy cup to assist with meals have a potential to be affected by this practice. 3. A review and audit of all residents that use a Kennedy cup was completed to confirm that the Kennedy cup was entered on the meal ticket initiated in Dietary. An inventory on internal stock of Kennedy cups was done. In-service to all dietary staff that work on the meal line was given by the Food Service Director to emphasize attention to the assistive devices required to be placed on a residents meal tray before delivery. In-service on meal ticket review, with attention to Kennedy cups and other assistive devices given to nurse aides and nurses that pass the meal trays to the residents upon delivery to the unit. These in-services were given by the Nurse Managers. In-service on Care Plan and Kardex entry	

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F 810	Continued From page 34 Resident #62. A review of the Admission Record (an admission summary) reflected the resident was admitted to the facility in August of 2021 with diagnoses which included Ex.Order 26.4(b)(1)) at multiple sites. A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated 1/28/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of out of 15, which indicated a Ex.Order 26.4(b)(1) The assessment further reflected that the resident was independent of staff with supervision for eating. A review of the active Order Summary Report reflected a physician's order (PO) dated 8/31/21, for a regular diet, regular texture with scoop dish and Kennedy cup (adaptive cup with a handle and a lid with hole for a straw, meant to prevent spills) with all meals. A review of the resident's individualized care plan initiated 1/31/22 and last revised on 1/31/22 for a history of EX Order 26 § 4b1 and EX Order 26 § 4b1 with EX Order 26 § 4 of supplements. Interventions included for staff to assist resident with EX Order 26 § 4b, if he/she agrees to the help; staff will continue to at minimum, set resident's meal tray up and open foods and liquids. The care plan did not include the use of adaptive equipment. On 4/1/22 at 12:09 PM, the surveyor observed the resident's lunch tray which contained coffee in a hard plastic cup with a handle, scoop dish with	F 810	for the assistive meal device given to nurse aides, nurses and occupational therapist. These in-services were given by the Nurse Managers. Daily audits on resident trays for the Kennedy cup assistive devices will be done by the Food Service Director or his designee. The daily audits performed for assistive devices will be reviewed bi-weekly by the Administer/DON. 4. The results of these audits will be presented by the Food Service Director and reviewed at the Quarterly Quality Committee meeting. These audits will be conducted for 3 months unless full compliance is not reached for a minimum of 2 consecutive months. The audits will continue until this goal is reached	

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F 810	Continued From page 35	F 810		

pork roll, iced tea in a hard plastic cup with a handle, two cans of ginger ale, a small carton of milk, and multiple straws but no adaptive cup.

On 4/1/22 at 12:30 PM, the surveyor interviewed the Certified Nursing Aide (CNA) who delivered the lunch tray to Resident #62 who stated she had worked at the facility for a couple of months. The CNA stated the lunch meal trucks arrived on the unit around 11:50 AM and she assisted in passing out the trays in the south hallway. The CNA stated she helped set up the trays and opened containers, cut up food, and handed out utensils. She further stated no one on the south side needed assistance with feeding or required a special bowl, cup, or utensil to eat.

On 4/4/22 at 12:45 PM, the surveyor observed Resident #62's meal tray on the meal truck waiting to be returned to the kitchen. The surveyor reviewed the meal ticket which indicated the resident was to receive a regular diet, Kennedy cup and scoop dish. The surveyor observed a scoop dish on the resident's tray, but not a Kennedy cup.

On 4/6/22 at 10:55 AM, the surveyor attempted to interview Resident #62, but the resident stated "no", they were on their way outside. When the surveyor asked if the resident would speak to the surveyor later, the resident stated, " I don't think so."

The surveyor continued to review the medical record for Resident #62.

A review of Resident #62's meal tickets dated 4/3/22 through 4/16/22 reflected to include a Kennedy cup and scoop dish" to all meals.

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F 810	Continued From page 36	F 810		

On 4/11/22 at 9:39 AM, the surveyor interviewed the Food Service Director (FSD) who stated each resident had a meal slip ticket that indicated which type of diet the resident was to receive, portion size, the menu items and any adaptive equipment required. The FSD added the dietary aides were responsible for adding the adaptive equipment to the meal trays. The surveyor and FSD reviewed Resident #62's meal tickets. In bold letters at the top was listed equipment required was a scoop dish and a Kennedy cup. The FSD acknowledged on each meal tray, at each meal the resident should be supplied a scoop dish and a Kennedy cup.

On 04/11/22 at 11:40 AM, the surveyor interviewed the Director of Nursing (DON) who stated the meal tickets were made in the Dietary Department, and the trays were assembled in the kitchen. The tickets were used as a reference guide as to what needed to be on the resident's meal tray. One dietary aide prepared the tray, and another dietary aide checked the tray for accuracy. Everything ordered on the meal ticket should be on the meal tray. The CNAs or nurses assigned to the residents were responsible for checking the trays for accuracy as well. The DON acknowledged she had been made aware earlier that day that Resident #62 had not been receiving their Kennedy cup last week. She further stated she knew the kitchen had received a delivery the previous week of Kennedy cups and the kitchen was very happy when they had come in. At that time the surveyor reviewed the meal tickets dated 4/3/22- 4/16/22 for Resident #62 with the DON who stated that the Kennedy cup should have been on Resident #62's meal tray for each meal and that the physician's order

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F 810	Continued From page 37 that should have been carried out. NJAC 8:39-27.5 (b)	F 810		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to maintain kitchen equipment and store/maintain food items to prevent microbial growth. This deficient practice was evidenced by: On 4/13/22 at 11:13 AM, the surveyor in the presence of the Food Service Director (FSD) conducted a follow-up kitchen tour and observed the following:	F 812	1.The sanitation bay of the three bay sink was immediately cleaned to remove discoloration at the drain and in the corners. Trash lids were placed on the trash receptacles throughout the kitchen to cover any refuse present. The bread and hot dog buns found were immediately discarded. The remaining stock was inspected by the FSD to assure	5/16/22

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F 812	Continued From page 38 1. In the three compartment sink, the sink designated as the sanitizing sink, a black residue in the drain and a brown discoloration in the corner of the the sink. The FSD used a clean paper towel to wipe off the black residue in the drain which transferred onto the paper towel. The FSD stated "the sanitizing chemical does that to stainless steel of the sink." The FSD further stated the three compartment sink was cleaned after every shift, and then he stated twice a day. The FSD confirmed there were no documentation for the sink cleaning. 2. At 11:31 AM, the surveyor observed an uncovered large multi-gallon garbage receptacle (trash can) without a lid which was halfway full of various trash located next to the food preparation table, across from the walk-in refrigerator. The FSD stated the table was not currently in use and he did not think the trash can needed to be covered. The FSD further stated, the trash cans did not have lids because "the lids get dirty and disgusting." The FSD stated it was his understanding that trash cans did not need to be covered if they were not in direct contact and changed often. The surveyor did not observe garbage can lids near the garbage receptacle during the tour. At 11:38 AM, the surveyor and FSD observed on the bread storage rack the following: 1. Two full bags of cinnamon raisin bread and one hot dog bun package that contained small insects flying in the bag. 2. Four packages of hot dog buns labeled discard 4/10/22. One of the packages had a dark green furry substance on the hot dog bun.	F 812	no further items were outdated or showing signs of spoilage. 2. All residents have the ability to be affected if food is not stored, prepared distributed, and served in accordance with professional standards for food safety. 3.Policy and procedure was developed for routine and ongoing cleaning of the 3 bay sink. In servicing to staff regarding new policy and procedure was provided to all kitchen staff. Initiation for use of trash lid containers when containers are not in use was performed. Policy and procure for use of lids and cleaning of lids was developed. All Dietary staff was provided in servicing for the new policy and procedure. Policy and procedure specific for bread delivery was created to include daily inspection of delivered items and current stock by FSD or designee to assess for spoiled our outdated items. The FSD and or designee will perform weekly audits on cleaning of 3 bay sink and documentation to verify compliance. The FSD and or designee will audit use and cleanliness of receptacle lids daily to assure compliance. FSD and or designee will utilize the added daily inspection of the bread stock and delivery to create a daily audit to assure all outdated items are properly disposed	

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F 812	Continued From page 39 At that time, the surveyor interviewed the FSD who stated "he believed" the flying insects inside the cinnamon raisin bread and hot dog bun packages were "fruit flies". The FSD confirmed there were four bags of hot dog buns expired and identified the green furry substance was "mold." The FSD stated the supply of bread was checked three times a week on Monday, Tuesday, and Thursday by him. He further stated, he was responsible for discarding the expired bread. The FSD stated the exterminator was just there and that the log was contained in the Maintenance Director's office. On 4/14/22 at 9:33 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, the Assistant Director of Nursing (ADON), and survey team acknowledged these findings. The LNHA stated that the facility at the time of the observation had no policy and procedure regarding the maintance and sanitation of the three compartment sink. A review of the Service Inspection Report revealed a service work date of 3/24/22 which included under General Comments/ Instructions... treated kitchen, ants seen around the juice machine. No other reported problems throughout the service. A review of the facility's "Bread Receiving and Storage" policy dated reviewed 3/19/21, included... any out of date bread, or bread that appears molded or otherwise not safe, will be discarded... the Food Service Director, or designee will be responsible for ensuring that this policy will be followed. A review of the facility's "Labeling and Dating	F 812	of. 4.All audits listed above will be provided to the Administrator on a Monthly basis for a minimum of 6 months. If concerns exist after six months, audits will continue until compliance is achieved for a minimum of 3 consecutive months. A quarterly report summarizing a audits performed by the FSD will be provided at the Quarterly Quality meetings for team review.	

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F 812	Continued From page 40 Procedure in the Dietary Department" policy dated reviewed September 2021 included... perishable foods are checked daily for spoilage by FSD/designee; dated products are checked daily for expiration by FSD/designee... There was no additional information provided regarding the uncovered garbage can receptacle found in the kitchen. NJAC 8:39-17.2 (g)	F 812		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents,	F 888		5/16/22

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under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this

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section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the

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F 888	Continued From page 43 CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to track and securely document the COVID-19 vaccination status for all staff, both direct facility hires and contracted hires/outside vendors. The deficient practice was evidenced by the following: Reference: Centers for Medicare and Medicaid Services (CMS) QSO-22-07 ALL, dated 12/28/21, included the following: Within 30 days after issuance of this memorandum 2, if a facility demonstrates that: Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; and 100% of staff have received at least one dose of COVID-19 vaccine, or have a	F 888	1. All required vaccination cards from vendors and volunteers were requested by the Infection Control Coordinator and Department Heads to assure all individuals who provide any care, treatment, or other services for the facility and or the residents. 2. All residents have the potential to be affected if proper surveillance and documentation of staff, practitioners, students, trainees, and volunteers Covid-19 vaccination status is not properly maintained and documented. 3. All Practitioners, vendors, and volunteers who were not currently documented and reported were updated	

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F 888	Continued From page 44 pending request for, or have been granted qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the facility is compliant under the rule; or Less than 100% of all staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the facility is non-compliant under the rule. Reference: CMS QSO-22-07 ALL Attachment A included the following: Definitions: ... "Staff" refers to individuals who provide any care, treatment, or other services for the facility and/or its residents, including employees; licensed practitioners; adult students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangements. This also includes individuals under contract or by arrangement with the facility, including hospice and dialysis staff, physical therapists, occupational therapists, mental health professionals, licensed practitioners, or adult students, trainees, or volunteers Facilities have the flexibility to use the tracking tools of their choice; however, they must provide evidence of this tracking for surveyor review. Additionally, facilities' tracking mechanism should clearly identify each staff's role, assigned work area, and how they interact with residents. This includes staff who are contracted, volunteers, or students. Reference: CMS COVID-19 STAFF VACCINATION MATRIX INSTRUCTIONS FOR PROVIDERS included the following: The Matrix is used to identify the vaccination status for all staff. The facility completes this form, including section	F 888	on the NHSN website to accurately show status of all individuals. Written letters to all vendors and Practitioners requiring vaccination information for all new employees prior to facility entrance and providing care was completed. In servicing from the Administrator was given to the Activities Director informing requirement to inform and receive documentation from all new volunteers vaccination status prior to providing services to facility residents was completed. All Covid-19 vaccination information will be retained and reviewed by the Infection Control Coordinator. The Administrator, DON, Infection Control Coordinator, and Assistant Administrator will review vaccination status of facility staff, residents, vendors, students, volunteers, and trainees on a weekly basis to assure compliance. The Infection Control Coordinator will perform monthly audits to assure compliance with maintaining vaccination records on all the above personnel, volunteers, and any newly hired staff. 4. The conclusion of the audits completed by the Infection Control Coordinator will be review with the Administrator for a minimum of six months. If concerns	

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F 888	Continued From page 45 I, staff name, and columns 1-11, which are described in detail below, or provide a list containing the same information required in the matrix. Unless stated otherwise, for each staff mark an X for all columns that are pertinent. 1. Direct facility hire (DH), Contracted hire (C), or Other (O): Direct facility hires (DH) are employees who are directly hired by the facility. Contracted hires (C) provide care, treatment, or other services for the facility and/or its residents under contract or by other arrangements. Other (O) includes adult students, trainees, and volunteers. On 3/31/22 during entrance conference, the Team Coordinator of the survey team requested the COVID-19 Staff Vaccination Matrix (used to identify the vaccination status for all staff) as per the CMS Entrance Conference Worksheet (guide given to the facility which lists all the documentation the facility must provide to the survey team). On 4/4/22 at 10:00 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor a document titled "Staff Vaccination Status for Providers" with an attached untitled document which included the COVID-19 vaccination status of 200 facility staff. The attached document included 197 direct hire staff. The document also included one (1) contracted hire, the Medical Director, and two (2) "other" staff, the Assistant Administrator and the Business Office Manager. The document did not include other contracted hires that provided care, treatment or other services for the facility and/or its residents under contract or by other arrangements which included but was not limited to physicians and hospice providers. The	F 888	continue, audits will continue is achieved for a minimum of three months. These conclusions will be presented at the Quarterly Quality Meeting by the Infections Control Coordinator.	

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document also did not include volunteers that provided services which included but was not limited to pet therapy. The document included an "X" to indicate if the staff member received the COVID-19 vaccination and a booster. The document also included if the staff member was granted an exemption from the COVID-19 vaccination.

On 04/11/22, the surveyor reviewed the National Healthcare Safety Network (NHSN) (a data tracking system which provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections) data, that the facility was required to report, for the week ending 3/27/22 which included the following: Staff fully vaccinated 95.6%.

On 4/11/22 at 11:51 AM, the surveyor interviewed the LNHA regarding the vaccination status of all staff. The LNHA stated that he reported only the "in house" staff to NHSN. The surveyor then asked the LNHA if the 200 number that was listed on the COVID-19 Staff Vaccination Matrix that was provided to the surveyor included all contracted hires/outside vendors. The LNHA responded that the 200 staff did not include physicians or hospice staff. He then added that all the physicians have been vaccinated because that was the requirement at the hospital. He then stated that the facility had a contract with one hospice company and that he would now get the information on the vaccination status of their staff that came to the facility. The surveyor then asked the LNHA if the facility had a pet therapy program and the LNHA responded that there was one animal that came in but not routinely and that he

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did not have the vaccination status of the pet handler.

On 4/14/22 at 9:39 AM, in the presence of the survey team, the LNHA confirmed that the COVID-19 Staff Vaccination Matrix did not contain all staff, which included contracted hires/outside vendors. He also confirmed that all staff had not been included in the weekly report to NHSN.

The facility did not provide a complete COVID-19 Staff Vaccination Matrix which included both direct hires and contracted hires/outside vendors.

A review of the facility provided policy titled "COVID-19 Vaccination Policy for Mandatory Vaccinations", dated effective 1/27/22, included this policy applies to all personnel that could potentially expose other staff and/or residents ...Purpose:
Considering the ongoing COVID-19 pandemic, CMS regulation and as part of our continued efforts to maintain a safe workplace for employees, [facility] is requiring all personnel, as defined below, to receive an FDA authorized and/or approved COVID-19 vaccination as a condition of continued employment ...The Home fully intends this policy to comply with all applicable federal, state, and local laws and applicable guidance. The Home is monitoring guidance from all appropriate public health authorities and we reserve the right to modify this policy as we deem necessary. Time Frame & Confirmation of Vaccination: Employees vaccinated prior to implementation of this policy shall provide documentation of vaccination status to Human Resources. This documentation must be presented no later than the effective date of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 888	Continued From page 48	F 888		

this policy. Deadline for COVID-19 Vaccinations: Single dose and the First Dose of a Multi-Dose COVID-19 vaccine series must be completed by January 27, 2022. Second Dose of a multi-dose COVID-19 vaccine must be completed consistent with recommendations of medical provider and current accepted practice and no later than February 28,2022. This was extended to April 11, 2022 by the Governor on 3.2.2022 ...Failure to Comply or Cooperate with Vaccination Policy: Depending upon individual circumstances and applicable law, failure to comply or cooperate with this vaccination policy may result in denied access to the facility, disciplinary action, up to and including termination of employment, it may also result in placement on medical or administrative leave.
The policy did not include the process the facility would use to track and securely document the COVID-19 vaccination status for all staff, both direct facility hires and contracted hires/outside vendors.

The facility did not have a policy regarding reporting the COVID-19 vaccination status for all staff, both direct facility hires and contracted hires/outside vendors to NHSN.

NJAC 8:39-5.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061113	A. BUILDING: _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 2 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	1.The two weekend shifts not meeting staffing ratios did not result in any resident care issues. 2.All Residents have the ability to be affected when staffing ratios are not met. 3. The nurse staffing coordinator will meet with the DON and the Assistant Administrator, Human Resource Director, and or Designee every Tuesday to review open shifts for upcoming weekends.	5/16/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061113	A. BUILDING: _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One 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. During entrance conference on 3/31/22 at 9:51 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), informed the surveyor that the facility staffing was good. The LNHA stated that the facility used Temporary Nursing Aides (TNA) as well as offered overtime to staff the facility. The LNHA stated that the facility used Agency staff as their contingency plan as a last resort. As per the "Nurse Staffing Report" completed by the facility for the weeks of 3/13/22 to 3/19/22 and 3/20/22 to 3/26/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 3/19/22 had 15 CNAs for 129 residents on the	S 560	The HR Department will perform wage survey in area of local competitors bi-annually . Facility will collaborate with local Certified Nursing Aide Training schools to increase awareness of facility and potential employment opportunities. Inservice staff on employee referral bonus provided by facility. Staffing Coordinator will provide Weekly reports on weekend staffing and turn over to Corporate supervisors and Facility Administration for review and trading of trends. Facility will perform exit interviews with staff to audit trends on employees' reasons for resigning. 4.Above reports will be reviewed by the DON, Administrator, and Human Resources Director. The results and trends obtained from the above reports will be provided to the team at the Quarterly Quality meeting.	

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	061113	A. BUILDING: _____ B. WING _____	04/14/2022

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S 560	Continued From page 2 day shift, required 17 CNAs. 3/20/22 had 13 CNAs for 130 residents on the day shift, required 17 CNAs. NJAC 8:39-5.1(a)	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide residents two evening activity programs per week. This deficient practice was identified for 3 of 3 months reviewed (January, February, and March of 2022) and was evidenced by the following: On 4/6/22 at 10:00 AM, the surveyor observed an activity calendar for April 2022 posted on the wall across from the Nurse's Station on the second floor unit. A review of the calendar indicated the latest activity scheduled was at 3:00 PM. On 4/6/22 at 10:04 AM, the surveyor interviewed the Director of Activities (DA) regarding the activity schedule at the facility. The DA stated that the last activity of the day was usually scheduled for 2:00 PM and it was the main activity. The surveyor then asked the DA if the facility had any activities in the evening. The DA responded that the facility did not have any activities in the	S 720	1. The current Activities calendar was updated with two evening activities for the remainder of the month to achieve compliance. 2. All Residents have the ability to be affected if activities are not planned and performed in accordance to regulation. 3. The Director of Activities and staff were provided with in servicing regarding the requirement for two evening activities per week. Staff schedules in the activities department were modified to align with scheduled evening events. The Activities Director will meet with the Administrator monthly to review scheduled evening activities for the upcoming month to assure compliance with regulation.	5/16/22

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	061113	A. BUILDING: _____ B. WING _____	04/14/2022

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S 720	Continued From page 3 evening because the staff member that was hired for two evenings a week was out on medical leave. He added that the Licensed Nursing Home Administrator (LNHA) was aware. A review of the January 2022 activity calendar provided by the DA reflected the last activity scheduled for the day was at 3:00 PM during that month. A review of the February 2022 activity calendar provided by the DA reflected that there was one date (2/13/22) that had an activity that was scheduled for 6:30 PM and one date (2/22/22) that had an activity that was scheduled for 3:00 PM. During the rest of the month, the last activity scheduled for the day was at 2:00 PM. A review of the March 2022 activity calendar provided by the DA indicated there was one date (3/29/22) that had an activity that was scheduled for 3:00 PM. During the rest of the month, the last activity scheduled for the day was at 2:00 PM. On 4/14/22 at 9:39 AM, the LNHA in the presence of the Director of Nursing, Assistant Director of Nursing, and the survey team, confirmed that the facility did not have activities two evenings a week for the last three months. A review of the facility provided policy titled, "Activities" dated issued January 2022, included the following...4. Activities shall be offered at a variety of times throughout the day, including morning, afternoon, and some evenings and weekends. N.J.A.C. 8:39-7.3(d)	S 720	The Activities Director will audit completion of evening activities to assure compliance. 4. The Director of Activities shall perform above auditing for a minimum of 6 months. If concerns continue following six months, tracking will continue for a minimum of 3 more months or until compliance is achieved. The Director of Activities shall present the information from the audits to the team at the scheduled Quarterly Quality meetings.	

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
315324 Y1	A. Building B. Wing Y2	6/20/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE HEALTHCARE & REHAB	512 UNION STREET TRENTON, NJ 08611

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 F0578	Correction	ID Prefix F0582	Correction	ID Prefix F0656	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.21(b)(1)	Completed
LSC	05/16/2022	LSC	05/16/2022	LSC	05/16/2022
ID Prefix F0657	Correction	ID Prefix F0755	Correction	ID Prefix F0810	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(g)	Completed
LSC	05/16/2022	LSC	05/16/2022	LSC	05/16/2022
ID Prefix F0812	Correction	ID Prefix F0888	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(i)(1)-(3)(i)-(x)	Completed	Reg. #	Completed
LSC	05/16/2022	LSC	05/16/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/14/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061113	A. Building B. Wing	6/20/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE HEALTHCARE & REHAB	512 UNION STREET TRENTON, NJ 08611

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

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/16/2022	ID Prefix S0720 Reg. # 8:39-7.3(d) LSC	Correction Completed 05/16/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315324	A. BUILDING **01** B. WING _____	**04/14/2022**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/12 and 13/22 and Waters Edge Healthcare and Rehabilitation was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Waters Edge Healthcare and Rehabilitation is a five (5), Type II Protected building that was built in June 1993. The facility is divided into 15 smoke zones.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation, it was	K 281	1.The Director of Maintenance Contacted a certified Electrician to request quote to	5/16/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/29/2022

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K 281	Continued From page 1 determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps for 2 of 9 exit discharge doors. This deficient practice was evidenced by the following: On 4/13/22, the surveyor with the Director of Facility Maintenance (DFM) toured the facility and observed two areas that failed to provide proper emergency lighting in the following locations: 1. At 11:47 AM, an inspection outside of a designated exit discharge door (doors that put you outside of the building) near the Physical Therapy area was performed. The surveyor observed no evidence of an automatic egress lighting. At this time, the surveyor reviewed the facility provided lay-out which identified that there was no exit discharge door on the facility print. The surveyor asked the DFM if there had always been an exit discharge door here, and the DFM responded that he had been at the facility for a year and seven months and the exit door had been there the entire time. The DFM stated that the Licensed Nursing Home Administrator (LNHA) had been at the facility for years so he might know. 2. At 12:10 PM, an inspection outside of a designated exit discharge door near the soiled linen chute room identified that there was one light fixture. At this time, the surveyor asked the DFM if there were two light bulbs inside the fixture, and the DFM responded no. The findings were verified and confirmed by the DFM during the observations.	K 281	remediate deficiency and place facility into compliance. 2.All Residents have the ability to be affected proper lighting around facility is not maintained. 3. Quote from certified Electrician was received for remediation and remediation of egress lighting was performed. Director of Maintenance performed whole house inspection of egress doors and lighting to assure compliance. Director of Maintenance will perform weekly audit of all egress lighting to assure on going compliance. 4.The Director of Maintenance will provide Monthly reports to the Administrator regarding the status of all exterior lighting and when required servicing is performed for a six month period. If concerns continue, this audit will continue for an additional 3 months or until compliance is achieved. The Director of Maintenance will provide information from the audit inspections performed to the team at the Quarterly Quality Meetings.	

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K 281	Continued From page 2 On 4/13/22 at 1:22 PM, the surveyor asked the LNHA if the exit discharge door near the Physical Therapy area had been there since the building was built, and the LNHA responded no, it had to be put in when we leased a section of the building to a Dialysis Center. On 4/13/22 at 1:31 PM, the surveyor informed the LNHA of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to a.) provide a battery backup emergency light above the emergency generator's three transfer switches, independent of the building's electrical system and emergency generator and b.) provide a battery backup emergency light above 1 of 1 emergency generator, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following:	K 291	1. Director of Maintenance contacted certified Electrician to request quote to remediate deficiency and place facility into compliance. 2.All Residents have the ability to be affected if compliance with need for emergency lighting is not maintained. 3. Quote from the certified Electrician was received and remediation for emergency back-up lighting was performed. The Director of Maintenance will perform monthly testing of the battery backup lighting in the generator room to assure	5/16/22

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K 291	Continued From page 3 On 04/13/2022, the surveyor with the facility's Director of Facility Maintenance (DFM) conducted a tour of the facility and observed two locations that failed to provide battery backup emergency lighting as followed: 1. At 12:21 PM, an inspection inside the main electrical room where the emergency generator's three transfer switches were located was performed. The surveyor observed no evidence of a battery backup emergency light in the room for the generator's three transfer switches. At this time, the surveyor asked the DFM if there was a battery backup emergency light for the transfer switches, and the DFM responded, no. 2. At 12:25 PM, an inspection inside the emergency generator was performed. The surveyor observed no evidence of a battery backup emergency light in the room. At this time, the surveyor asked the DFM if there was a battery backup emergency light in the generator room, and the DFM responded, no. These findings were verified and confirmed by the DFM during the observations. On 4/13/22 at 1:31 PM, the surveyor informed the Licensed Nursing Home Administrator of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	ongoing compliance. 4.The Director of Maintenance will provide the Administrator a monthly report regarding the operation fo the emergency battery backup for a minimum of 6 months. If concerns continue the audit will continue for a minimum of three months or until compliance is achieved. The Director of Maintenance will provide results of the monthly testing to the team at the Quarterly Quality Meeting.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		5/16/22

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K 321	Continued From page 4 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 1 of 1	K 321	1. An automatic door closure to the Medical Records office was installed to bring the facility into compliance. 2.All residents have the ability to be affected if doors that provide a fire barrier do not operate as outlined by NFPA regulation. 3.The Director of Maintenance assessed	

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	315324	A. BUILDING **01** B. WING _____	**04/14/2022**

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K 321	Continued From page 5 Medical Records room and was evidenced by the following: During the survey entrance on 4/12/22 at 8:40 AM, the surveyor requested the facility's Director of Facility Maintenance (DFM) to provide a copy of the facility's lay-out which identified the various rooms and smoke compartments in the facility. On 4/12/22 at 12:29 PM, during a tour of the facility, the surveyor with the DFM inspected the third floor Medical Records room. The surveyor observed that the 3/4-hour fire rated corridor door leading into the Medical Records room was in the open position and had no means to self-close the door into its frame. The surveyor observed inside the room, 29 four-drawer filing cabinets filled with combustible medical records. There were approximately 60 combustible records stored on top of the filing cabinets and desks. The surveyor in the presence of the DFM, measured and recorded the size of the room, which was 15 feet deep by 25 feet wide. The total room measurement was 375 square feet which was larger than 50 square feet. The door failed to self-close into its frame as required by code. A review of an evacuation diagram posted in the area identified that the Medical Records room was in the primary exit access path to reach an exit. This condition would allow fire, smoke and poisonous gases to pass from the Medical Records room into the exit access corridor in the event of a fire. The findings were verified and confirmed by the	K 321	all doors in the facility to assure proper function of current door closures and that no further closures were required based on regulation. The Director of Maintenance will perform monthly audits of facility door closures to assure proper function and that all doors needing closures are in place. 4. The Director of Maintenance will provide the Administrator monthly reports on the audit performed above for a minimum of 6 months. If concerns continue, the audits will continue for a minimum of 6 months or until compliance is achieved. The Director of Maintenance will provide results of the audit to the team at the Quarterly Quality meeting.	

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	315324	A. BUILDING **01** B. WING _____	**04/14/2022**

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K 321	Continued From page 6 DFM during the observations. On 4/13/22 at 1:31 PM, the surveyor informed the Licensed Nursing Home Administrator of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to a.) perform and document on the tag attached to the fire extinguisher a monthly visual examination for 4 of 26 fire extinguishers, as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers: - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.	K 355	1. The Director of Maintenance reviewed all extinguishers in house to assure all tags were up to date for current month inspection to assure compliance in cited area. 2.All Residents have the ability to be affected if the facility fire extinguishers are not inspected and maintained according to NFPA regulations. 3.The Maintenance Director and or Designee will perform monthly inspections on all fire extinguishers and date inspections on tags accordingly. The Maintenance Director and or Designee will keep a separate tracking audit tool confirming the inspection. This	5/16/22

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	315324	A. BUILDING **01** B. WING _____	**04/14/2022**

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K 355	Continued From page 7 According to NFPA 10- 4-3.4, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. During the building tour on 4/12/22 and 4/13/22, in the presence of the facility Director of Facility Maintenance (DFM), the surveyor observed 26 fire extinguishers in various locations that were last annually inspected April 2021 with no evidence of a monthly visual inspection being documented on the tags attached to four (4) fire extinguishers in the following location: 1. On 4/13/22 at 12:14 PM, in the facility kitchen one (1) class "K-Type" wet chemical fire extinguisher was last annually inspected April 2021, had no evidence of a monthly visual examination documented on the tag for November 2021. 2. On 4/13/22 at 12:19 PM, in the main electrical room one (1) ABC type fire extinguisher was last annually inspected April 2021, had no evidence of a monthly visual examination documented on the tag for May, June, and July 2021. 3. On 4/13/22 at 12:23 PM, in the elevator mechanical room one (1) ABC type fire extinguisher was last annually inspected April 2021, had no evidence of a monthly visual examination documented on the tag for May, June, July, August, and September 2021. 4. On 4/13/22 at 12:31 PM, in the elevator pit room one ABC type fire extinguisher was last	K 355	tool will be completed simultaneously with extinguisher inspections. This tool will list all in house extinguishers to assure 100% compliance. The Director of Maintenance will provide the audit tool monthly to the Administrator for his review. 4.This audit will be performed for a minimum of six months. If concerns continue, the audit will continue until a minimum of three consecutive months of compliance is achieved. The Director of Maintenance will provide the results of the audit to the team in the Quarterly Quality Meeting.	

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	315324	A. BUILDING **01** B. WING _____	**04/14/2022**

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K 355	Continued From page 8 annually inspected April 2021, had no evidence of a monthly visual examination documented on the tag for May 2021. The findings were verified and confirmed by the DFM during the observations. On 4/13/22 at 1:31 PM, the surveyor informed the Licensed Nursing Home Administrator of the findings at the Life Safety Code exit conference. NFPA 10 NJAC 8:39 -31.1(c), 31.2(e).	K 355		
K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further	K 541		5/16/22

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K 541	Continued From page 9 use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure 2 of 5 laundry chute access doors closed and positive latched into their frames to maintain the 1-hour fire protection rating of laundry chute doors. This deficient practice was evidenced by the following findings: During the building tour on 4/12/22 and 4/13/22 in the presence of the facility's Director of Facility Maintenance (DFM), the surveyor observed the following: 1. On 4/12/22 at 10:23 AM, an inspection in the 4th floor laundry chute room was conducted. The surveyor observed that the 1-hour fire rated wash-down chute door was ajar from its frame and the door's handle and latching mechanism were missing. During a closure test of the door, the door did not close and positive latch as required to maintain the 1-fire rating. This test was repeated two additional times with the same results. 2. On 4/13/22 at 11:10 AM, an inspection inside the 2nd floor laundry chute room was conducted. During a closure test of the laundry chute door, the chute door self-closed but did not positive latch into its frame. This test was repeated two additional times with the same results. The building's laundry chute door and wash-down chute door was not protected against the passage of smoke, fire and poisonous gases to	K 541	1. The Director of Maintenance Replaced the fourth floor laundry chute latching mechanism to assure a positive latch and achieve compliance. The Director of Maintenance replaced the entire chute door and latching mechanism in the second floor laundry room to assure positive latch and achieve compliance. 2. All Residents have the ability to be affected if laundry chute doors and latches do not operate in the manner outlined in the NFPA regulations. 3.The Director of Maintenance or Designee shall perform monthly audits of all laundry chute doors and latches to assure proper latching and closure to maintain ongoing compliance with National Fire Protection Association regulation. The Director of Maintenance or Designee will provide monthly audit reports of the laundry chute doors and latches for review of status and ongoing compliance to the Nursing Home Administrator. 4.The Director of Maintenance or Designee shall perform monthly audits of all laundry chute doors and latches to assure proper latching and closure to maintain ongoing compliance with	

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K 541	Continued From page 10 pass from one floor to another floor in the event of a fire. The findings were verified and confirmed by the DFM during the observations. On 4/13/22 at 1:31 PM, the surveyor informed the Licensed Nursing Home Administrator of the findings at the Life Safety Code exit conference. NFPA 101:2012 - 19.5.4 and 9.5 NJAC 8:39-31.2(e)	K 541	National Fire Protection Association regulation. The Director of Maintenance or Designee will provide monthly audit reports of the laundry chute doors and latches to the Administrator for a minimum of six months. If concerns continue, this audit will continue for an additional 3 months or until compliance is achieved. The Director of Maintenance will provide this information from the audit to the Q.A. team a scheduled quarterly meeting.	

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
315324 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/20/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE HEALTHCARE & REHAB	512 UNION STREET TRENTON, NJ 08611

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	05/16/2022	LSC K0291	05/16/2022	LSC K0321	05/16/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0355	05/16/2022	LSC K0541	05/16/2022	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	
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	
4/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO