STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315324	A. BUILDING _____ B. WING _____	05/10/2024

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

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F 000	INITIAL COMMENTS Survey Date: 5/10/2024 Census: 144 Sample: 30 + 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents it was determined that the facility failed to ensure the [redacted] policy was followed to screen and assess a resident for the ability to NJ Exec Order 26.4b1. The deficient practice occurred for 1 of 5 residents reviewed for accidents (Resident #127) and was evidenced by the following: On 4/30/24 at 10:18 AM, during the entrance conference, the facility provided a [redacted] Policy and Procedure and the "[redacted] Schedule" which revealed that Resident #127 was listed as	F 689	1. Resident 127 had [redacted] or [redacted] due to this deficiency 2. All active smoking resdients have the potential to be affected 3. An audit of residnets that currently smoke was completed by the Assistant Director of Nursing. The audit covered: Smoking assessment was completed The smoking contract was signed and present in the medical record	6/6/24

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

Electronically Signed | 05/29/2024

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F 689	Continued From page 1 NJ Exec Order 26.4 during shift #1 from 9:00 AM-9:10 AM, 10:30 AM-10:40 AM, 2:00 PM-2:10 PM, 5:00 PM-5:10 AM. On 5/2/24 at 8:40 AM, Resident #127 was observed NJ Exec Order 26.4b1 from the designated NJ Exec Order 26.4b1 onto the elevator. On 5/2/24 at 8:59 AM, the surveyor reviewed the electronic medical record (EMR) which revealed the most recent signed NJ Exec Order 26.4b Assessment dated NJ Exec Order 26 indicated "1. Is Resident a NJ Exec Order 26.4b and " NJ Exec was checked off. A review of the Admission Record for Resident #127 revealed diagnoses which included, but were not limited to, NJ Exec Order 26.4b1 A review of the most recent 48-page Interdisciplinary Care Plan (including canceled items) initiated NJ Exec Orde did not contain a focus area for NJ Exec Order 26.4b A review of the most recent quarterly Minimum Data Set dated NJ Exec Order 26, revealed the resident scored " NJ out of 15 on the Brief Interview of Mental Status which indicated the resident was NJ Exec Order 26.4b1. On 5/2/24 at 10:44 AM, the surveyor interviewed the US FOIA (b)(6) about Resident #127 and asked if the resident " NJ Exec Order 26.4 as the US FOIA (b)(6) was observed NJ Exec Order 26.4b1 to residents. The US FOIA (b)(6) stated Resident #127 NJ Exec Order 26 and he/she NJ Exec Order 26 this morning. The surveyor asked what the process entailed, and the US FOIA (b)(6) stated there was a " NJ Exec Order 26.4b1 outside who " NJ E the NJ Exec Order 26.4b1 and at that time, the surveyor	F 689	Smoking times were assinged An individualized smoking care plan is in place. Staff education will be provided to all adminssion nurses and Social Workers on the Smoking Policy. Audits on new admissions are in place to verify an admission smoking assessment was completed. If the admission smoking assessment confirms the new admission is a smoker, then the audit will extend to confirm the smoking contract is signed and the indivdualized care plan is in place. These audits will be completed by the unit nurse manager. The Director of Nursing or thier designee wil review these audits every week. 4. The audit will be conducted for six months unless full compliance is not reached for a minimum of three consecutive months. The audit will continue until this goal is reached. THe results of this audit will be presented to the Quality team at the Quarterly Quality meeting.	

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F 689	Continued From page 2	F 689		

observed the "NJ Exec Order 26.4b1" sitting in the NJ Exec Order 26.4 area. The US FOIA (b)(6) stated all the residents received NJ Exec Order 26.4b1 in the morning, and except for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and stated "everyone else was NJ Exec Order 26.4b1

On 5/2/24 at 11:46 AM, the surveyor reviewed the paper medical record for Resident #127 which revealed a document titled "NJ Exec Order 26.4b Contract" which had a hand-written slash over it, and "NJ Exec [redacted]" was written on the documented which was dated, NJ Exec Order 26.4b and signed by staff.

On 5/2/24 at 11:51 AM, in the presence of another surveyor the, the surveyors interviewed Resident #127 in the resident's room. The surveyors asked if the resident was a NJ Exec Order 26 and the resident confirmed that he/she NJ Exec Order 26.4 Resident #127 informed the surveyors that the facility held the NJ Exec Order 26.4b1 at the front desk.

On 5/2/24 at 11:54 AM, the surveyor, in the presence of another surveyor, conducted an interview with the U.S. FOIA (b) (6) [redacted]). The surveyors asked the U.S. FOIA (b) (6) if there were residents that she was aware of that NJ Exec Order 26 on the unit, and the U.S. FOIA (b) (6) stated, "yes we do". The surveyors asked how she would know, and she stated, it was included in the admission assessment and if residents are NJ Exec O they could tell you. The U.S. FOIA (b) (6) stated we have a "NJ Exec Order 26.4b Contract" and the surveyor asked if the resident was required to sign it and the U.S. FOIA (b) (6) U.S. FOIA (b) (6) stated, "yes, they have to sign it". The stated the resident was informed that they needed to adhere to the NJ Exec Order 26.4 schedule and they were not allowed to have NJ Exec Order 26.4 [redacted] in the room. The U.S. FOIA (b) (6) stated

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F 689	Continued From page 3	F 689		

"we have a [redacted] Assessment", and that was completed on admission, then repeated quarterly and annually.

On 5/2/24 at 11:57 AM, the surveyor asked the [redacted] if Resident #127 was a [redacted] and they replied "[the resident] doesn't [redacted] The surveyor asked the [redacted] if she was aware that Resident #127 was listed on the [redacted] schedule and [redacted] The [redacted] looked at the most recent [redacted] assessment and confirmed that it was documented that Resident #127 was not a [redacted] and confirmed that she had not been aware, and she completed the assessment. The surveyor asked the [redacted] if she should have been aware and she stated, "I should be aware, and maybe he just started [redacted] again". The [redacted] stated, "[he/she] probably told me [he/she] was [redacted], because when I asked [him/her] and [he/she] stated [he/she] doesn't [redacted] The surveyor asked where the breakdown in communication occurred and the [redacted] stated, that she "was not sure since it was a team effort".

On 5/2/24 at 12:04 PM, the surveyor asked the [redacted] if the resident was care planned for [redacted] and the UM/RN stated, "we don't care plan [redacted] The [redacted] stated the [redacted] reviewed the contract and confirmed that the only contract in effect was the one that was crossed off. The [redacted] confirmed that the [redacted] contract dated [redacted] was completed on admission and when asked if there was another contract, the [redacted] stated, " I don't see anything here."

On 5/6/24 at 12:40 PM, the facility administration was made aware of the above concerns.

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F 689	Continued From page 4 On 5/7/24 at 10:42 AM, the U.S. FOIA (b) (6), in the presence of the U.S. FOIA (b) (6) [redacted], confirmed that there was no [redacted] contract that was located in the medical record and confirmed the [redacted] was not in Resident #127's Interdisciplinary Care Plan. The Smoking Policy and Procedure, Revised 11/2024, provided during the entrance conference on 04/30/24 at 10:18 AM revealed: Purpose: To provide a safe environment for all at [Facility Name] and provide clear directions for residents that are active cigarette smokers. Procedure/Protocol: 1. Residents will be screened for the use of tobacco products and for their ability to smoke safely upon admission, and a smoking assessment will be completed with the Admission MDS, Quarterly ...; 2. All Residents will be places into one of the following categories based on the most recent smoking assessment: a. Independent-requires no supervision, b. line of sight supervision or c. direct supervision; 3. Based on the most recent assessment the IDC [Interdisciplinary] team will address smoking interventions the care plan for those Resident's assessed as requiring line of sight or direct supervision. Determination of the Resident's level of supervision when smoking will also be noted on the Nursing Assistant Kardex; 4. All resident who smoke will sign the facility smoking contract upon admission prior to being allowed to smoke. NJAC 8:39-27.1(a)	F 689		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804		6/14/24

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F 804	Continued From page 5 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure safe and appetizing temperatures of food for 3 of 4 entree meals observed on 1 of 3 nursing units ([redacted] Floor). This deficient practice was evidenced by the following: On 5/3/24 at 10:07 AM, the surveyor conducted a Resident Council meeting which included four residents (Resident #13, #27, #46, and #48). Resident #46 stated lunch and dinner were served cold and in takeout containers and not on hot plates since[redacted]. On 5/8/24 at 11:32 AM, the surveyor informed the [redacted]) they wanted to observe the lunch meal for the day including food temperatures. The surveyor asked the [redacted] to calibrate two thermometers in their presence; which the [redacted] completed using an ice bath, and the thermometers reached 32 degrees Fahrenheit (F). On 5/8/24 at 11:33 AM, the surveyor observed the [redacted] using one of the thermometers calibrated to 32 F and took the following temperatures for the lunch meal:	F 804	1. The residents that received this meal [redacted] based on food temperatures. 2. All residents have the ability to be affected if food is not provided at a proper temperature. 3. The facility sent the needs list for insulated bases and dome lids to the company purchasing group. Order was placed by the purchasing group to meet the needs of current resident census and bring the facility into compliance and improve ability to maintain temperature of food. The Food Service Director will provide in-servicing to cooks and frontline staff regarding proper food temperatures for hot and cold items. The Food Service Director or designee shall perform weekly temperature test trays. The test trays shall be done prior to leaving the kitchen and again following meal delivery on the units. This test tray check shall include at least one breakfast, lunch and dinner meal per week.	

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F 804	Continued From page 6 Barbecue chicken 178 F Scalloped potatoes 178 F Lima beans 160 F Sausage and peppers 170 F Chopped chicken 168 F Pureed lima beans 168 F Mashed potato 182 F Pureed chicken 158 F Carrots 200 F Yogurt 47 F Milk 41 F On 5/8/24 at 11:47 AM, the surveyor observed dietary staff began plating lunch. The U.S. FO stated the facility used insulated bases and dome lids, pellets (plate liner), and heated plates to maintain food temperatures. The U.S. FO stated the facility currently did not have enough insulated bases and dome lids to plate all the residents food, so they used disposable Styrofoam containers with lids to serve residents at all three meals. On 5/8/24 at 12:40 PM, the surveyor observed the dietary staff began to plate the last food cart using disposable trays. At 12:44 PM, the last meal was plated, and the surveyor requested four test tray meals; a regular texture, alternative regular texture, and ground texture meals. The regular meal contained barbecue chicken, lima beans, scalloped potatoes, milk, and yogurt; the alternative regular meal included sausage and pepper sandwich, lima beans, and lactaid milk; the mechanical soft meal contained chopped chicken, scalloped potatoes, and lima beans; and the pureed meal contained pureed chicken, mashed potatoes, and pureed lima beans. At this time, the U.S. FOIA (b) (6) accompanied by the surveyor and U.S. FO left the kitchen with the dining	F 804	All results of the test trays shall be kept by the Food Service Director in a food temperature log to assess for patterns or areas of concern. 4. The above food tempurature audits shall continue for a minimum of 6 months unless full compliance is not reached for a minimum of 3 months. The audit shall continue until this goal is achieved. The Food Service Director shall provide the results of the audits to the Administrator for review. The results of the audits will also be presented to the Quality assurance team during the scheuduled Quarterly Meeting.	

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F 804	Continued From page 7	F 804		

cart and proceeded to the Third-floor nursing unit.

On 5/8/24 at 12:45 PM, the lunch meal arrived on the Third-floor nursing unit.

On 5/8/24 at 12:50 PM, the U.S. FOIA (b) (6) began delivering the meal trays to the residents.

On 5/8/24 at 12:57 PM, the U.S. FOIA delivered the last resident meal.

On 5/8/24 at 12:58 PM, the U.S. FO informed the surveyor that hot food should be served at 135 F or higher, and cold food should be 41 F or lower. At this time, the U.S. FO using the calibrated thin probe digital thermometer obtained the following food temperatures:

Regular meal texture:
Barbecue chicken 145 F
Scalloped potatoes 141 F
Lima beans 129 F
Whole milk 56 F
Yogurt 69 F

Regular alternative meal texture:
Sausage and pepper sandwich 121 F
Lima beans 129 F

Mechanical soft meal texture:
Chopped chicken 108 F
Scalloped potatoes 141 F
Lima beans 124 F

Pureed meal texture:
Pureed chicken 114 F
Mashed potatoes 132 F
Pureed lima beans 105 F

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F 804	Continued From page 8 At this time, the U.S. FOIA (b) (6) acknowledged the only food served at acceptable temperature was the barbecue chicken and scalloped potatoes. On 5/10/24 at 10:21 AM, the U.S. FOIA (b) (6)) in the presence of the U.S. FOIA (b) (6) and survey team acknowledged the food and beverages were served at unacceptable temperatures. A review of the facility's "Food Serving Policy and Procedure" dated revised May 2024, included food items will be served to the residents at proper temperatures; hot food will be served at a minimum temperature of 135 degrees when the resident receives their tray; cold food items will be served at a maximum temperature of 41 degrees...	F 804		
F 812 SS=E	NJAC 8:39-17.4(a)(2) 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	F 812		6/14/24

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F 812	Continued From page 9 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 pertinent facility documents, it was determined that the facility failed to a.) store, label, and date potentially hazardous foods to prevent food-borne illness; b.) discard potentially hazardous foods past their date of expiration; and c.) maintain storage areas in a sanitary manner. This deficient practice was evidenced by the following: On 5/2/24 at 8:49 AM, the surveyor with the U.S. FOIA (b) (6)) toured the kitchen and observed the following: 1. The handwashing sink had no paper towels. The [redacted] acknowledged there should be paper towels by the sink at all times. 2. In the walk-in refrigerator, one gallon of ranch dressing dated opened 3/30/24. The rim of the bottle, lid, and outside of the container all contained ranch dressing spillage. The [redacted] acknowledged the bottle should have been cleaned after use to prevent bacterial growth. 3. In the walk-in refrigerator, one opened jug of salsa dated received 1/18/24. The was no opened date, and the packaging indicated best within seven to ten days after opening. 4. In the walk-in refrigerator, one gallon of hot sauce dated opened 4/30/24. The outside of the container and rim contained hot sauce spillage.	F 812	1. The following actions were taken immediately to place the facility back into compliance Hand towels were placed into the dispenser at the washing station. The ranch dressing, jug of salsa, gallon of hot sauce, gallon jar of dill pickles, gallon of sweet relish were disposed of from the walk in refrigerator. The five pound container of sour cream, the two opened boxes of portion control sour cream packets, and one box of portion control cream cheese were disposed of from the reach in refrigerator. The ice cream freezer was thawed in order to assure proper closing of the lid. The gallon of milk from the refrigerated milk box was discarded. The portion control container of cole slaw, sliced provolone cheese, and sliced tomatoes were all discarded from the cooks refrigerator. The large can blocking the dry storage door was removed for proper closing.	

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F 812	Continued From page 10 5. In the walk-in refrigerator, one-gallon jar of dill pickle chips. The lid of the container had a large slit in the top exposing the inside contents to air, and there was visible condensation in the bottle. The U.S. FC stated the slit was made with a knife to open the jar more easily. The U.S. FC confirmed the contents should not be exposed to air. 6. In the walk-in refrigerator, one opened gallon of sweet relish dated received 7/6/23 with no opened date. The packaging indicated to use by 4/20/24. There was green fuzzy debris on the outside packaging and the inside contents. 7. In the walk-in refrigerator, one opened gallon of French dressing dated received 1/8/24. There was no date when opened. The U.S. FC stated dressing was good for three months after opening. 8. In the reach-in refrigerator, one five-pound container of sour cream opened with no date. The packaging indicated to use by 5/28/24. 9. In the reach-in refrigerator, two opened boxes of portion control packets of sour cream dated use by 2/2/24. The one box contained approximately twenty packets, and the second box contained approximately forty packets. 10. In the reach-in refrigerator, one opened box of portion control containers of cream cheese. The box contained approximately twenty containers, and was dated received 10/19/23 with no use by date. 11. The ice cream freezer chest had ice accumulation on the sides approximately	F 812	The large dented pear can and the large can with no manufacture date or label was removed from the dry storage. 2. All residents have the ability to be affected if the facility fails to store, prepare, distribute and serve food in accordance with professional standards for food service safety. 3. The Food Service Director performed inservices to the dieatry staff on the following topics: The facility policy and procedure for labeling and dating of items. Dispensing of out of date food items Removal of dented cans Container cleaning following spillage Defrosting of freezers to prevent closure issues. Doors and doorways remain free of items to assure closure and prevent blocking. The facility food storage policy and procedure was reviewed and revised to meet current requirements. The Food Service Director will perform weekly audits of the walk in refrigerator, the reach in refrigerator, the milk boxes, the cooks refrigerator, and dry storage area to assure no items are outdated or improperly stored. The Housekeeping Director or Designee will check the daily for adequet, redily available paper towel supplies.	

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F 812	Continued From page 11 one-inch thick as well as the inside of the sliding glass doors. The ice accumulation prevented the [redacted] from sliding the freezer door opened from the left side. The [redacted] acknowledged the ice accumulation prevented air circulation and was a sanitation concern. 12. In the milk refrigerated box, one opened half gallon container of milk not dated when opened. 13. In the [redacted]'s refrigerator, one portion control container of cole slaw with no date when prepared or when to use by. 14. In the [redacted]'s refrigerator, a bin which contained sliced provolone cheese dated opened 3/6/24, and additional undated package that was dried that contained no date. The [redacted] identified the second packaging as provolone cheese and stated both packages should be discarded. 15. In the [redacted]'s refrigerator, a container of sliced tomatoes labeled prepared 4/28/24 and discard 5/1/24. 16. In dry storage, the door was being held open by a box of condensed tomato soup that was placed directly on the floor. The box contained five fifty-ounce cans of soup with the lids that contained black debris. The [redacted] acknowledged food should not be stored on the floor, and the lids should remain free of debris and dust. 17. In dry storage on the can rack, one large can with no manufacture's product label. The can contained a label that indicated pears, and there was a large visible dent on the can. The [redacted] acknowledged dented cans should not be with inventory.	F 812	The Food Service Director will audit the ice cream box for ice build up schedule routine defrosting to assure proper closure. The Food Service Director will provide these audits to the Administrator and the Infection Control Nurse for review. 4. The above audits shall be performed for a minimum of six months unless full compliance is not reached for a minimum of 3 consecutive month. This audit will continue until this goal is reached. The results of these audits will be presented to the Quality team at the scheduled quarterly meeting.	

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18. In dry storage on the can rack, one large can with no manufacture's label or written label. The can was written in black marker TD, and the U.S. FO stated he did not know what the product was or how long it had been there.

On 5/8/24 at 10:40 AM, the surveyor interviewed the U.S. FO in the presence of the U.S. FOIA (b) (6)) who confirmed the cream cheese packets were only good for six months so should have been discarded; milk was only good for seven days once opened; salad dressing was good for two months after opening; and sour cream was only good for two weeks after opening.

On 5/10/24 at 10:21 AM, the U.S. FOIA (b) in the presence of the U.S. FOIA (b) (6)) and survey team, acknowledged the kitchen findings.

A review of the facility's "Food Storage" policy dated reviewed February 2018, included dry food and food supplies shall be stored in a clean, dry location not exposed to splash, dust, or other contamination...all foods and supplies will be stored at least six feet off the floor...food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants...the inside surfaces of any refrigeration units must be free of chipping, cracking, corrosion, debris, moisture, ice build-up, and condensation...

A review of the facility's "Labeling and Dating Procedure in the Dietary Department" dated revised July 2023, included food items as appropriate will be labeled and dated upon by

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F 812	Continued From page 13 dietary staff using the facility labeling system...all perishable products will be dated using the date of production, dated product will be used up to and including the third day of production unless otherwise marked. All products after this date will be discarded; perishable foods are checked daily for spoilage by the [Food Service Director]/designee...food items will be labeled with an open date once individual item is opened for use... NJAC 8:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		6/14/24

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F 880	Continued From page 14 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 15 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to a.) perform hand hygiene during and after medication administration; b.) perform hand hygiene before and after serving residents meals; and c.) maintain NJ Exec Order 26.4b1 to maintain NJ Exec Order 26.4 control standards. This deficient practice was identified on 2 of 3 nursing units (NJ Exec Order 26 and NJ Exec Or Floor), and was evidenced by the following: 1. On 5/8/24 at 10:29 AM, the surveyor observed Unit Manager/Licensed Practical Nurse (UM/LPN #1) perform NJ Exec Order 26.4b1 care on Resident #47 and observed the following: UM/LPN #1 performed hand hygiene with soap and water lathering outside the flow of running water for thirteen seconds and put on a pair of gloves. UM/LPN #1 then cleaned the bedside table and removed the pair of gloves, and performed hand hygiene with soap and water lathering outside the flow of running water for ten seconds. At 10:40 AM, UM/LPN #1 opened the NJ Exec Order 26.4b1 and touched the inside of the sterile items with their gloved hand; then proceeded to change gloves without performing hand hygiene. UM/LPN #1 then applied the left sterile glove by touching the palm area with the right non-sterile glove hand.	F 880	1. Residents 47, 31, 51, 295, 133 were observed for signs of NJ Exec Order 26.4 with no symptoms found to be present. All residents on the NJ Exec Order 26 floor, NJ Exec Order 26.4 , rooms NJ Exec O NJ Exec Order 26.4b1 were observed for signs of NJ Exec Order 26.4 NJ Exec Order 26 or symptoms presented. All sanitizer dispensers in the facility were checked for battery function and and product dispensing by the Housekeeping Director and the Infection Control Nurse. 2. All Residents have the potential to be affected by these deficient practices. 3. Widespread education to staf on the hand washing policy, both water based and hand sanitizer use, will be provided by the Infection Control Nurse. A minimum of 10 staff members with be audited weekly for correct hand washing technique. this audit will be extensive across all shifts and all departments. These audits will be done by the Infection Control Nurse and the Department Directors. The House Keeping Director has included routine daily checks of the sanitizer dispensers to the daily duties list of the assigned floor staff. 78 hand sanitizer units have been ordered for inreased hand sanitizer availability on the resident units.	

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F 880	Continued From page 16 During NJ Exec Order 26.4b1 care from 10:44 AM to 10:48 AM, UM/LPN #1 completed a glove change without performing hand hygiene in between. On 5/8/24 at 11:00 AM, the surveyor interviewed UM/LPN #1 who confirmed that handwashing was not completed for the required 15-20 seconds lathering outside the flow of running water, and that alcohol based hand rub (ABHR) should have been used between glove changes. UM/LPN #1 also admitted that sterility was broken upon opening the NJ Exec Order 26.4b1 and while applying gloves. On 5/8/24 at 11:02 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that hand sanitizing using ABHR was required between every resident, but was not able to answer if hand hygiene was necessary between glove changes. When asked regarding opening sterile packing, if touching the inside items with a gloved hand or applying a sterile glove with a non sterile glove was best practice, the U.S. FOIA (b) answered "no, sterile was sterile". The U.S. also confirmed that hand washing should be at least 20 to 30 seconds lathering outside the flow of running water. On 5/8/24 at 1:39 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who acknowledged that hand hygiene should be completed between glove changes; hand hygiene with soap and water lathering for twenty second outside the flow of running water, and and you would not touch the inside of a sterile object or glove with a non-sterile glove. A review of the facility's undated "Competency	F 880	Tracheostomy treatment procedure education with a follow up competency will be given to all nursig staff by the Infection Control Nurse and the Assistant Director of Nursing. These competencies will be placed in the employees' human resources file. Oxygen tubing changes , as per policy, will be completed every other week. These tubing changes will be documented in the residents medical record. All Nursing staff will be educated by Nurse leaders on oxygen tubing change and the medical record recording of the procedure. Bi weekly audits will be completed by the Unit Managers and Nurse supervisors to assure compliance with oxygen tubing changes. All nursing staff will be re-educated on Enhanced Barrier precautions by the Infection Control Nurse and the Nurse Leaders. A minimum of 6 weekly audits will be completed by the Infection Control Nurse and Nurse and Nurse Supervisors on residents that are on Enhanced Barrier precautions. These audits will be completed by the Infection Control Nurse and reported to the Director of Nursing. 4. The above audits, excluding hand washing, wil be conducted for 6 months unless full compliance is not achieved for a minimum of 3 consecutive months. This	

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F 880	Continued From page 17 Tracheostomy Care" document included...remove gloves and perform hand hygiene... A review of the facility's undated "Protocol for Suctioning of Tracheostomy Tube" document included...use sterile technique to open package...designate a sterile and non-sterile hand... 2. During medication pass on 5/2/24 at 8:40 AM, the surveyor observed Licensed Practical Nurse (LPN #1) administer medications to Resident #31, and then proceed to perform hand hygiene using soap and water lathering outside the flow of running water for ten seconds. LPN #1 then picked up [NJ Exec Order 26.4b1] from the floor, and performed hand hygiene again lathering with soap outside the flow of running water for five seconds. On 5/2/24 at 8:53 AM, the surveyor interviewed LPN #1 who acknowledged that handwashing should be completed by lathering with soap outside the flow of running water for thirty seconds, and confirmed that they did not wash their hands for that amount of time. On 5/8/24 at 1:39 PM, the surveyor interviewed the [U.S. FOIA (b) (6)]) who stated when performing hand hygiene with soap and water, you lathered outside the flow of running water for twenty seconds. On 5/10/24 at 10:21 AM, the [U.S. FOIA (b) (6)]), in the presence of the [U.S. FOIA (b)] acknowledged the surveyor's above identified concerns.	F 880	audit will continue until this goal is reached. The weekly handwashing audit of at least 10 staff members will remain on-going. The results of these audits will be presented to the Director of Nursing for review. The Director of Nursing shall report the audit results to Quality Assessment team at the scheduled quartertly meetings.	

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F 880	Continued From page 18 3. On 5/3/24 at 12:03 PM, while on the [NJ Exec Order 26.4b1] Floor nursing unit identified as the "[NJ Exec Order 26.4b1]", the surveyor attempted to use ABHR at the dispensers located in between Resident Room #[NJ Exec] and #[NJ Exec] #[NJ Exec] and #[NJ Exec] and #[NJ Exec] and the Activity Room. All three dispensers were empty. On 5/3/24 at 12:24 PM, the surveyor interviewed LPN #2 and LPN #3 who were seated together, and stated hand hygiene was to be completed all the time both in between and during patient care. LPN #2 and #3 acknowledged that hand hygiene could be completed either by washing with soap and water for twenty-six seconds or by ABHR. Both LPN's confirmed that they were not required to carry ABHR on their person since it was available on the medication cart or on the walls. On 5/3/24 at 12:26 PM, the surveyor in the presence of UM/LPN #1 attempted to use the above identified ABHR dispensers and confirmed that they were empty. UM/LPN #1 confirmed that they needed to be filled. On 5/10/24 at 10:21 AM, the U.S. FOIA (b) (6)), in the presence of the [US FOIA (b)(6)] acknowledged the surveyor's above identified concerns. 4. On 5/2/24 at 11:39 AM, the surveyor observed outside Resident #51's room, a sign that indicated the resident was on [NJ Exec Order 26.4b1] which included: everyone must clean their hands, including before entering	F 880		

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and when leaving the room; wear gloves and a gown for the following NJ Exec Order 26.4b1 resident care activities which included..NJ Exec Order 26.4b1 [redacted] or assisting with NJ Exec Order 26.4b1 NJ Exec Order [redacted] care or use including NJ Exec Order 26.4b1 [redacted] NJ Exec Order [redacted] care including any NJ Exec Order 26.4b1 requiring a NJ Exec Order 26.4b1 The surveyor observed a bag containing personal protective equipment (PPE) hanging on the closet door.

At that time, the surveyor knocked on the door and upon entering observed a staff member behind the resident's curtain wearing only gloves on both hands. The staff member stated that she was a Licensed Practical Nurse (LPN #4), and had just completed flushing the resident's NJ Exec Order 26.4b1 LPN #4 then stated that she should have been wearing a gown with the gloves when she performed care. The surveyor interviewed the U.S. FOIA (b) (6)) who stated the resident was on NJ Exec Order 26.4b1 and LPN #4 should have been wearing a gown with the gloves when providing direct care such as NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 [redacted]

On 5/6/24 at 9:04 AM, the surveyor interviewed UM/LPN #1 who stated that when a resident was on NJ Exec Order 26.4b1 the nurse wore a gown and gloves when providing direct care. When asked if flushing a NJ Exec Order 26.4b1 was providing direct care, LPN/UM #1 stated "No, only gloves were needed when NJ Exec Order 26.4b1 [redacted]

On 5/6/24 at 9:51 AM, the surveyor interviewed

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the [redacted] who stated that [redacted] were used for any resident that had a [redacted] such as [redacted]; the staff were to wear a gown and gloves when doing direct care to that [redacted]. The [redacted] further stated that [redacted] was providing [redacted] care and a gown and gloves were to be worn. The [redacted] then stated that it was important to wear a gown and gloves when providing [redacted] care to a resident on [redacted] because it decreased the [redacted]. The [redacted] stated that all the staff including LPN #4, [redacted] and UM/LPN #1 were educated on [redacted] and provided the sign-in sheets for the education completed in [redacted]

On 5/7/24 at 10:27 AM, the [redacted] stated that a gown and gloves should have been worn when [redacted] a [redacted].

A review of the facility's policy titled "Policy and Procedure Infection Control Program Standards," dated 07/2023, revealed that Contact Precautions/Enhanced Barrier Precautions are used to prevent transmission of illnesses easily spread through contact with residents or contaminated items in their environment. Enhanced Barrier Precautions are used when a resident has any break in the skin and direct care is being administered.

5. On 5/2/24 at 9:56 AM, the surveyor observed Resident #51's [redacted] dated [redacted] attached to the [redacted] The [redacted] dated [redacted] was observed again on 5/2/24 at 11:39 AM and on 5/3/24 at 9:06 AM.

On 5/3/24 at 11:08 AM, the [redacted] provided the

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surveyor with a policy titled "Oxygen Administration," dated March 2024, which did not include when the oxygen tubing should be changed.

On 5/6/24 at 9:04 AM, the surveyor interviewed UM/LPN #1 who stated that the NJ Exec Order 26.4b1 should have a date on it that it was changed and should be changed weekly. UM/LPN #1 stated that there was not a physician's order to change the NJ Exec Order 26.4b1 weekly, "we just follow our policy."

On 5/6/24 at 9:51 AM, the surveyor interviewed the U.S. FOIA (b) who stated that the NJ Exec Order 26.4b1 should be NJ Exec Order 26.4 and dated every two weeks and as needed and was not documented in the Electronic Medical Record (EMR). The U.S. FOIA (b) further stated that it was important to change the NJ Exec Order 26.4b1 because the NJ Exec Order 26.4b1 contained NJ Exec Order 26.4 and "you need to keep the NJ Exec Order 26.4b1."

On 5/6/24 at 12:41 PM, during an interview with the U.S. FOIA and the U.S. FOIA (b) in the presence of the survey team, the U.S. FOIA stated that the NJ Exec Order 2 should be NJ Exec Order 26.4 and dated every two weeks. The U.S. FOIA further stated that the NJ Exec Order 2 change did not need a physician's order and they did not document the NJ Exec Order 26.4b1 in the EMR.

On 5/7/24 at 9:38 AM, during an interview with the U.S. FOIA (b) and U.S. FOIA (b) the U.S. FOIA stated that the facility had a NJ Exec Order 26.4b1 until NJ Exec Order 26.4b1 who had changed all the NJ Exec Order 26.4b1 every two weeks. The NJ Ex had her own calendar and schedule for NJ Exec Order 26.4b1, but they did not have a chance to put

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the [redacted] protocols on paper until yesterday. The [redacted] provided the surveyor with a protocol titled "Protocol on Resident Respiratory Equipment," dated May 2024, which revealed that oxygen tubing was to be changed every two weeks and as needed. The oxygen tubing change will be documented in the computer under Respiratory and the oxygen tubing will be tagged with the resident name and date of change.

On 5/7/24 at 10:27 AM, during an interview with the [redacted] and the [redacted] in the presence of the survey team, the [redacted] confirmed that Resident #51's [redacted] should have been [redacted] and dated on [redacted]. The [redacted] stated that the nurses should be checking the [redacted] expiration date when performing [redacted] care.

6. On 5/2/24 at 8:30 AM, the surveyor during Medication Pass observation with LPN #5 on the [redacted] Floor nursing unit made the following observations:

LPN #5 prepared Resident #295's medications; administered the medications; and signed for the administration in the resident's electronic medical record (eMR). The surveyor did not observe LPN #5 sanitize her hands with alcohol-based hand rub (ABHR) before or after she administered the medications.

On 5/2/24 at 11:19 AM, the surveyor interviewed LPN #5 who confirmed that prior to preparing Resident #295's medications and after she administered the medications, she should have

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performed hand hygiene before moving on to the next resident.

On 5/2/24 at 8:45 AM, the surveyor during Medication Pass observation of LPN #5 made the following observations:

LPN #5 prepared Resident #133's medications; administered the medications; and signed for the administration in the resident's eMR. The surveyor did not observe LPN #5 sanitize her hands ABHR before or after she administered the medications.

On 5/2/24 at 11:19 AM, the surveyor interviewed LPN #5 who confirmed that prior to preparing Resident #133's medications and after she administered the medications, she should have performed hand hygiene before moving on to the next resident.

On 5/2/24 at 9:00 AM, the surveyor during Medication Pass observation of LPN #5 made the following observations:

LPN #5 prepared Resident #85's medications; administered the medications; and signed for the administration in the resident's eMR. The surveyor did not observe LPN #5 sanitize her hands with ABHR before she administered the medications. After LPN #5 administered the medications, she stated that she would now wash her hands with soap and water since it was the facility policy to wash her hands after every third resident.

On 5/2/24 at 11:19 AM, the surveyor interviewed LPN #5 who confirmed that prior to preparing Resident #85's medications, she should have

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performed hand hygiene and sanitized her hands between residents. The LPN further stated that the facility's policy was to sanitize hands between residents and in addition to sanitizing between residents she should wash her hands with soap and water after passing medications to every three residents.

On 5/6/24 at 10:35 AM, the surveyor interviewed the [U.S. FOIA (b)] who stated LPN #5 should have sanitized her hands between residents during medication administration.

On 5/8/24 at 10:53 AM, the surveyor interviewed the [U.S. FOIA] who confirmed that LPN #5 should have sanitized her hands with ABHR before she prepared the medications and after she administered the medications to each resident. The [U.S. FOIA] further stated that the [U.S. FOIA] should have washed her hands with soap and water after administering the medications to the third resident per the facility policy.

Review of LPN #5's "Medication Pass Observation" dated 3/19/24 provided by the [U.S. FOIA] revealed ...during the medication pass ... hands washed appropriately per facility policy; before and after the use of gloves...after direct contact and when visibly soiled; after 3 uses of alcohol gel/per facility policy.

7. On 4/30/24 at 12:26 PM, the surveyor observed outside Resident Room #310 a sign that indicated the resident was on [NJ Exec Or] The surveyor observed PPE which included but not limited to [NJ Exec Order 26] gowns, disposable gloves and ABHR stored in a container that was affixed to the outside of the resident's bathroom door.

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At that time, the surveyor observed Certified Nursing Assistant (CNA #1) enter Resident Room [NJ Ex Order] without performing hand hygiene or using ABHR. The surveyor observed CNA #1 set up the lunch tray for the resident in bed A. CNA #1 removed the lid, buttered the bread, opened the drinks, and then left the room without performing hand hygiene or using an ABHR. CNA #1 re-entered the room with a towel and proceeded to feed the resident without performing hand hygiene or using an ABHR.

On 5/2/24 at 12:00 PM, the surveyor observed outside Resident Room [NJ Ex Order] a sign that indicated the resident was on [NJ Exec Order] The surveyor observed PPE which included but not limited to [NJ Exec Order 26] gowns, disposable gloves and ABHR stored in a container that was affixed to the outside of the resident's bathroom door.

At that time, the surveyor observed the [U.S. FOIA (b)]) entered Resident Room [NJ Ex Order] without performing hand hygiene or using an ABHR. The surveyor observed the [U.S. FOIA] placed a cup of tea on the resident in bed [NJ Exec] bed side table (BST) . The [U.S. FOIA] moved the resident's BST closer to the resident and left the room without performing hand hygiene or using an ABHR.

On 5/2/24 at 12:10 PM, the surveyor interviewed the [U.S. FOIA] who stated that hand hygiene only had to be performed when providing [NJ Exec Ord] care to the resident. The surveyor asked the [U.S. FOIA] if she should be following the sign outside Resident Room [NJ Ex Order] which instructed before entering and exiting the room, you must perform hand hygiene. The [U.S. FOIA] did not respond to the surveyor.

On 5/2/24 at 12:15 PM, the surveyor observed

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the U.S. FOIA (b) (6)) who approached the food cart, removed a tray and entered Resident Room NJ Ex Orde. The surveyor observed the U.S. FOIA (b) (6) place the tray on the BST of the resident in bed NJ and moved the BST closer to the resident. The U.S. FOIA (b) (6 left the room and went directly to the food cart, removed a tray for the resident in Resident Room # NJ Exec with no observed hand hygiene.

On 5/2/24 at 12:20 PM, the surveyor observed the U.S. FOIA (b) (6) approach the food cart, removed a tray, entered Resident Room # NJ Exec and placed the tray on the BST of the resident in bed NJ Ex The U.S. FOIA (b) (6), opened the milk and poured it into a cup, removed the silverware from the plastic and moved the BST closer to the resident. The U.S. FOIA (b) (6) then left the room with no observed hand hygiene.

On 5/2/24 at 12:25 PM, the surveyor observed the U.S. FOIA (b) (6) approach the food cart, removed a tray, entered Resident Room # NJ Exec and placed the tray on the BST of the resident in bed NJ Ex The U.S. FOIA (b) (6) removed the top and moved the BST closer to the resident. The surveyor observed the U.S. FOIA (b) (6) then left the room and picked up the hall phone with no observed hand hygiene.

On 5/2/24 at 12:34 PM, the surveyor observed LPN #5 entered Resident Room # NJ Exec with no observed hand hygiene. The surveyor observed LPN #5 feed the resident in bed NJ E with no observed hand hygiene.

On 5/2/24 at 12:37 PM, the surveyor interviewed LPN #5 who stated that staff were not required to perform hand hygiene unless providing direct care. The surveyor asked LPN #5 if serving trays

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and feeding residents were considered direct care, and LPN #5 did not respond.

On 5/2/24 at 12:44 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated that the facility policy was that staff performed hand hygiene before they pass the first meal tray and then again after the last tray was passed. The surveyor asked the [U.S. FOIA (b) (6)] if staff should perform hand hygiene between residents including setting up meal trays and feeding residents, and the [U.S. FOIA (b) (6)] replied, only if their hands were visibly soiled.

On 5/6/24 at 10:35 AM, the surveyor interviewed the [U.S. FOIA (b)] who confirmed that staff were expected to perform hand hygiene using ABHR before entering and exiting the rooms of all of the residents, especially those residents who were on [NJ Exec Ord]

On 5/9/24 at 10:45 AM, the surveyor observed outside Resident Room #[NJ Exec] a sign that indicated the resident was on [NJ Exec Ord] The surveyor observed PPE which included but not limited to [NJ Exec Order 26] gowns, disposable gloves and alcohol-based hand rub (ABHR) stored in a container that was affixed to the outside of the resident's bathroom door.

At that time, the surveyor observed CNA #2 enter Resident Room #[NJ Exec] without sanitizing her hands or using ABHR. CNA #2 repositioned the resident in bed [NJ E] handled items on the bedside table, and removed items from their dresser. The surveyor observed CNA #2 exit Resident Room #[NJ Exec] without performing hand hygiene or using an ABHR.

On 5/9/24 at 10:55 AM, the surveyor interviewed

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CNA #2 who confirmed that she should have sanitized her hands before entering and exiting the room.

A review of the facility's "Policy and Procedure Infection Control Program Standards" dated 7/2023, included Contact Precautions/Enhanced Barrier Precautions (EBP) are used to prevent transmission of illnesses easily spread through contact with residents or contaminated items in their environment. Enhanced Barrier Precautions are used when a resident has any break in the skin and direct care is being administered...personnel should demonstrate a high standard of hygienic practice...hand washing is to be performed before and after each resident contact and according to the hand washing policy and procedures.

8. On 4/30/24 at 11:59 AM, the surveyor observed staff deliver lunch meal trays to the residents on the [redacted] Floor nursing unit and observed the following:

The surveyor observed the [redacted] who approached the food cart, removed a tray and entered Resident Room #[redacted]. The [redacted] placed the food tray on the bed side table (BST) of the resident in bed [redacted] applied a clothing protector, removed the plate cover, opened the juice and the fruit, and moved the BST closer to the resident with no observed hand hygiene.

On 4/30/24 at 12:17 PM, the surveyor observed the [redacted] enter the dining room and stated that she was going to feed the resident in Resident Room #[redacted] bed [redacted]. The surveyor observed the [redacted] applied soap to her hands, and immediately placed her hands under the stream of water

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without lathering and applying friction to her hands outside the water. The surveyor observed the U.S. FOIA then dried her hands, and proceeded to feed the resident.

On 5/2/24 at 12:10 PM, the surveyor interviewed the U.S. FOIA who acknowledged that she should have performed hand hygiene by applying soap and lathering outside the stream of running water for at least 20 seconds.

On 5/8/24 at 10:53 AM, the surveyor interviewed the U.S. FOIA who stated that staff should perform hand hygiene between residents when serving meal trays, setting up trays, and feeding residents. The U.S. FOIA further stated that staff should be lathering their hands with soap outside the stream of water for at least 20-30 seconds before placing their hands under the stream of water.

On 5/10/24 at 10:21 AM, the U.S. FOIA (b) in the presence of the U.S. FOIA and survey team acknowledged the surveyor's above identified concerns.

A review of the facility's undated "Outbreak Response Plan" document included ..monitor all soap, paper towels, and hand sanitizer dispensers' multiple times throughout the day and replenish as needed.

A review of the facility's undated "Licensed Practical Nurse Staff Nurse Job Description" document include ...thorough knowledge of principles and methods involved in handling of sterile/clean materials and daily hygienic care of residents...

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F 880	Continued From page 30 A review of the facility's "Hand Washing" policy dated revised June 2023, included...hand hygiene products and supplies (sinks, towels, alcohol-based hand rub, etc) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies ...employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap...The use of gloves does not replace hand washing/hand hygiene... NJAC 8:39-19.4 (a-c)(k)(n); 27.1 (a)	F 880		

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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 documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 14 out of 42 shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	1. The shifts not meeting staffing ratios did not result in any residnt care issues. 2. All residents have the potential to be affected if staffing ratios are not met. 3. The nurse staffing coordinator will meet with the Director of Nursing, Administrator, or designee weekly to review open shifts. The Human Resources department will conduct bi-annual wage surveys in our local area of competition.	6/14/24

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

Electronically Signed | 05/29/24

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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 4/30/24 at 10:29 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staffing was, and the DON stated that staffing was fair; that the facility did not always meet the state minimum required staffing. At this time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 4/14/24 to 4/20/24 and 4/21/24 to 4/27/24. The surveyor reviewed the facility completed Nurse Staffing Reports which revealed the facility did not have the required staff on day shift as follows: 4/14/24 had 13 CNAs for 143 residents on the day shift, required at least 18 CNAs.	S 560	In House marketing program to non CNA staff to consider Nursing Aide Certification. Initiation of referral bonus for staff to encourage new CNA employment. Initiation of new sign on bonus for both Nursing and CNA staff to encourage new employment. The Staffing Coordinator will provide Bi-weekly reports on staffing, turnover, and the progress of new hire orientation. Administration and Nursing leaders will review. Facility will perform exit interviews to audit trends on employees' reasoning for resigning. Facility is expanding agency contracts to attempt to increase the potential number of available staff to meet staffing minimums. 4. Above reports will be reviewed by the DON, Administrator, and Human Resourses Director. The results and trends obtained from the above reports will be provided to the Quality team at the Quarterly meetings.	

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S 560	Continued From page 2 4/15/24 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. 4/16/24 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. 4/17/24 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. 4/18/24 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. 4/19/24 had 14 CNAs for 144 residents on the day shift, required at least 18 CNAs. 4/20/24 had 14 CNAs for 144 residents on the day shift, required at least 18 CNAs. 4/21/24 had 14 CNAs for 144 residents on the day shift, required at least 18 CNAs. 4/22/24 had 14 CNAs for 147 residents on the day shift, required at least 18 CNAs. 4/23/24 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. 4/24/24 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. 4/25/24 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. 4/26/24 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. 4/27/24 had 14 CNAs for 140 residents on the day shift, required at least 17 CNAs.	S 560		
S1230	8:39-17.2(e) Mandatory Dietary Services (e) The facility shall routinely provide nondisposable dishes and cutlery at all meals except for special meal activities or individual resident needs. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide all	S1230	1. The residents that received disposable items on their meal trays did [redacted]	6/14/24

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S1230	Continued From page 3 residents with nondisposable dishware and drinkware for meals for 3 of 3 meals. This deficient practice was evidenced by the following: On 5/3/24 at 10:07 AM, the surveyor conducted a Resident Council meeting which included four residents (Resident #13, #27, #46, and #48). Resident #46 stated lunch and dinner were served cold and in takeout containers and not on hot plates since NJ Exec Order 26.4b1. On 5/8/24 at 10:40 AM, the surveyor interviewed Resident #46's Licensed Practical Nurse (LPN) who stated there was NJ Ex Order 26.4b1 that would have warranted the resident to receive disposable dishware. The LPN confirmed she had seen other residents receive disposable dishware for meals when there was NJ Ex Order 26.4b1 [redacted], but stated the surveyor needed to ask the kitchen the reason. On 5/8/24 at 10:48 AM, the surveyor interviewed the Dietary Director (DD) who confirmed the facility did not have enough insulated bases and dome lids to serve all the residents; the facility had enough reusable plates. The DD stated he requested additional insulated bases and lids months ago, and could not speak to why the facility had not received. The DD stated that at each meal, at least 12-15 residents received disposable Styrofoam containers with lids for their meals, which he alternated between floors for each meal. The DD stated for breakfast the first cart on the Second Floor nursing unit, for lunch the tenth cart served on the Third Floor nursing unit, for dinner the tenth cart on the Third Floor nursing unit received disposable containers. A review of the "Dining Order Report" indicated that for breakfast, nineteen residents received	S1230	any NJ Exec Orde 2. All residents have the ability to be affected if the facility does not provide non disposable dishes and cutlery at all meals. 3. The facility sent the needs list for insulated bases and dome lids to the company purchasing group. Order was placed by the purchasing group to meet the needs of current resident census and bring the facility into compliance. The Food Service Director shall perform weekly audits of food trucks at all meal times to assure all trays are equipped with proper domes and lids for food delivery. This audit will also include utensils and cups to assure a complete tray is being provided to all residents. The results of these audits shall be provided to the Administrator for review. Any shortages in products shall be reported to the Administrator so orders can be established to replenish products and maintain compliance. 4. The above audit shall be performed for a minimum of 6 months unless full compliance is not met for 3 consecutive months. This audit shall continue until that goal is reached. The results of the audit will be presented to the Quality Assurance team during the scheduled quarterly meetings.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1230	Continued From page 4	S1230		

meals on the first dining cart; for lunch nine residents received meals on the tenth dining cart; and for dinner nine residents received meals on the tenth dining cart.

On 5/8/24 from 11:32 AM to 12:45 PM, the surveyor observed meal service in the kitchen and counted 112 insulated bases at the start of tray service. The surveyor observed while the dietary staff plated the ninth dining cart to the Third Floor nursing unit, the staff started utilizing disposable containers to serve the meals. The dietary staff continued to serve meals in disposable containers for the tenth dining cart for a total of thirteen meals served in disposable containers.

On 5/8/24 at 12:45 PM, the surveyor accompanied by the DD observed on the Third Floor nursing unit a Certified Nursing Aide (CNA) pouring coffee into disposable coffee cups. The surveyor asked the DD if the facility had enough reusable coffee mugs for all the residents, and the DD stated the facility did not. The DD stated he distributed reusable coffee mugs on amongst the three nursing units, and any additional coffee mugs needed, staff used disposable cups.

On 5/10/24 at 10:21 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) and survey team acknowledged the facility did not have enough reusable dishware and drinkware for all of the residents.

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	6/18/2024 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 F0689	Correction	ID Prefix F0804	Correction	ID Prefix F0812	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	06/06/2024	LSC	06/14/2024	LSC	06/14/2024
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/14/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
5/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061113 Y1	A. Building B. Wing Y2	6/18/2024 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 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 06/14/2024	ID Prefix S1230 Reg. # 8:39-17.2(e) LSC	Correction Completed 06/14/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315324	A. BUILDING **01** B. WING _____	**05/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 05/01/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/01/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Waters Edge Healthcare and Rehab is a five-story building built in June 1993and is composed of Type II protected construction. The facility is divided into 15 - smoke zones. The generator does approximately 80 % of the building per the Maintenance Director. The current occupied beds are 142 of 230.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6	K 311		6/14/24

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

Electronically Signed | 05/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315324	A. BUILDING **01** B. WING _____	**05/10/2024**

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K 311	Continued From page 1 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one out of 15 stairway exit doors' fire rated door assemblies were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: Observation on 05/01/24 at 2:00 PM revealed the stairway exit door on the first-floor center stair beside the elevators was equipped with panic hardware and not the required fire exit hardware which violated the listing of the rated fire door assemblies. During an interview at the time of observations, the U.S. FOIA (b) (6) confirmed the stairway door was equipped with panic hardware.	K 311	1. A third party vendor was immediately contacted to assist with obtaining the proper hardware for the fire door. New hardware will be installed immediately following delivery and bring the facility in compliance. No resident was injured or harmed due to this deficiency. 2. All resident's have the ability to be affected if fire doors are not maintained in accordance with written National Fire Protection Associations guidelines. 3. All fire doors will be audited by the Maintenance Director quarterly to assure all hardware on fire doors meets requirements and is in good working order. 4. The Maintenance Director will complete the above audits and will be ongoing for the purpose of continuous Quality Assurance. The results of this audit will be provided to the Administrator every quarter and to the Quality Assurance committee for the quarterly meetings.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		6/14/24

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K 321	Continued From page 2 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 interview, the facility failed to ensure the boiler room was rated for one hour fire resistance in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.2.1. This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: Observation on 05/01/24 at 12:47 PM of the	K 321	1. The Maintenance Director immediately purchased and sealed the three inch sprinkler pipe with the appropriate fire rated material to acheive compliance. No Residents were affected my this deficiency. 2. All residents have the ability to be affected if all hazardous areas are not properly maintained with appropriate fire	

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K 321	Continued From page 3 boiler room revealed a three-inch automatic sprinkler pipe in the east wall was not sealed with a fire rated material. The U.S. FOIA (b) (6) was present at the time of the observations and confirmed the sprinkler pipe was not sealed in the boiler room.	K 321	barriers. 3. The Maintenance department performed a full inhouse inspection of the hazardous areas according to National Fire Protection Association regulations for sprinkler pipe wall penetrations. - The Maintenance Director will perform quarterly audits of all hazardous areas to assess for wall penetrations to assure the fire barrier is maintained. Any penetrations found will be repaired with appropriate fire rated materials. The Director of Maintenance will provide the Administrator a copy of the audits following each quarterly review 4. The above audits will be performed for a minimum of two quarters or until 2 consecutive quarters of one hundred percent compliance is achieved. . These results will also be provided to the Quality Assessent team during each quarterly meeting.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		6/14/24

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K 353	Continued From page 4 _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the sprinkler system's control valves, water flow alarms, and tamper switches or supervisory signals were inspected and/or tested annually in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems (2011 Edition) section 5.1.1.2 and 5.1.1.2 Table. This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: Review of the facility's "Fire Sprinkler Inspection Reports," dated 2023 and 2024 revealed the sprinkler system had only been inspected quarterly on 03/06/24, 09/12/23, and 06/05/23. There was no documented evidence of an annual inspection. Observation on 05/01/24 at 1:22 PM of the tag on the sprinkler system revealed the sprinkler system was only inspected quarterly and lacked the annual inspection/testing. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the sprinkler	K 353	1. An annual inspection of the facilities sprinkler system was completed by the facilities third party vendor on May eighth of this year to bring the facility into compliance. No residents were affected by this deficency 2. All residents have the ability to be affected if the facilities sprinkler system is not inspected and maintained according to the National Fire Protection Associations guidelines. 3. The Maintenance Director shall schedule the quarterly and annual inspection with the facilities third party vendor. The Maintenance Director will document and obtain proof of all quarterly and annual inspections of the faiclity fire system. The Director of Maintenance will provide the Administrator documented scheduling of quarterly and annual inspections ongoing to assure continued compliance. 4. The Director of Maintenance will provide the quarterly and annual reports	

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K 353	Continued From page 5 system was not tested annually.	K 353	from the third party vendor to the Administrator ongoing. The results of these quarterly and annual reports will also be provided to the Quality Assessment team at each quarterly meeting.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure low voltage wiring under seven feet was in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 760.130 (B) (1). This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: Observation on 05/01/24 at 12:33 PM revealed low voltage wiring under seven feet for the fire alarm system module in the kitchen at the automatic extinguishing system was not protected in conduit.	K 511	1. No Residents suffered any injury or harm from this deficiency. 2. All residents have the ability to be affected if wiring is not covered in proper conduit according to National Fire Protection Associations guidelines. 3. The Maintenance Department performed a whole house review to assess for any low voltage wiring not placed in proper conduit. Low voltage wire was placed into conduit by third party vendor.	6/14/24

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K 511	Continued From page 6 During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the low voltage wiring was not protected in conduit.	K 511	The Maintenance Director shall perform Monthly audits of 5 specified areas of the facility per month to assess for any low voltage wiring that does not meet code.The Director of Maintenacne shall provide the audit result to the Administrator every month. 4. The Maintenance Director shall perform these audits for a minimum of months unless full compliance is not reached for a minimum of three consecutive months. The audit will continue until the goal is reached. The Maintenance Director will provide the results of these audits to the Quality Assesement team at every quarterly meeting.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 761		6/14/24

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K 761	Continued From page 7 Based on observation and interview, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: Review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence that the facility's fire doors were inspected. Observation of the facility's fire doors on 05/01/24 from 11:30 AM to 02:00 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of each observation, the U.S. FOIA (b) (6) confirmed the fire doors had not been inspected annually.	K 761	1. No Residents suffered any injury or harm due to this deficiency. The Facility contacted our third party vendor and received a quote for the inspection of the fire doors. The quote was signed and is awaiting the confirmed date for the inspection. 2. All residents have the ability to be affected if the fire doors are not inspected and maintained according to National Fire Protection Association Standards. 3. The Maintenance Director will complete monthly inspections of the fire doors to assure inspection tags are in place and visible. Missing door tags were replaced to show all doors in compliance. The Maintenance Director will provide the Administrator a copy of the the monthly audits for review 4. The audits will continue for a minimum of six months unless full compliance is not reached for a minimum of three consecutive months. The audit will continue until this goal is reached. The results of the audit will be provided to the Quality Assemment team at the quarterly meetings.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing	K 914		6/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 914	Continued From page 8 Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: Review of the facility's fire inspection binder provided by the U.S. FOIA (b) (6) revealed the electrical outlet testing was not completed on the electrical outlets. During an interview on 05/01/24 at 3:00 PM, the	K 914	1. The facility immediately purchased an appropriate outlet tester. The Maintenance department began testing of all outlets in the facility to bring the facility into compliance with National Fire Protection Association regulation. No Residents were harmed due to this deficiency. 2. All residents have the potential to be affected if outlets are not maintained according to National Fire Protection Association regulation. 3. The Maintenance Director will perform monthly audits of 40 outlets. This is to	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 9 U.S. FOIA (b) (6) confirmed that the electrical outlet testing was not completed on the electrical system.	K 914	assure testing of all outlets yearly as required for National Fire Protection Association standards. Results of these monthly audits will be presented to the Administrator for review. 4. The results of the above audits will be performed on going to assure ongoing compliance in order to meet requirements outlined National Fire Protection Association. - The Director of Maintenance will provide the results of the ongoing audits will be presented to the Quality Assurance team at the quarterly 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 01 - MAIN BUILDING 01 B. Wing Y2	6/18/2024 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 K0311	06/14/2024	LSC K0321	06/14/2024	LSC K0353	06/14/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0511	06/14/2024	LSC K0761	06/14/2024	LSC K0914	06/14/2024
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	
5/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO