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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315177	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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F 000	INITIAL COMMENTS Complaint NJ #: 165453; 159439; 156933; 164687; 157073; 165453; 164539 STANDARD SURVEY: 9/29/2023 CENSUS: 148 SAMPLE SIZE: 30 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		10/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 10/19/2023

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

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint NJ #165453; 159439; 156933; 164687 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain a clean, comfortable, homelike environment for the residents. This deficient practice was identified on 3 of 3 nursing units, (the 100, 200, and 300 units) and was evidenced by the following: On 09/21/23 at 12:54 PM, in room [Ex Order 26] the surveyor observed that the window in the resident's room had a portable air conditioning unit which had a piece of cardboard surrounding the cylinder that was positioned outside of the window. The cardboard was observed to be bent, exposing outside air.	F 584	Element 1: The deficiency was corrected by re-painting areas with chipped paint, removing portable air conditioning units, patching up penetrations, and re-aligning crooked paintings. Element 2: All residents are affected by this deficiency. Element 3: The Guardian Angel program (comprehensive auditing tool used to identify issues throughout the facility) was expanded to include two audits a week, in order to ensure the facility remains in compliance with F584; the Guardian Angel program also includes a section for	

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F 584	Continued From page 2 On 09/22/23 at 8:50 AM, on the 300 unit, the surveyor was standing in Resident #104 and Resident #149's room and observed a small black bug flying around the room. A Certified Nursing Assistant (CNA) was also in the room at the time of the surveyor's observation. The surveyor asked the CNA if she saw the bug and the CNA did not respond to the surveyor. Resident #104 told the surveyor to go look in the bathroom. The surveyor entered the resident's bathroom and observed approximately 30 small black spots that appeared to be dead bug carcasses throughout the walls in the resident's bathroom. Resident #104 told the surveyor that the black spots on the walls were bugs that he/she had killed. On 09/22/23 at 9:55 AM, the surveyor observed a large horizontal picture hanging on the wall in between rooms [Ex Order] and [Ex Order]. The picture was crooked with the left-hand side of the picture frame hanging lower than the right. At 10:56 AM, the surveyor observed on the 200 unit, a crooked picture of a peacock hanging on the wall to the left of the nurse's station. The right-hand side of the picture frame was hanging lower than the left. At 11:20 AM, in room [Ex Order], the surveyor observed a blue piece on masking tape on the plastic molding next the sink. The plastic molding was observed peeling up from the floor. Further observations in the room included black scratches and indentations on and in the wall between the sink and the bathroom. The surveyor further observed black horizontal scratches in the wall to the left of the resident's bedroom door and a small rectangular hole in the wall.	F 584	resident concerns. Additionally, the Administrator makes daily rounds to ensure identifies issues are corrected in a timely manner. Element 4: The Guardian Angel/Homelike Environment Audit is being conducted by all Department Heads twice a week for six months, and then once a week for three months. Identifies issues will be corrected as they are discovered, results will be reported to the Administrator, and will be reviewed at quarterly QAPI meetings.	

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At 11:26 AM, in room [Ex Order], the surveyor observed that the edges of the wall surrounding the heating and air conditioner unit were not flat, exposing an opening around the upper left area of the heating and air conditioner unit. The wall above the heating and air conditioning unit was painted a light brown and the surrounding wall was a white color. Further holes, indentations and scratches were observed on the wall under the window next to the heating and air conditioner unit. In addition, the walls to the resident's room were bare. There was one picture on the resident's wall to the right of the television.

At 11:35 AM, the surveyor observed that the wood doors to the entrance of the main dining area on the 200 unit were scratched and chipping on the edges, bottom section, and in between the door closure, leaving exposed and chipped, lighter colored wood present.

On 09/26/23 at 8:33 AM, in room [Ex Order], the surveyor observed a hole in the wall to the right of the bathroom door, above the gray plastic molding on the floor.

At 9:32 AM, on the 100 unit, the surveyor observed in the hallway by the kitchen entryway, the bottom portion of the wall under the grab bar between the maintenance shop and shower room, had a thick yellowish-brown colored wall covering that was peeling from the wall. In addition, the surveyor observed that the plastic, grey colored molding was peeling up from the bottom of the wall. There was a crack, observed to the right of the wall by the maintenance door, leaving an open, exposed area.

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On 09/27/23 at 10:22 AM, on the 300 unit, the surveyor observed scratches and indentations on the bottom half of the door into the main dining/activity room on the unit. The scratches and indentations were black against the yellow painted door.

At 10:24 AM, on the same unit, in the main dining/activity room the surveyor observed under the dry erase board, that the wallpaper was peeling from the wall throughout and at the edges.

At 10:49 AM, the surveyor interviewed the Housekeeping Director (HD) who stated that the Maintenance Department was responsible for fixing holes in the walls, spackling, and painting. The HD further stated that the housekeeping department was responsible for the cleanliness of the common areas and resident rooms. He explained that housekeeping staff were supposed to go into the resident's rooms, clean, dust, and wash the curtains in the resident's rooms. The HD stated that the hallways were swept, mopped, and the handrails were routinely wiped and cleaned. The HD stated that if his staff saw dead bugs throughout a resident room or bathroom, the expectation would be for staff to clean the area, remove the bugs, and disinfect the area.

At 11:17 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) on the 100 unit who stated that the holes in the walls were a problem which were usually caused by the resident's wheelchairs knocking into the walls. The LPN/UM further stated that when she identified that there was a hole in the resident's wall, she would notify Maintenance to patch up the hole.

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F 584	Continued From page 5 At 11:25 AM, in room [redacted], the surveyor observed to the left of the entryway door, black scratches, and indentations throughout the wall. Yellow paint was observed surrounding the black scratches. In addition, the plastic molding that was touching the floor and the wall was observed to be slightly peeling from the wall. At 11:35 AM, the surveyor made a second observation of room [redacted] and observed in the window to the left, a portable air conditioning unit that had a piece of cardboard surrounding the cylinder that was positioned outside of the window. The cardboard was observed to be bent, exposing outside air. At 11:42 AM, the surveyor interviewed the Maintenance Director (MD) who stated that the maintenance department was currently working to fix the holes in the walls throughout the facility and was in the process of spackling and painting. The MD told the surveyor that in the past, the building had flooring concerns, so the facility was working to fix the resident's environment based on priority and safety. On 09/29/23 at 10:12 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the facility was committed to making the facility comfortable for the residents and his staff were focused on the cleanliness of the furniture, air quality, and safety of the building for the resident's. The LNHA told the surveyor that he implemented a program called, "Guardian Angel Rounds" in which the facility staff had assigned rooms to monitor, so they could focus on maintaining a clean, comfortable, homelike environment for the	F 584		

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residents.

A review of the Housekeeper's Job description dated 4/20, indicated, "Under the close direction of the Director and/or Supervisor is responsible to perform designated cleaning duties, routine housekeeping and preventative maintenance services in an efficient manner."

A review of the Director of Environmental Services (Housekeeping Director) Job description dated 4/20, indicated, "The position of Environmental Service Director is to plan, organize, develop, and direct the overall operation of the Environmental Services Department in accordance with current federal, state and local standards, guidelines and regulations, our established policies and procedures, as may be directed by the Administrator." The HD's Job Description further included, "Keep abreast of current federal and state regulations, economic conditions, as well as professional standards, and make recommendations on changes in the department's policies and procedures to the Administrator to assure the facility's continued ability to provide a clean, safe comfortable environment for its residents, visitors, and staff."

A review of the Director of Building Management Services (Maintenance Director) Job Description, revised 3/11, indicated the MD was to, "Ensure the overall operations of the Building Maintenance is operated based on the facility's policy and procedures as regulated by Department of Health and Federal Standards." A further review of the Job Description indicated that the MD was, "Responsible for contract vendors providing a variety of repair,

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F 584	Continued From page 7 maintenance or building management services for buildings and property, which may include medical waste management and recycling. Assist in ensuring the effective maintenance of property including building infrastructure and exterior grounds, and efficient administration management through establishment of quantitative and qualitative controls. Participates in Quality Rounds to inspect and evaluate the physical condition of the facility including residents' rooms, bathrooms, solariums, dining rooms, laundry area, grounds and Parking lots. Demonstrate knowledge of State & Federal regulations specific to Maintenance Services. A review of the facility's Environmental Policy annually reviewed 2023, indicated, "Our facility is committed to providing person-entered care to our residents, prioritizing their comfort, independence, and personal needs and preferences. We believe that a homelike environment can significantly improve the quality of life for our residents Therefore, we have established the following environmental policy: 1. Cleanliness and order: We maintain cleanliness and order at all times to promote a healthy and safe living environment for our residents .... We are committed to providing our residents with the best possible care in a safe, comfortable, and homelike environment." NJAC 8:39-31.4(a)(f)	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		10/19/23

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F 656	Continued From page 8 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 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged	F 656		

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F 656	Continued From page 9 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of medical record it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for a resident's personal preference to wear a specific Ex Order 26. 4B1 during the day while the resident was out of bed. This deficient practice was identified for 1 of 29 residents reviewed, (Resident #25) and was evidenced by the following: On 09/21/23 at 11:19 AM, during tour the surveyor observed the resident sitting up in his/her wheelchair in their room. The resident was interviewed at this time and stated that he/she had an Ex Order 26. 4B1. The resident stated that he/she wore a Ex Order 26. 4B1 during the day and a Ex Order 26. 4B1 at night that hung on the resident's bedframe. According to the Admission Record, Resident #25 was admitted to the facility with the diagnoses which included but was not limited to: Ex Order 26. 4B1. According to the significant change in status Minimum Date Set (MDS), an assessment tool utilized to facilitate care dated 08/17/23, indicated that the resident had Ex Order 26. 4B1, required extensive assistance with	F 656	Element 1: Resident #25 was care-planned for their personal preference to utilize a Ex Order 26. 4B1 during the day. Element 2: All residents that have a Ex Order 26. 4B1 have the potential to be affected. An audit was completed on all residents to ascertain who had a Ex Order 26. 4B1, and reviewed their preferences for Ex Order 26. 4B1. Element 3: Clinical staff were in-serviced on utilizing the resident's preference for Ex.Order 26.4(b)(1) ensuring their preferences were utilized, and written in Kardex. Element 4: To maintain and monitor ongoing compliance, DON/designee will audit all residents that have a Ex.Order 26.4(b)(1) to ensure their Ex.Order 26.4(b)(1) is per the residents preference, and the preference is documented in Kardex daily x5 days, weekly x2, and then monthly x2. Needed corrections will be addressed as they are discovered, and findings will be reported monthly to the QAPI team for review and action as necessary.	

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F 656	Continued From page 10 Ex Order 26. 4B1 and had an Ex Order 26. 4B1. On 09/21/23 at 12:26 PM, the surveyor reviewed the resident's medical record and the Care Plan (CP) did not indicate that the resident wore a Ex Order during the day. Based on record review the resident had not had a Ex Order since 2017. On 09/27/23 at 11:00 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that he had been employed in the facility for approximately 9 (nine) months. The CNA stated that the resident required extensive assistance with care and had a Ex Order 26. 4B1. He added that Resident #25 was Ex Order 26. 4B1 of the Ex Order 26. 4B and was able to be toileted. He stated that the resident wore a Ex Order 26. 4B1. He added that the Ex Order 26. 4B1 was applied during morning care. He stated that he had to disconnect the Ex Order 26. 4B1 and hook up to the Ex Order 26. 4B1. The CNA stated that he wiped the end on the Ex Order 26. 4B1 with disinfectant wipes and then attached the Ex Order 26. 4B1. He stated that the Ex Order 26. 4B1 was thrown away daily and a new bag Ex Order 26. 4B1 was obtained daily. He stated that he knew the resident and that was why he knew that the resident wore a Ex Orde during the day. He stated that he did not document that the resident wore a Ex Order 26. 4B1 during the day. On 09/27/23 at 11:05 AM, the surveyor	F 656		

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F 656	Continued From page 11 interviewed the Licensed Practical Nurse (LPN) who stated that Resident #25 had an Ex Order 26. 4B1 . The LPN reviewed the physician orders and reviewed the Care Plan in the presence of the surveyor and revealed that there was no documentation that indicated that the resident utilized a Ex Order 26. 4B1 during the day nor that the Ex Order 26. 4B1 to the Ex Order 26. 4B1 was changed daily during the day. He stated that there should be documentation on the Care Plan related to the resident's personal preference on wearing a Ex Order 26. 4B1 during the day, however, he could not find the documentation in the resident's medical records. The LPN stated that he had only been employed in the facility for one month and was not familiar with the process of who was responsible to assure that the resident had a Ex Orde applied during the day but would find out the information. On 09/27/23 at 11:16 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that Resident #25 wore a Ex Order 26. 4B1 during the day and had a regular Ex Order 26. 4B1 applied at night. The surveyor asked the LPN/UM where it was documented in the resident's medical record that the resident had a preference to wear a Ex Order 26. 4B1 during the day. The LPN/UM stated that it should be documented on the resident's CP. The LPN/UM reviewed the residents CP in the presence of the surveyor and admitted to the surveyor that there was no documentation on the CP or in the resident's medical record that indicated that the resident had the preference to wear a Ex Order 26. 4B1 during the day. The LPN/UM stated that it would have been important to document the resident's preference on the CP so that the staff knew what care was to be	F 656		

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F 656	Continued From page 12 provided for the resident and what the resident's preference was. On 09/29/23 at 10:38 AM, the surveyor interviewed the Director of Nursing who stated that any personal preference the resident had should have been addressed on the CP. The facility policy dated 02/2023 and titled, Ex Order 26. 4B1 indicated that application of the Ex Order 26. 4B1 was required to be documented on the resident's Care Plan and CNA assignment sheet. The facility undated policy titled, "Care Plans" indicated that residents would have comprehensive person-centered comprehensive care plans. NJAC 8:39-11.2 (d)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to complete an incident report, after a resident sustained an injury in the facility. This deficient practice was identified for 1 of 3 residents reviewed for Ex Order 26. 4B1 (Resident	F 658	Element 1: Resident #28 Incident/Accident report completed, and Care Plan updated to reflect Ex Order 26. 4B1 to the Ex Order 26. 4B1 and intervention. Element 2:	10/19/23

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	315177	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 658	Continued From page 13 #28), and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions " b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health	F 658	Any resident who has sustained an incident/accident has the potential to be affected. The Director of Nursing conducted an audit of the last thirty days of twenty-four hour report, noting any new orders for Ex Order 26. 4B1 or documentation regarding any potential incident/accidents to ensure that the incident/accident was complete, reported as needed, new interventions in place, and Interdisciplinary Care Plan Team updated the plan of care. Element 3: Staff were in-serviced on reporting incident/accidents in a timely manner to a supervisor, and ensuring an Incident/Accident form is completed. Element 4: Director of Nursing/designee to audit daily (indefinitely) twenty-four four report, noting any new orders for Ex.Order 26.4(b)(1) or documentation regarding any potential incident/accident to ensure the incident/accident is completed, reported as needed, new interventions in place, and Interdisciplinary Care Plan Team updated the plan of care. Needed corrections will be addressed as they are discovered, and findings will be reported monthly to the QAPI team for review and action as necessary.	

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F 658	Continued From page 14 need or reaction to an actual or potential health problem. On 09/21/2023 at 10:56 AM, the surveyor observed Resident #28 sitting in a Ex Order 26. 4B1 next to their bed. The resident was and alert and oriented to person, place, and time. The surveyor observed Resident #28 with an undated Ex Order 26. 4B1 on the Ex Order 26. 4B1 area. Resident #28 stated that they developed the Ex Order 26. 4B1 by accidentally Ex Order 26. 4B their Ex Order 26 on the bedframe. Resident #28 indicated that the Ex Order 26. 4B1 occurred approximately two weeks ago and that they still had Ex.Order 26 in the area. According to the Admission Record Resident #28 was admitted to the facility with the following but not limited to diagnoses: Ex Order 26. 4B1 . According to the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care dated XX/XX.XX, Resident #28 had a Brief Interview for Mental Status score of Ex Ord /15, indicating Ex Order 26. 4B1 . A further review of Section G - Functional Mobility of the MDS, indicated Resident #28 required Ex.Order 26.4(b)(1) assistance with Ex Order 26. 4B1 . Resident #28 required limited assist with transfers and was an	F 658		

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F 658	Continued From page 15 independent eater. Section I - Diagnoses of the MDS revealed that Resident #28 had active diagnoses of Ex Order 26. 4B1 . Section M - Skin Conditions revealed Resident #28 had an Ex Order 26. 4B1. A review of the Order Summary Report, dated 08/01/23 - 08/31/23, Resident #28 had the following physician order: "Cleanse [sic] Ex Order 26. 4B1 with Ex Order apply Ex Order 26. 4B1 with Ex Order 26. 4B1 and wrap with Ex Order 26. 4B1 qd [every day]." A review of the Order Summary Report, with active orders as of 09/28/23, revealed the following physician order: "Cleanse [sic] Ex Order 26. 4B1 with Ex Order apply Ex Order 26. 4B1 Ex Order 26. 4B1 and wrap with Ex Order 26. 4B1 every day shift." A review of the Medical Record revealed the following progress note, dated effective date: 08/18/2023 14:04: "Seen by [name redacted] DNP [doctor of nursing practice], Ex Order 26. 4B1.	F 658		

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F 658	Continued From page 16 Ex Order 26. 4B1 resolved to nursing. Ex Order 26. 4B1 1.0 x 0.5 x 0.2 and Ex Order 26. 4B1 3.0 x 1.0 x 0.2 Ex Order 26. 4B1 and cover daily Ex Order 26. 4B1 2.0 x 1.3 x 0.2 Ex Order 26. 4B1 daily and cover Ex Order 26. 4B1 3.5 x 4.0 x 0 Ex Order 26. 4B1 and wrap with Ex Order 26. 4B1." According to Resident #28's comprehensive care plan, Resident #28 had a care plan Focus of: [Resident name redacted] has alteration in his/her Ex Order 26. 4B1 R/T (related to) Ex Order 26. 4B1 Ex Order 26. 4B1 manifested by Ex Order 26. 4B1, created on 03/31/23 and revision on 09/12/23. Interventions included, "8/18/2023 Administer Ex.Order 26.4(b)(1) as prescribed MD [medical doctor], Ex Order 26. 4B1. Revision on: 8/30/2023." On 09/27/23 at 11:10 AM, the surveyor requested any incident/accident reports for Resident #28 for the past 90 days from the facility Director of Nursing (DON). On 09/28/2023 at 09:24 AM, the surveyor conducted an interview with the Registered Nurse (RN) assigned to Resident #28 on that shift. The surveyor asked the RN when an accident/incident report should have been completed for a resident who sustained an Ex.Order 26.4(b)(1) The RN explained, Ex Order 26. 4B1 The surveyor asked the RN if an accident/incident report should have been completed and if the resident was Ex Order 26. 4B1 and was able to explain how the Ex.Order 26.4(b)(1) occurred. The RN responded that she would still have filled out an incident report if a Ex Order 26. 4B1 resident told her what happened because	F 658		

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F 658	Continued From page 17 the Ex Order 26 was opened. The RN further stated that she would have also written a progress note that described what happened. On 09/28/2023 at 10:43 AM, the DON told the surveyor that there was only one incident/accident report for Resident #28 on 08/18/23 related to an Ex Order 26. 4B1 to Resident #28's Ex Order 26. 4B1. The DON stated that there was not an accident/incident form completed on 08/18/23 related to Resident #28's Ex Order 26. 4B1 injury. The surveyor asked the DON if an accident/incident form should have been completed for the Ex Order 26. 4B1 Ex.Order 26.4 Resident #28 sustained and in what time frame. The DON stated, Ex Order 26. 4B1 The DON further explained, "An incident report should have been filled out for Resident #28 because [gender redacted] had an Ex.Order 26.4 to his/her Ex Order 26. The nurse should have documented it in a progress note. The family should have been notified and the care plan should have been updated, as well." On 09/28/2023 at 12:38 PM, the facility DON provided the surveyor with documentation that revealed Resident #28 sustained a Ex Order 26. 4B1 Ex.Order 26.4 on 8/18/2023. The DON further acknowledged that the nurse who observed and obtained a physician's order for the treatment of the Ex Order 26. 4B1 Ex.Order 26.4 failed to fill out an accident/incident report. On 09/29/2023 at 9:01 AM, during a meeting with the facility administration, the Licensed Nursing Home Administrator stated that after the fact, the facility created the incident and accident report for	F 658		

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F 658	Continued From page 18 Resident #28. The facility's DON explained that the main purpose of doing the incident and accident report was so that everyone knew there was an incident and there was a full investigation that was reviewed to rule out abuse and neglect for the resident. The DON did not mention implementing interventions to prevent future accidents as part of the facility's incident/accident investigative process. The surveyor reviewed a facility policy titled Accidents and Incidents - Investigating and Reporting, date: 5/18/2023. The following was revealed under Policy Statement: "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and results reported to the appropriate department manager and the Administrator." The following was revealed under Policy Interpretation and Implementation: 1. "The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document investigation of accidents or incidents as appropriate." N.J.A.C. 18:39-27.1(a)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		10/19/23

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F 677	Continued From page 19	F 677		

Complaint NJ: 165453, 163618

Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to provide dependent residents with routine and appropriate Ex Order 26. 4B1 care, specifically by applying Ex Order 26. 4B1. This deficient practice was identified for 1 of 6 residents observed for Ex Order 26. 4B1 care, (Resident #71) and was evidenced by the following:

On 09/27/2023 at 8:47 AM, the surveyor performed a care tour of the 200 unit with the Licensed Practical Nurse/Unit Manager (LPN/UM). At 08:55 AM, Resident # 71 gave permission to the surveyor and the LPN/UM to observe his/her Ex Order 26. 4B1. The surveyor observed that Resident #71 had two green colored Ex Order 26. 4 on. The Ex Order 26. 4 were dry. At that time the LPN/UM confirmed that Resident #71 had Ex Order 26. 4B1 on and said, "I am sorry."

On 09/27/2023 at 9:01 AM, the surveyor interviewed the assigned Certified Nursing Assistant (CNA) who confirmed she was assigned to Resident #71. When asked when the last time Ex Order 26. 4B1 care was provided for Resident #71 the CNA said, "When I come in, I start rounds. I was a little late today and I started rounds and then breakfast came so I stopped to pass trays and feed residents." She said "not yet" when the surveyor asked if she had provided Ex Order 26. 4B1 care for Resident #71. The surveyor then asked the CNA how many Ex Order 26. 4 a resident was to wear, and the CNA replied, "one." On the same date at 9:03 AM, the LPN/UM said, "It was probably night shift" when asked who would have put Ex Order 26. 4B1 on this resident.

Element 1:
Resident #71 was provided Ex Order 26. 4B1 care and one Ex Order 26. 4B1 was placed on the resident.

Element 2:
All Ex Order 26. 4B1 residents have the potential to be affected. An audit was completed by the VP of Clinical Services on all residents that are Ex Order 26. 4B1 and dependent on the use of protective briefs, top ensure only one protective brief was in use, unless the resident desired two briefs.

Element 3:
Clinical staff was in-serviced on Ex.Order 26.4(b)(1) including but not limited to the utilization of one protective brief at a time.

Element 4:
Unit Managers/Assistant Director of Nursing/designee will audit five Ex.Order 26.4(b)(1) residents on each unit each shift, daily x14 days, then weekly x4, and then monthly x2 to ensure residents are in a single protective brief. Needed corrections will be addressed as they are discovered, and findings will be reported monthly to the QAPI team for review and action as necessary.

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On 09/27/2023 at 12:51 PM, the surveyor placed a telephone call to the 11:00 PM -7:00 AM assigned CNA on 09/26/2023 and left a message requesting a call back. The 11:00 PM - 7:00 AM CNA did not return the surveyor's call.

The surveyor reviewed the medical record for Resident #71.

According to the Admission Record, Resident # 71 was admitted to the facility with diagnoses including but not limited to: Ex Order 26. 4B1 .

A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 08/29/2023, that revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score Ex Ord /15 indicating Resident #71 had Ex Order 26. 4B1 . The MDS further revealed Resident #71 was dependent for toileting and required staff assistance of one person. The MDS also indicated Resident #71 was Ex Order 26. 4B1 of Ex Order 26. 4B1 and Ex Order 26. 4B .

A review of Resident #71's Care Plan (CP) revealed a focus area with an initiated date of 05/31/2022, [Resident name] had an Ex Order 26 deficient related to Ex Order . He/She requires total assistance with Ex Order 26. 4B . Under the Goal section [Resident name] will maintain current level of participation without farther{sic}[further] decline through the next review dated. Interventions included but were not limited to Resident #71 required total assist x one by staff with Ex Order 26. 4B1 with a Date Initiated:

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F 677	Continued From page 21 05/31/2022. A further review of the CP with an initiated date of 05/31/2022, revealed Resident #71 was at risk for alteration in Ex Order 26. 4B1 Ex Order 26. 4B1 and Ex Order 26. 4B1 . Under the Goal section with an initiated date of 05/31/2022, Resident's Ex.Order 26.4(b)(1) would remain intact within the next review date. Interventions included call physician with any concerns. Ex.Order 26.4(b)(1) Ex Order 26. 4B1 after each inc Ex Order 26. 4B1 episode. On 09/28/2023 at 8:39 AM, the surveyor interviewed the assigned CNA who stated that the facility Ex Order 26. 4B1 policy was to check the resident every two hours and change the resident if needed. The CNA told the surveyor that the staff would have offered the bathroom if the resident could have used the bathroom and ambulated. The CNA further stated, "Just one brief is to be on a resident and never to put two briefs on a resident." The CNA added that the aides were responsible to provide Ex Order 26. 4B1 care. On 09/28/2023 at 9:22 AM, the surveyor interviewed the Director of Nursing (DON) who was asked what the facility's Ex Order 26. 4B1 policy was. The DON replied that they do preventative care and use Ex Order 26. 4B1 cream for each Ex Order 26. 4B1 care. They (residents) should be checked every two hours. Some residents were changed every two hours. Some residents were alert and would tell you and then care was provided as needed. When asked by the surveyor if CNAs were to apply Ex Order 26. 4B1 on residents, the DON said, "Not at all." The DON went on to say that not	F 677		

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F 677	Continued From page 22 unless the resident was awake, alert and oriented x3 with a BIMS score of Ex Order 26. 4B1 out of fifteen and the residents asked to be able to wear Ex Order 26. 4B1. We would have an IDCP (Interdisciplinary Care Plan) meeting and would decide if a Ex Order 26. 4B1 was appropriate for them. The DON said Ex Order 26. 4B1 when the surveyor reviewed the observation for Resident #71. The DON also said Ex Order 26. 4B1 On 09/29/2023 at 09:05 AM, the surveyor interviewed the Vice President of Clinical Services (VPCS) who stated that the 11:00 PM - 7:00 AM CNA was educated along with the rest of the staff and was disciplined. The VPCS went on to say this could lead to skin breakdown and possibly could lead to infections, and all sorts of skin issues. A review of an facility policy reveiewed 2023, titled Bowel and Bladder Incontinence did not address the use of double briefs. NJAC 8:39-27.2(h)	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		10/19/23

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

PRINTED: 11/29/2023
FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 23 by: Complaint#: NJ157073 Based on interview, review of clinical records, and other pertinent facility documentation it was determined that the facility failed to provide timely treatment and care for a resident. This deficient practice was identified for 1 for 32 residents, (Resident #252) reviewed for quality of care and was evidenced by the following: According to the Admission Record (AR), Resident #252 was admitted to the facility with the diagnoses which included but were not limited to Ex Order 26. 4B1 . The admission Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care dated 07/01/2022, indicated that the resident was Ex Order 26. 4B1 and required extensive assistance of two staff members for Ex Order 26. 4B1 . The surveyor was unable to interview Resident #252. The resident was discharged from the facility on Ex Order 26. 4B1, with a Ex Order 26. 4B1 in the Ex Order 26. 4B1. The surveyor reviewed the medical records for Resident #252. The Incident Report (IR) dated 07/28/22 at 17:45 (5:45 PM), indicated that the resident made the nurse aware about Ex Order 26. 4B1 on his/her Ex Order 26. 4B1. The IR indicated that the resident stated that he/she tried to transfer Ex Order 26. 4B1 from Ex Order 26. 4B1 the to bed and got	F 684	Element 1: Resident #252 was discharged on Ex Order 26. 4B1. Element 2: All residents in need of a Ex Order 26. 4B1 to rule out an acute illness have the potential to be affected. Element 3: All clinical staff was educated on acceptable turnaround time for a resident in need of a Ex Order 26. 4B1. This education included but is not limited to updating resident and next of kin (if applicable), establishing a time of Ex Order 26. 4B1 with Ex Order 26. 4B1 group, if exam could not be completed within twenty-four hours, call MD to make aware, and follow MD directives. In addition, any resident that requires a Ex Order 26. 4B1 exam, the Director of Nursing/Supervisor/designee will be made aware, monitor time-frame of exam, and intervene as necessary. Element 4: Director of Nursing/designee will monitor all residents requiring a Ex.Order 26.4(b)(1) daily indefinitely to ensure Ex.Order 26.4(b)(1) exams are occurring within twenty-four hours, and if not completed, MD is made aware, and MD directive is followed. Needed corrections will be addressed as they are discovered, and findings will be reported monthly to QAPI team for review and action as necessary.	

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OMB NO. 0938-0391

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	315177	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 684	Continued From page 24 the Ex Order 26. 4B1 stuck on the Ex Order and that was how he/she got the Ex Order 26. 4B1. The nursing assessment of the Ex Order 26. 4B1 area revealed a Ex Order 26. that could be felt under the Ex Order 26. The IR indicated that Resident #252 was on the medication Ex Order 26. 4B1 (prevention). The IR indicated that Resident #252 denied Ex Order 2. The IR also revealed that the resident's Ex Order 26 reported to the Director of Nursing (DON) on 07/28/22 that the resident was prone to Ex Order 26. 4B. The IR reflected that the physician was notified and informed about the incident and that the nurse received an order for Ex Order 26. 4B1 on Ex Order 26. 4B1 on 07/28/23 at 07:00 AM. The surveyor reviewed the Nursing Progress Note (NPN) dated 07/28/22 at 17:44 (05:44 PM), that indicated that the physician ordered Resident #252 to have a Ex Order 26. 4B1 of the Ex Order 26. 4B1. The physician progress note dated 07/30/22 at 07:16 AM, indicated that the had a history of Ex Order 26 and a Ex Order 26. 4B1. The note did not specify what Ex Orde. The surveyor reviewed that nursing progress noted dated 07/31/22 at 18:35 (06:35 PM), indicated that the resident had a Ex Order 26. 4B1 performed of the Ex Order 26. 4B1 and the technician reported that the resident had a Ex Order 26. The physician was notified and ordered the resident to be sent to the hospital and the family was made aware. The surveyor then reviewed the Ex Order 26. 4B1 scan report which revealed that the Ex Order 26. 4B1 including Ex Order 26. 4B1	F 684		

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F 684	Continued From page 25 was not performed until 07/31/22. This study was not performed until three (3) days after the physician ordered the test to be performed. The test results indicated that the resident was Ex Order 26. 4B1 for a Ex Order 26. 4B1 of the Ex Order 26 . On 09/22/23 at 10:11 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who went over the IR with surveyor. The ADON stated that the nurses and Director of Nursing (DON) that documented the incident that occurred with Resident #252s Ex Order 26. 4B1 on 07/28/22, were not employed at the facility any longer and could not be interviewed. The ADON explained to the surveyor that if a Ex Order 26 was suspected on Resident #252's Ex Order 26. 4B1 on 07/28/22, that a Ex Order 26. 4B1 study should have been done the same day. On 09/27/23 at 09:44 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) for the Ex Order 26. 4B1 unit. The LPN/UM stated that if a resident was suspected of having a Ex Order 26 the facility would contact the resident's physician, assure that the resident was non-weight bearing to that area, assess the area for redness, swelling, pain and check the resident's pulses. She then added that findings would be reported to the resident's physician. She stated that the Ex Order 26. 4B1 department would also be informed so that the Ex Order 26. 4B1 department does not perform Ex Order 26. 4B1 to the extremity that was suspected of having a Ex Order 26. She stated that if a resident was suspected on having a Ex Order 26. 4B1 you would not want to move that extremity. She also stated that if a Ex Order 26. 4B1 study was ordered that the facility would call an outside company to come to the facility to perform	F 684		

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F 684	Continued From page 26	F 684		

the study. She continued to explain that the nurses would usually ask the company what an estimated time they would come out to perform the study. She said that if the Ex Order 26. 4B1 could not be done within 24 hours, then the physician would be notified to see what he would want to do. She confirmed that it would be important not to wait for the Ex Order 26. 4B1 and to get the study done right away because you would want to start treatment right away, so the Ex Order doesn't move. She stated that you would not want to wait over 24 hours for the Ex Order 26. 4B1 study because if the Ex Order 26. 4B1 moved and lodged somewhere else in the body it could be life threatening to the resident.

The surveyor reviewed the Ex Order 26. 4B1 notes dated 07/29/22 that indicated that the resident was waiting for a Ex Order 26. 4B1 study to be performed and educated on the importance of decreasing activity and reducing mobility until the Ex Order 26. 4B1 results were received.

On 09/27/23 09:57 AM, the surveyor interviewed Registered Nurse (RN) who stated that she had been employed in the facility for two years. She explained to the surveyor the process the facility took if a Ex Order 26 was suspected for any resident in the facility. She stated that if a Ex Order 26 was suspected, the nurse would assess the extremity for redness, swelling and pain. She explained that the nurse would get the residents vital signs, call the physician and the family. She explained that if a Ex Order 26. 4B1 study was ordered by the physician, the nurse would call the company the facility used to perform the Ex Order 26. 4B1 study. The study should be ordered Ex Order 26. 4B1 because the Ex Order could dislodge and go to the resident's Ex Order 26. 4B1 or the resident could have a Ex Order 26. 4B1. The RN confirmed that you should not

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wait 3 days to get a Ex Order 26. 4B1 study done for a resident suspected of having a Ex Order 26 and that if the Ex Order 26. 4B1 could not get done right away then the resident should be discharged to the hospital for the study and treatment.

On 09/27/23 at 10:07 AM, the surveyor interviewed the current DON who stated that if Resident #252 had a Ex Order 26. 4B1 study ordered on 07/28/22, then it should have been done right away. She stated that the resident could have had life threatening complication if the Ex Order 26. 4B1 dislodged and that why it was important to have the study the same day if was ordered. The DON stated that she was not employed by the facility at the time of this incident and could not speak to why the Ex Order 26. 4B1 study was not performed until 07/31/22.

On 09/29/23 at 10:38 AM, the surveyor interviewed the Regional Vice President of Clinical Services in the presence of the survey team who stated that when the physician ordered the Ex Order 26. 4B1 study to be done on 07/28/22, then it should have been done immediately and should not have been completed three days later on 07/31/22.

The 09/29/23 at 09:32 AM, Licensed Nursing Home Administrator stated that there was not a specific policy pertaining to timeframe of when a Ex Order 26. 4B1 study was to be performed, but that the Ex Order 26. 4B1 study should have been performed of the resident's Ex Order 26. 4B1 on 07/28/22 when it was ordered by the physician.

The undated facility policy titled, "Change of Condition" indicated that the purpose of the policy was to provide a safe and appropriate care when

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F 684	Continued From page 28 there is a change in a resident's medical condition or status. The policy also indicated that staff would carry out any physician/medical provider orders as a result of the change of condition. NJAC 8:39-27.1(a)	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint NJ#: 164539; 165453 Based on observation, interview, record review, and review of facility documents it was determined that the facility failed to: a.) accurately document body check assessments, b.) obtain physician orders based on the recommendations of the wound care consultant in a timely manner, and c.) ensure that an Ex Order 26. 4B1 was accurately set according to the resident's weight. This deficient practice was identified for 2 of 4	F 686	Element 1: Resident #255 was discharged from the facility. Resident #49's Ex Order 26. 4B1 was set to the appropriate setting. Element 2: All residents that have Ex Order 26. 4B1 are potentially affected by this deficiency. An audit was completed on all residents to determine any residents that have a Ex Order 26. 4B1 to ensure orders are complete, being carried out timely,	10/19/23

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F 686	Continued From page 29 residents (Resident #49 and #255) reviewed for Ex Order 26. 4B1 and was evidenced by the following: 1.) The surveyor reviewed Resident #255's closed Electronic Medical Record (EMR). According to the Admission Record, Resident #255 had diagnoses which included, but were not limited to: Ex Order 26. 4B1 . Review of the significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 10/22/22, included the resident had a Brief Interview for Mental Status (BIMS) score of Ex out of 15, which indicated the resident's cognition was Ex Order 26. 4B1 . Further review of the MDS included the resident had an Ex Order 26. 4B1 that was not present on the resident's admission to the facility. Review of the Care Plan (CP) included focuses that the resident was Ex Order 26. 4B1 and, Ex Order 26. 4B1 Further review of the CP included the following interventions: Ex Order 26. 4B1 initiated 10/03/22, Ex Order 26. 4B1 initiated 10/03/22, and Ex Order 26. 4B1 initiated 10/03/22. The CP did not include any interventions to document weekly body check assessments.	F 686	preventative measures are in place, and working appropriately. Element 3: All clinical staff were in-serviced on Ex Order 26. 4B1 prevention and treatment, including but not limited to: turning and repositioning, maintaining air mattress at appropriate inflation, nutrition, completing skin assessments, completing orders/recommendations in a timely manner and ensuring completion. Element 4: Director of Nursing/designee will audit all residents that have a Ex.Order 26.4(b)(1) to ensure orders are complete and being carried out timely, and preventative measures are in place and working appropriately daily x7 days, weekly x2 weeks, and monthly x2. Needed corrections will be addressed as they are discovered, and findings will be reported monthly to the QAPI team for review and action as necessary.	

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Review of the September 2022 Treatment Administration Record (TAR) included a physician's order for "body checks weekly every evening shift every Sun [Sunday] for Ex.Order 26.4(b)(1), Open body check under assessment tab in [the EMR] and complete" with an order date of 02/12/21. The order was signed out as completed on 09/04/22, 09/11/22, 09/18/22, and 09/25/22.

Review of the assessments tab in the EMR revealed the only body check assessment completed in September 2022 was on 09/11/22 which indicated that the resident's Ex.Order 26.4(b)(1).

According to the SBAR [Situation Background Assessment Request] Communication Form, dated 09/17/22, the resident was observed to have a Ex Order 26. 4B1 on the Ex Order 26. 4B1 on that day.

Review of a Progress Notes (PN) written by the Wound Care Consultant (WCC), dated 09/21/22 at 9:32 AM, included, Ex Order 26. 4B1 Further review of the PN revealed the resident had a Ex Order 26. 4B1 and the WCC recommended changing the Ex Order 26. 4B1 care treatment to Ex Order 26. 4B1 and Ex Order 26. 4B1 daily. The WCC also recommended to offload pressure using an Ex Order 26. 4B1.

Review of a PN written by the WCC, dated 09/28/22 at 8:59 AM, included that the resident's Ex Order 26. 4B1 was improving, but that the WCC still recommended changing the Ex.Order 26.4(b)(1) treatment to Ex Order 26. 4B1 and the use of an Ex Order 26. 4B1 to offload pressure.

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Further review of the September 2022 TAR indicated that the treatment order, Ex Order 26. 4B1 was not ordered until 09/28/22 at 9:17 PM. Further review of the TAR revealed there was no order for an Ex Order 26. 4B1.

Review of a PN written by the WCC, dated 10/05/22 at 9:33 AM, included that the resident's Ex Order 26. 4B1 was larger and that the WCC still recommended the use of an Ex Ord to offload pressure.

Review of the October 2022 TAR indicated that the physician's order for Ex Order 26. 4B1 was not ordered until 10/14/22 at 3:47 PM. Further review of the TAR included the aforementioned weekly body check order which was signed out as completed on 10/02/22, 10/09/22, 10/16/22, 10/23/22, and 10/30/22.

Further review of the assessments tab in the EMR revealed the only body check assessment completed in October 2022 was on 10/02/22 which indicated that the resident's Ex.Order 26.4(b)(1).

On 09/27/23 at 11:48 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that when she observed a new Ex Order 26, she notified the nurse. The CNA further stated that Resident #255 had a Ex Order 26. 4B and interventions the CNA performed included frequent Ex Order 26. 4B1 care and repositioning.

On 09/27/23 at 11:55 AM, the surveyor

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interviewed the Licensed Practical Nurse (LPN) #1 who stated that Ex.Order 26.4(b)(1) were signed off in the TAR and the details of the assessment were documented in a body check assessment in the EMR. LPN #1 further stated that the WCC comes to the facility weekly and that recommendations made by the WCC should be ordered the same day as the consult to prevent further Ex Order 26. 4B1.

On 09/28/23 at 10:00 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who stated Ex.Order 26.4(b)(1) were performed weekly and documented in the TAR and in the assessments tab in the EMR. The LPN/UM further stated that the WCC comes to the facility weekly, and recommendations made by the WCC were verified with the physician to obtain new orders the same day as the WCC visit. The LPN/UM further stated that she was on vacation at the time Resident #255 developed a Ex Order 26. 4B, but would expect nurses to accurately document the Ex Order 26. 4B1 during the weekly body check assessments and to obtain physician's orders the same day that the WCC made the recommendations.

On 09/28/23 at 10:15 AM, the surveyor interviewed the Director of Nursing (DON) who stated that weekly Ex.Order 26.4(b)(1) are signed off on the TAR and there should be a corresponding body check assessment in the EMR. The DON further stated that the WCC comes to the facility weekly and if a recommendation was made, the nurse should have notified the physician and obtained orders for the recommendations within 24 to 48 hours. The DON added that it was important that interventions for Ex Order 26. 4B1 were put into

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place in a timely manner to prevent further Ex Order 26. 4B1 and to aid in the healing process. When asked about Resident #255, the DON stated she was not the DON at the facility when the resident's Ex Order 26. 4B1 developed, but that she would expect nurses to accurately document the Ex Order 26. 4B1 during the weekly body check assessments and to obtain physician's orders based on the WCC recommendations within 24 to 48 hours.

On 09/29/23 at 10:10 AM, in the presence of the survey team, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Vice President of Clinical Services (VPCS) who verified that if the body check was signed off on the resident's TAR, there should have been a corresponding body check assessment in the EMR that included any Ex Order 26 the resident had. The VPCS further stated that she had no explanation for why the resident's Ex Order 26. 4B1 care treatment was not changed until a week after the WCC made the recommendation, and that the nurse should have obtained a physician's order for the Ex Order 26. 4B1 the same day it was recommended.

Review of the facility's Body Checks policy, undated, included, "A weekly Ex.Order 26.4(b)(1) will be scheduled in [the EMR] in the TAR upon admission/readmission," and, "On the designated day, the licensed nurse document in the TAR and will open and complete a [EMR] body check form.

The facility was unable to provide a policy related to Ex.Order 26.4(b)(1) Consultant recommendations.

2.) On 09/21/23 at 10:34 AM, during the initial tour, the surveyor interviewed the Licensed

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Practical Nurse/Unit Manager (LPN/UM) for the 200 unit who stated that Resident #49 had a facility acquired Ex Order 26. 4B1

The surveyor observed Resident #49 lying in bed with his/her Ex Order 26. 4B1 set to the Ex Order 26. 4B1 setting at 350 pounds (lbs) on the following dates and times:

-9/21/23 at 11:01 AM
-9/22/23 at 10:14 AM
-9/26/23 at 09:26 AM

The surveyor further observed Resident #49 lying in bed with his/her Ex Order 26. 4B1 set between 120 lbs to 150 lbs on the following date and time:

-09/26/23 at 12:33 PM

According to the Admission Record, Resident #49 had diagnoses which included, Ex Order 26. 4B1

Review of the quarterly Minimum Data Set (MDS), dated 07/26/23, included a BIMS score which was blank. Further review of the MDS included the resident had Ex Order 26. 4B1 that was not present on admission.

Review of the Order Summary Report as of 09/26/23, included a physician's order dated 05/20/23, for, "Ex Order 26. 4B1 - every shift check for placement and function."

Review of the September 2023 TAR included the

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F 686	Continued From page 35 Ex Order 26. 4B1 PO and was signed with a check mark on each shift from 09/01/23 through 09/26/23. Review of the (CP) revised 08/09/23, included a focus area of, "3/25/23 Ex Order 26. 4B1 unavoidable due to Ex Order 26. 4B1 on Ex Order 26. 4B1." A further review of the resident's CP specified an intervention, "3/25/23 Ex Order 26. 4B1 for the maintenance of Ex Order 26.4 Review of the Braden Scale for Predicting Pressure Sore Risk dated 07/21/23, revealed the resident was at high risk for Ex Order. Review of the list of weights in the electronic medical record (EMR) revealed the resident's weight on 04/14/23 was Ex Order 26. 4B. On 09/26/23 at 09:30 AM, the surveyor interviewed the CNA who stated to prevent Ex Order 26. 4B1 residents were placed on an Ex Ord. The CNA stated that the Ex Order 26. 4B1 was set up by the maintenance department and that they were responsible for checking the numbers on it and to ensure it was working properly. When asked did the nurses adjust the setting to assure it was accurate? The CNA stated she was not sure if the nurse adjusted the Ex Order 26. 4B1 setting. On 09/26/23 at 09:32 AM, the surveyor interviewed LPN #2 who stated that the Ex Order precautions included to reposition the resident every two (2) hours and to follow the PO. LPN #2 stated that if the resident had an Ex Order 26. 4B1 the nurse was responsible for checking the mattress. He stated when they checked the Ex Order 26. 4B1,	F 686		

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F 686	Continued From page 36 they looked at the pounds (lbs) to see if it was accurate and to see if the Ex Order 26. 4B1 had a leak. When asked why they checked to assure the lbs were accurate? LPN #2 stated because if it was not set correctly, it could make the Ex Order worse. LPN #2 stated when they signed off in the electronic medical record (EMR) they were confirming that the Ex Order 26. 4B1 setting was checked and set accurately. LPN #2 further stated that the Ex Order 26. 4B1 should be set to the lbs of the resident because not every Ex Order 26. 4B1 should be the same. He explained if there were any issues with the Ex Order 26. 4B1 then there was an alarm to go off to let you know something was wrong. On 09/26/23 at 09:42 AM, the LPN/UM came into the resident's room in the presence of LPN #2 and the surveyor. At that time, the LPN/UM stated that the Ex Order 26. 4B1 was set correctly to Ex Order 26. 4B1 She further stated that since it was not beeping that meant it was "working good." On 09/26/23 at 09:43 AM, the surveyor asked what the numbers on the Ex Order 26. 4B1 meant? LPN #2 in the presence of the LPN/UM and the surveyor stated the Ex Order 26. 4B1 had to be set to a certain weight to prevent Ex Order 26. 4B1. At that time, the LPN/UM in the presence of LPN #2 and the surveyor stated the Ex Order 26. 4B1 needed to be set to the accurate weight to prevent Ex Order 26. 4B1. The LPN/UM stated that the resident had a Ex Order 26. 4B1 but that it had decreased in size. On 09/26/23 at 09:45 AM, the surveyor again asked if the current Ex Order 26. 4B1 setting of 350 lbs	F 686		

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F 686	Continued From page 37	F 686		

Ex Order 26. 4B1 an accurate setting for Resident #49? Both the LPN/UM and LPN #2 stated Ex Order 26., the Ex Ord was set correctly.

On 09/26/23 at 12:17 PM, the surveyor interviewed LPN #1 who stated that the purpose of an Ex Order 26. 4B1 was to prevent Ex.Order 26.4(b)(1) LPN #1 stated that the nurses were responsible to ensure the Ex Order 26. 4B1 was at the appropriate setting to coincide with the weight. For prevention Ex Order 26. 4B1 LPN #1 explained the Ex Order 26. 4B1 had to coincide with the resident's weight because if a resident was 200 lbs then the Ex Order 26. 4B1 should be between the 200 to 300 lbs. When asked if a resident was 100 lbs, should the Ex Order 26. 4B1 be set to 350lbs? LPN #1 replied Ex Order 26. 4B1 LPN #1 stated again that the Ex Order 26. 4B1 should have been set to the accurate weight to prevent Ex Order 26. 4B1 and promote Ex.Order 26.4(b)(1). She reiterated the Ex Order 26. 4B1 Ex Order 26. 4B1 LPN #1 stated she was not sure if they had to document in the EMR but knew they had to check it to ensure the accuracy.

On 09/26/23 at 12:31 PM, the surveyor interviewed the DON who stated that the purpose of the Ex Order 26. 4B1 was to prevent residents from acquiring a Ex Order, especially if they stayed in bed for a long period of time. The DON stated that staff adjusted the setting, but it was mostly the unit managers who adjusted them. The DON stated that the setting was based on the weight of the resident. She further stated that it was important to be based on the weight for safety of the resident and to prevent the resident from rolling if the bed was too firm. When asked if the resident

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F 686	Continued From page 38 weighed 150lbs and it was set to 300lbs would that be appropriate? The DON replied, "it should be within the range of the weight." On 09/26/23 at 12:33 PM, the surveyor and the DON went into the resident's room and at the time observed the Ex Order 26. 4B1 was set between 120 lbs and 150 lbs. The surveyor informed the DON of the Ex Order 26. 4B1 350lbs setting from 9/21/23 to that morning 9/26/23. The surveyor informed the DON that both the LPN/UM and LPN #2 confirmed that the Ex Order 26. 4B1 was accurately set at 350 lbs. The DON stated that it Ex Order 26. 4B1 and should have been "set towards soft and on the appropriate weight setting." On 09/27/23 at 09:47 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who provided a documented email from the Ex Order 26. 4B1 company. The LNHA stated that the documented email reflected the Ex Order 26. 4B1 company manufacturer's guideline for the Ex Order 26. 4B1. The LNHA stated that the Ex Order 26. 4B1 company provided the Ex Ord to the facility. On 09/27/23 at 01:25 PM, the DON in the presence of the LNHA, Regional Nurse #1, Regional Nurse #2, the Regional LNHA, and the survey team confirmed that Resident # 49's current weight was Ex Order 26.4(b) and acknowledged that the Ex Order 26. 4B1 was still set to the incorrect weight when both the surveyor and DON observed it together yesterday, 9/26/23. On 09/29/23 at 10:39 AM, the Vice President of Clinical Services (VPCS) acknowledged, in the presence of the LNHA and the survey team, that	F 686		

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F 686	Continued From page 39 the Ex Order 26. 4B1 should have been set to the appropriate weight setting. She stated that it was important that it was set to the appropriate setting to ensure that the resident was comfortable and to prevent Ex Order 26. 4B1 on the Ex.Order 26.4(b)(1). A review of the provided documented email from the Ex Order 26. 4B1 company dated 9/26/23, reflected "low air loss mattresses are designed to distribute the patient's body weight over a broad surface area and to help preven Ex.Order 26.4(b)(1). Air continually flows through tiny laser-made air holes in the top of the mattress surface so that the user floats on a soft cushion of air." A review of an in-service dated 9/26/23 after surveyor inquiry revealed "the dial [is set] to as close to the resident's weight as possible." A review of the facility's Pressure Ulcers policy, undated, included "To implement best practices aimed at prevention and treatment of Ex Order 26. 4B1 ... ...Interventions will be resident-specific and may include items such as turning and positioning, elevating heels, Ex Order 26. 4B1, Ex Order 26. 4B1, specialty cushions, and Ex Order 26. 4B1." NJAC 8:39-27.1(a)	F 686		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698		10/19/23

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F 698	Continued From page 40 by: Based on observation, interview, and record review it was determined that the facility failed to maintain ongoing complete communication notes between the facility and the Ex Order 26. 4B1. This deficient practice was identified for 1 of 1 resident reviewed for Ex Order 26. 4B1, (Resident #110) and was evidenced by the following: On 09/26/23 at 09:45 AM, on the Ex Order 26. 4B1 unit, Resident #110 was observed seated in a chair in the main dining room. The resident stated that before he/she went to Ex Order 26. 4B1 that the nurse checked his/her vital signs and that he/she would take the Ex Order 26. 4B1 binder with them. The resident denied the nurse ever checked the Ex Order 26. 4B1 in their arm or listened to it with a stethoscope. On 09/26/23 at 12:26 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that Resident #110 went to Ex Order 26. 4B1 every Tuesday, Thursday, and Saturday and that she would fill out their Ex Order 26. 4B1 binder with vital signs and then the resident would take the binder to Ex Order 26. 4B1. LPN #1 stated that when the resident returned to the facility the LPN #1 would document the Ex Order 26. 4B1 weight, as per the Ex Order 26. 4B1, into the electronic medical record and that she would assess the resident's Ex Order 26. 4B1 skin visually and Ex Order 26. 4B1 which would then be documented in the dialysis binder. On 09/27/23 at 10:43 AM, the surveyor interviewed the Registered Nurse (RN) who	F 698	Element 1: LPN #2 was immediately educated on Ex Order 26. 4B1 communication sheets and assessing residents on Ex Order 26. 4B1 for Ex Order 26 and Ex Order 2, and a competency on such was completed with LPN #2 and nursing staff. Element 2: All residents who require Ex Order 26. 4B1 have the potential to be affected. Element 3: Nursing staff was educated on completing and reviewing the Ex Order 26. 4B1 communication sheet, assessing Ex Order 26. 4B1 access site for signs and symptoms of Ex Order 26. 4B1, and Ex Order 26. 4B1 and Ex Order 26 and Ex Order 2 (if applicable). A competency was completed for nursing staff (RN/LPN) on assessing Ex Order 26. 4B1 access site for signs and symptoms of Ex Order 26. 4B1, and for Ex Order 26 and Ex Order 2 (if applicable). Element 4: Director of Nursing/Assistant Director of Nursing will monitor Ex.Order 26.4(b)(1) communication sheets daily x14 days, weekly x2, and monthly x2 for accuracy and completeness of Ex Order 26. 4B1 communication sheets. In addition, the Assistant Director of Nursing/designee will complete a competency on assessing Ex Order 26. 4B1 access sites for signs of infection, bleeding, and Ex Order 26 and Ex Order 2, and documentation of such in Ex Order 26. 4B1 communication sheets on 2 nurses weekly x4, then monthly x2. Needed corrections will be addressed as they are	

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F 698	Continued From page 41 stated that prior to and upon return from Ex Order 26. 4B1 that a resident's vital signs were taken, the Ex Order 26. 4B skin was assessed for wounds or discolorations and the Ex Order 26 and Ex Order 26 were also checked and recorded in the MAR and in the Ex Order 26. 4B1 binder. The surveyor and RN reviewed the resident's Ex Order 26. 4B1 binder together and the RN acknowledged that there was no documentation for the Ex Order 26 and Ex Order 26 recorded on the forms. The RN stated that it was important to fill out the form correctly to make sure the Ex Order 26. 4B was working correctly. On 09/27/23 at 10:50 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM) who stated that the nurse's responsibility with a Ex Order 26. 4B1 resident included communicating the vital signs, assessment of the Ex Order 26. 4B1 site, and resident weight via the Ex Order 26. 4B1 binder. The surveyor and the LPN/UM reviewed the Ex Order 26. 4B1 binder, and the LPN/UM acknowledged that the Ex Order 26 and Ex Order 26 were not documented and that they should have been. The LPN/UM stated, "I can't say with 100% confidence that it was done." On 09/27/23 at 11:01 AM, the surveyor interviewed the Registered Nurse/Director of Nursing (RN/DON) who stated that when a resident went to Ex Order 26. 4B1 that there was a sheet in the binder that the nurse completed prior to Ex Order 26. 4B1 and upon return which included the vital signs and that the Ex Order 26 and Ex Order 26 were checked. The surveyor and the RN/DON reviewed the resident's Ex Order 26. 4B1 binder and the RN/DON acknowledged that the Ex Order 26 and Ex Order 26 were not documented. On 09/27/23 at 11:29 AM, the surveyor interviewed LPN #2 who stated for a Ex Order 26. 4B1	F 698	discovered, findings will be reported monthly to the QAPI team for review and action as necessary.	

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F 698	Continued From page 42	F 698		

resident that he would complete the form in the Ex Order 26. 4B1 binder with the Ex Order 26. 4B1 and the observation of the Ex Order 26. 4B site. When the surveyor inquired as to whether the Ex Order 26 and Ex Order 26 were checked, LPN #2 stated he could not recall what Ex Order 26 nor Ex Order 26 were. The surveyor and LPN #2 reviewed the resident's Ex Order 26. 4B1 binder and the LPN acknowledged that on 09/14/23, he had the resident and that he did not fill out the Ex Order 26 and Ex Order 26 section.

On 09/27/23 at 01:25 PM, the surveyors met with the administration team who acknowledged that Resident #110's Ex Order 26. 4B1 communication form was not filled out correctly and that it was the expectation of the nurses to fill the form out in its entirety.

On 09/29/23 at 10:22 AM, the surveyors met with the Licensed Nursing Home Administrator and the RN Vice President of Clinical who acknowledged that no Ex Order 26 and no Ex Order 26 could have been a complication with the Ex Order 26. 4B and that all nurses who cared for residents on Ex Order 26. 4B1 should have checked for Ex Order 26 and Ex Order 26 to make sure the Ex Order 26. 4B was functioning.

The surveyor reviewed the medical record for Resident #110.

A review of the resident's Admission Record (an Admission Summary) reflected that Resident #110 was admitted to the facility with diagnoses that included but were not limited to: Ex Order 26. 4B1 .

A review if the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool

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F 698	Continued From page 43 used to facilitate the management of care dated 7/27/23, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of Ex Order out of 15 which meant that the resident was Ex Order 26. 4B1. The MDS also indicated that the resident required Ex.Order 26.4(b)(1) A review of the resident's September 2023 Order Summary Report revealed an order dated 06/19/23, that stated Ex Order 26. 4B1 site Ex Order 26. 4B1 every shift Check AV Ex Order 26. 4B1 (Specify Location) for presence of bleeding, drainage, and signs of infection. Notify physician of abnormal findings." A review of the resident's September 2023 Medication Administration Record (MAR) revealed that the above order was documented as completed every shift. A review of the resident's Care Plan (CP) revealed an Intervention, dated 07/25/2022, to "Check for Ex Order 26. 4B1 q [every] shift to Ex Order 26. 4B1 [sic]." A review of the facility's dialysis binder/communication book revealed "Hemodialysis Dialysis Communication Sheet for Dialysis Book-COVID-19: (Negative)" forms. The form had three sections: two for the facility to communicate resident information to the dialysis center prior to and post treatment, and one section "Information from the Dialysis Center". Further review of the dialysis communication sheets noted that on 09/26/23, 09/23/23, 09/14/23, 09/12/23, 09/09/23, 09/07/23, 09/05/23, and 09/02/23 the facility did not document "AV	F 698		

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F 698	Continued From page 44 Shunt Only: Bruit () Thrill () (indicate (+) (or -), nor Access Site: Swelling () Drainage () Pain () on the upper portion of the form and "Once resident return from dialysis SPCC nurse is to sign resident back in below and check AV Shunt only: Bruit () Thrill () (indicate (+) (or -)" on the bottom portion of the form. The Ex Order 26. 4B1 communication sheets dated 09/21/23 and 09/16/23 revealed that the facility did not document "Once resident return from Ex Order 26. 4B1 SPCC nurse is to sign resident back in below and check Ex Order 26. 4B1 only: Ex Order 26 () Ex Order 26. () (indicate (+) (or -)" on the bottom portion of the form. A review of the undated facility policy, "Dialysis Policy," revealed, Purpose: The primary goals of dialysis care is to maintain integrity of the site is to prevent infection and promote patency of the catheter (preventing clots). Procedure: 6. Check for patency at the access site by palpating the site to feel the "thrill," or use a stethoscope to hear the "whoosh' or "bruit" of blood flow through the access q shift, pre and post dialysis visits, and/or as per orders. Care of Resident prior to Dialysis Treatment: 2. Assess the dialysis access sites for signs of infection/patency. 3. Complete the staff section of the dialysis communication form. NJAC 8:39 - 27.1 (a)	F 698		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Complaint NJ#: 159439; 165453	F 925	Element 1:	10/19/23

F 925

Continued From page 45

Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain an effective pest control program. This deficient practice was identified on 2 of 3 nursing units, (the 200 and the 300 unit), for 4 of 29 residents, (Resident #17, #64, #104 and #149), reviewed for concerns related to pests, and by 5 out of 6 alert and oriented residents during the Resident Council meeting.

This deficient practice was evidenced by the following:

On 09/21/23, the surveyor toured the 200 unit and observed dead insects on the floors in rooms [Ex Order] and [Ex Order].

At 11:16 AM, on the 200 unit, the surveyor observed a [Ex Order] on Resident #17's [Ex Order 26. 4B1]. At that time, the resident stated that the facility had, "quite a few flies." Resident #64, the roommate, told the surveyor that the facility supposedly fumigated a couple of days ago. The surveyor asked if the residents had seen bugs in their rooms since. Both residents told the surveyor that they stayed mostly in their room and had only seen flies and not roaches.

On 09/22/23, the surveyor observed the dead insect still on the floor in resident room [Ex Order]. That same day the surveyor observed additional dead and living insects in rooms [Ex Order] and [Ex Order].

On 09/21/23 at 11:41 AM, the surveyor toured the 300 unit and interviewed Resident #104 in his/her room. The resident stated that he/she had issues with bugs, namely flies, and roaches. The

F 925

The deficiency was corrected by performing a Pest Control Audit by the Housekeeping Director, so that the facility can see on a frequent basis areas in the facility that require extra cleaning, areas where food is being hidden by residents, or additional pest control treatment.

Element 2:
All residents are affected by this deficiency.

Element 3:
The deficiency was corrected by performing a Pest Control Audit by the Housekeeping Director. This audit will provide the facility with more frequent feedback on areas in the facility that require extra attention, in order to ensure the facility remains in compliance with F925; the Administrator performs daily rounds as well. Additionally, the residents are being asked for feedback in order to identify any other areas of concern, as well as to determine if improvement has been made.

Element 4:
The Pest Control Audit is being monitored by the Housekeeping Director or designee three times a week for four weeks, then twice a week for four weeks, and then once a week for four months. Identified issues will be corrected as they are discovered, results will be reported to the Administrator, and will be reviewed at quarterly QAPI meetings.

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F 925	Continued From page 46 resident stated that he/she had flies frequently land on his/her lunch tray and had taken pictures to prove it. Resident #104 then showed the surveyor the pictures he/she had taken on their cell phone which corroborated the resident's interview. The resident then pointed and showed the surveyor a plastic, plug-in night light with fragrance. Insects were observed throughout the plug-in light. The surveyor saw three roaches stuck on the sticky material on the plug-in light fixture. The resident asked the surveyor to show it to a staff member. At 11:47 AM, the surveyor showed the 300 unit Licensed Practical Nurse/Unit Manger (LPN/UM) the resident's plug-in light fixture. The LPN/UM stated that Resident #104 mentioned to her approximately a week ago that there were bugs in his/her room and pest management came to the facility one day last week to resolve the issue. The LPN/UM told the surveyor that the residents should not have bugs in their rooms. At 12:03 PM, the surveyor interviewed Resident #149, the roommate of Resident #104 in the main dining room on the 300 unit. The resident stated that he/she had seen a bug scurry off their roommate's meal tray, they told the staff, and someone came in and sprayed to get rid of the bugs about a week ago, but there were still bugs. On 09/22/23 at 8:50 AM, the surveyor was standing in Resident #104 and Resident #149's room and observed a small black bug flying around. A Certified Nursing Assistant (CNA) was also in the room at the time of the surveyor's observation. The surveyor asked the CNA if she saw the bug and the CNA did not respond to the surveyor. Resident #104 told the surveyor to go	F 925		

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F 925	Continued From page 47	F 925		

look in the bathroom. The surveyor entered the resident's bathroom and observed approximately 30 small black spots that appeared to be dead bug carcasses throughout the walls in the resident's bathroom. Resident #104 told the surveyor that the black spots on the walls were bugs that he/she had killed.

On 09/27/23 at 10:40 AM, the surveyor conducted the Resident Council Meeting. Five out of the six alert and oriented residents stated that they had seen flies in their rooms for a few weeks. Three out of the six stated that they had seen roaches. The residents told the surveyor that the pest control company had recently come to the facility.

On 09/26/23 at 11:53 AM, the surveyor interviewed the CNA on the 300 unit who stated that she had worked at the facility since January 2023. The surveyor asked the CNA if he had seen bugs around the facility and the CNA responded, "Not really." The surveyor further asked the CNA if residents had complained to him of bugs being in their rooms and the CNA nodded his head up and down indicating yes. The CNA told the surveyor that he didn't remember how many residents had complained. The CNA stated that if a resident complained to him about pests, he would let the nurse know and the nurse would inform the housekeeping and maintenance department.

On 09/26/23 at 12:24 PM, the surveyor interviewed the CNA on the 200 unit who had worked at the facility for 23 years. The CNA stated that she had seen pests or bugs in and around the facility about three weeks prior. The CNA further stated since then, the pest company had come into the facility and she had not seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315177	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 48	F 925		

any pests.

On 09/27/23 at 10:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) on the 200 unit who stated that she had seen bugs on the unit from time to time throughout the past year such as ants, crickets, and roaches. The LPN told the surveyor that if she saw pests on the unit, she would have notified the housekeeping department and the housekeeping department would have contacted the pest control company. The LPN further stated that the pest control company came to the facility about a week ago, had sprayed and since then she noticed that there were less bugs.

On 09/27/23 at 10:51 AM, the surveyor interviewed the Housekeeping Director (HD) who stated that the pest control company came weekly to the facility. The HD stated that if the staff observed a pest, they would document in the pest control logbook which was located on every unit, the staff would notify him, and he would then call the pest control company. The surveyor asked the HD if he had seen any pests. The HD stated that he had seen, "a few fruit flies" in the resident's rooms because they were leaving out food. The surveyor further questioned the HD about the time frame that the pests had been observed throughout the facility and the HD could not specify a time frame. The HD told the surveyor that the facility recently entered into a contract with a new pest control company about a week or two ago and they had performed, "a deeper spray of the facility to rectify the pests that were in the facility". The HD stated that if his staff saw dead bugs throughout a resident room or bathroom, the expectation would be for staff to clean the area, remove the bugs, and disinfect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315177	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 49	F 925		

the area.

At 11:44 AM, the surveyor interviewed the Maintenance Director (MD) who stated that there was a pest control book behind every nurse's station and the nurses were supposed to write down what they saw and the location into the book and the pest company would come in and take care of the issue. The MD told the surveyor that the facility had a company that was coming in before and "they weren't really on top of stuff", so that contributed to the pest problem. The MD explained that the facility hired a new company about one to two months ago and that had seemed to help. The MD stated that officially the roaches started in the 100 unit and gradually spread throughout the facility. He further stated that he and his staff were, "really on top of it due to resident concerns". The MD told the surveyor that the facility identified that some of the pests were related to resident food storage, so the facility educated the residents about proper food storage and provided them with plastic containers to put their food in.

The surveyor reviewed the 300-unit Pest Special Service Record (PSSR) from 03/01/23 to present which revealed the following:

03/01/23 - Roaches in breakroom and at nurse's station. The PSSR indicated that the technician came to the facility on 03/07/23 and 03/13/23.

03/29/30 - Roaches in room [Ex Order]. The PSSR indicated that the technician came to the facility on 03/29/23.

04/17/23 - Mice in kitchen, doors, and halls. The PSSR indicated that the technician came to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315177	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 50	F 925		

facility on 04/17/23.

04/26/23 - Roaches in the kitchen. The PSSR indicated that the technician came to the facility on 04/26/23.

05/01/23 - Bugs crawling at nurse's station. The PSRR indicated that the technician came to the facility on 05/15/23.

05/17/23 - Gnat's in the bathroom. No specific bathroom specified. The PSSR did not reveal a technician signature.

07/28/23 - Mouse in room [Ex Order]. The PSSR did not reveal a technician signature.

The surveyor reviewed the 200-unit PSSR from 02/13/23 to present which revealed the following:

02/13/23 - Roaches all over. The PSSR indicated that the technician came to the facility on 02/27/23.

03/03/23 - Roaches all over. The PSSR indicated that the technician came to the facility on 03/07/23.

04/24/23 - Roaches in rooms 200 - 218. "Lots of roaches." The PSSR indicated that the technician came to the facility on 04/26/23.

06/05/23 - Roaches in drawer of room [Ex Order 26.]. The PSSR indicated that the technician came to the facility on 05/09/23. The technician signed the PSSR approximately one month before the problem was documented in the PSSR.

06/07/23 - Roaches 200 - 219 in the rooms and

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	315177	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 51 hallways. The PSSR indicated that the technician came to the facility on 07/19/23. 06/19/23 - Roaches Ex.Order 26.4. "A lot of roaches". The PSSR indicated that the technician came to the facility on 07/19/23. 08/11/23 - Roaches and flies on the unit, nurse's station and in rooms Ex Order 26. 4B1 . The PSSR indicated that the technician came to the facility on 08/21/23. 09/10/23 - Cockroaches "A lot" at the nurse's station. The PSSR did not reveal a technician signature. A review of the facility's Pest Control Policy and Procedure dated 08/31/23, indicated that the facility would maintain an effective pest control program and, "This facility maintains an on-going pest control program to ensure that the building is kept free of insect and rodents." On 09/29/23 at 10:09 AM, the facility's Regional Registered Nurse (R/RN) stated that the pest problem was identified by the facility prior to the survey team entering the facility and the facility had recently switched pest control companies to help rectify the situation. The R/RN further stated that the facility would resolve the issue in its entirety and systematically. NJAC 8:39-31.5	F 925		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061305	A. BUILDING: ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint NJ #: 165453 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ#: 165453 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey. This deficient practiced was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	Element 1: The deficiency is being corrected by offering overtime and bonuses to staff to cover openings in the schedule, offering openings in the schedule to agency, and expanding the "Weekend Warrior" program which offers increased rated to staff members who work extra shifts on weekends, using job search engines to expand the view of job postings, and meeting with Certified Nursing Assistant schools to meet with newly graduating individuals. Element 2:	10/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/19/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061305	A. BUILDING: ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	**139 GRANT AVE EATONTOWN, NJ 07724**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 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. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: 1.) For the week of Complaint staffing from 11/06/2022 to 11/12/2022, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -11/06/22 had 12 CNAs for 150 residents on the day shift, required at least 19 CNAs. -11/07/22 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. -11/08/22 had 17 CNAs for 150 residents on the day shift, required at least 19 CNAs. -11/10/22 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. -11/12/22 had 14 CNAs for 150 residents on the	S 560	All residents are affected by this deficiency. Element 3: The deficiency is being corrected by offering overtime and bonuses, utilizing agency expanding the Weekend Warrior program, sing job search engines, and meeting with Certified Nursing Assistant schools to meet with newly graduating individuals. Additionally, a Staffing Audit is being conducted to ensure the facility remains in compliance with S560. Element 4: The Staffing Audit is being monitored by the Administrator or designee once a week for two months, then once every other week for two months, and then once a month for three months. The results of these audits will be reviewed at quarterly QAPI meetings.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061305	A. BUILDING: ______ B. WING ______	C 09/29/2023

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S 560	Continued From page 2 day shift, required at least 19 CNAs. 2.) For the week of Complaint staffing from 04/16/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -04/17/23 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. -04/22/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs. 3.) For the 2 weeks of Complaint staffing from 05/28/2023 to 06/10/2023, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -05/28/23 had 12 CNAs for 151 residents on the day shift, required at least 19 CNAs. -05/29/23 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs. -05/30/23 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -05/31/23 had 16 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/03/23 had 13 CNAs for 153 residents on the day shift, required at least 19 CNAs. -06/04/23 had 10 CNAs for 153 residents on the day shift, required at least 19 CNAs. -06/05/23 had 18 CNAs for 151 residents on the day shift, required at least 19 CNAs. -06/06/23 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. -06/07/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/08/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/09/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061305	A. BUILDING: ___ B. WING ___	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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S 560	Continued From page 3 4.) For the week of Complaint staffing from 07/03/2023 to 07/09/2023, there were no deficient practices in staffing identified as submitted. 5.) For the week of Complaint staffing from 08/07/2023 to 08/13/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -08/11/23 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. -08/12/23 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. -08/13/23 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. 6.) For the 2 weeks of staffing prior to survey from 09/03/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -09/03/23 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/09/23 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/10/23 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/10/23 had 9 total staff for 144 residents on the overnight shift, required at least 10 total staff. -09/11/23 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/12/23 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/13/23 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/14/23 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/15/23 had 16 CNAs for 144 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061305	A. BUILDING: ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	**139 GRANT AVE EATONTOWN, NJ 07724**

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S 560	Continued From page 4 day shift, required at least 18 CNAs. -09/16/23 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. During an interview with the surveyor on 09/28/23 at 10:36 AM, the Staffing Coordinator/Director of Human Resources stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for 10 residents on the 3:00 PM - 11:00 PM shift, and one CNA for 14 residents on the 11:00 PM - 7:00 AM shift. During an interview with the surveyor on 09/28/23 at 11:46 AM, the Licensed Nursing Home Administrator stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for 10 residents on the 3:00 PM - 11:00 PM shift, and one CNA for 14 residents on the 11:00 PM - 7:00 AM shift.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315177	A. Building B. Wing	11/8/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 10/19/2023	ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 10/19/2023	ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 10/19/2023
ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 10/19/2023	ID Prefix F0925 Reg. # 483.90(i)(4) LSC	Correction Completed 10/19/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315177 Y1	A. Building B. Wing Y2	11/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 10/19/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 10/19/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 10/19/2023
ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 10/19/2023	ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 10/19/2023	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 10/19/2023
ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 10/19/2023	ID Prefix F0925 Reg. # 483.90(i)(4) LSC	Correction Completed 10/19/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061305 Y1	A. Building B. Wing Y2	11/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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 10/19/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: 2ARK12

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061305 Y1	A. Building B. Wing Y2	11/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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 10/19/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315177	A. BUILDING **01** B. WING ______	**09/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	**139 GRANT AVE** **EATONTOWN, NJ 07724**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/29/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/29/23 and the facility 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. Gateway Care Center is a one-story, Type V protected building that was built in 1959. The facility is divided into eight smoke compartments. The diesel generator powers 30% of the building per the Maintenance Director. The number of occupied beds was 145 out of 178 at the time of the survey. .	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K 324		10/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/19/2023

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

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	315177	A. BUILDING 01 B. WING ______	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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K 324	Continued From page 1 Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to maintain the hood system in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition). This deficient practice had the potential to affect all residents. An observation on 09/29/23 at 10:00 am revealed the hood system, located in the Kitchen above the cooking equipment, had loose caulk hanging above the cooking equipment and unsealed gaps. Two grease drip trays were also missing from beneath the grease filters, and grease build up was observed on the floor around the cooking	K 324	Element 1: The deficiency was corrected by sealing all gaps above the cooking equipment, as well as replacing the identified loose caulk. Additionally, the two missing grease drip trays were replaced. Element 2: No residents are affected by this deficiency, as it is located in the kitchen, and not in a patient living area. Element 3: An audit of the cooking area will be conducted to ensure that the area is in	

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	315177	A. BUILDING **01** B. WING ______	**09/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	**139 GRANT AVE** **EATONTOWN, NJ 07724**

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K 324	Continued From page 2 equipment. During an interview at the time of the observation, the Maintenance Director confirmed the peeling caulk and the missing grease drip tray. He stated the facility was unaware of the missing grease traps and peeling caulk. NJAC 8:39-31.1(c), 31.2(e) NFPA 96 .	K 324	compliance with NFPA 96. Element 4: The Cooking Area audit will be monitored by the Maintenance Director or designee once per week for four months, then once every other week for four weeks, and then once a month for four months. Identified issues will be corrected as they are discovered, results will be reported to the Administrator, and will be reviewed at quarterly QAPI meetings.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on record review, observation, and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 9.6.1.3. This deficient practice had the potential to affect all 145 residents. Findings include:	K 345	Element 1: The deficiency was corrected by replacing the malfunctioning pull station with newer models. Additionally, the trouble signal for the identified smoke detector was fixed by Johnson Controls. Element 2: All residents are potentially affected by this deficiency. Element 3:	10/19/23

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	315177	A. BUILDING **01** B. WING ______	**09/29/2023**

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GATEWAY CARE CENTER	**139 GRANT AVE** **EATONTOWN, NJ 07724**

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K 345	Continued From page 3 A record review of the Fire Alarm Annual Inspection Reports conducted by Johnson Controls, dated 05/30/2023 and 06/24/2022, revealed two pull stations located by Rooms 202 and 212, were not connected to the fire alarm system. An observation on 09/29/23 at 9:37 AM revealed the Fire Alarm Control Panel had a trouble signal for a smoke detector. During an interview at the time of the observation, the Maintenance Director confirmed the Fire Alarm Control Panel had a trouble signal for a smoke detector. He stated the facility was waiting on the fire alarm servicing company to correct the issue. During an interview on 09/29/23 at 12:35 PM, the Maintenance Director at 12:35 PM stated the facility is planning to replace the pull stations with newer models that would be able to communicate with the fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	A Fire Alarm System Audit will be conducted to ensure all pull stations and smoke detectors are working properly in accordance with NFPA 70, 72. Element 4: The Fire Alarm System Audit will be monitored by the Maintenance Director or designee once per week for four months, then once every other week for four weeks, and then once a month for four months. Identified issues will be corrected as they are discovered, results will be reported to the Administrator, and will be reviewed at quarterly QAPI meetings.	
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	K 353		10/19/23

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K 353	Continued From page 4 available. a) Date sprinkler system last checked ______ 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 record review, observation, and interviews, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 145 residents. Findings Include: A record review of the facility's sprinkler inspection reports revealed the Full Flow Trip Test of the Dry Sprinkler System was not conducted at least every three years. The most recent Sprinkler Inspection Report conducted by Johnson Controls, dated 06/26/23, indicated the most recent Full Flow Trip Test was conducted on 05/27/2019. An observation on 09/29/23 at 9:49 AM revealed the sprinkler head, located behind the dryers in the Laundry Room, had excess lint buildup on the bulb and deflector. During an interview at the time of the observation,	K 353	Element 1: The deficiency was corrected by conducting the Full Flow Trip Test of the Dry Sprinkler System; testing performed by Johnson Controls. Additionally, the identified excess lint build-up on the sprinkler head behind the dryers in the laundry room was removed. Element 2: All residents are potentially affected by this deficiency. Element 3: A Lint Audit will be performed to ensure the laundry room is free of excessive lint build-up in accordance with NFPA 25. Additionally, a Full Flow Trip Test Audit will be performed to ensure the facility is properly scheduling and completing the test at minimum every three years. Element 4: The Lint Audit will be monitored by the Housekeeping Director or designee three times a week for four months, then once a	

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K 353	Continued From page 5 the Maintenance Director confirmed the Laundry Room sprinkler head had excess lint buildup. He stated the facility was not aware of the lint buildup on the sprinkler head. During an interview on 09/29/23 at 11:30 AM, the Maintenance Director confirmed the most recent Full Flow Trip Test was conducted on 05/27/2019. He stated the facility was unaware that the dry system needed to be trip tested every three years. NJAC 8:39-31.1(c). 31.2(e) NFPA 13, 25 .	K 353	week for three months, and then once every other week for two months. Identified issues will be corrected as they are discovered, results will be reported to the Administrator, and will be reviewed at quarterly QAPI meetings. The Full Flow Trip Test Audit will be monitored by the Maintenance Director or designee every twelve months for three years, results will be reported to the Administrator, and will be reviewed at quarterly QAPI meetings.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no	K 363		10/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315177	A. BUILDING 01 B. WING ______	09/29/2023

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GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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K 363	Continued From page 6 impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 68 residents. Findings include: An observation on 09/29/23 at 9:40 AM revealed the corridor door of Room 204 was hitting the door frame and failed to latch. An observation on 09/29/23 at 9:41 AM revealed the corridor door of Room 205 was hitting the door frame and failed to latch.	K 363	Element 1: The deficiency was corrected by installing new latches in the identified doors, re-mounting the doors on hinges, and shaving down excess paint which prevented the doors from properly latching. Element 2: The residents located in the identified rooms are potentially affected by this deficiency. Element 3: A Door Audit will be conducted to ensure all doors are able to be properly closed and latched, in order to resist the passage of smoke, in accordance with NFPA 101.	

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	315177	A. BUILDING 01 B. WING	09/29/2023

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GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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K 363	Continued From page 7 An observation on 09/29/23 at 9:42 AM the corridor door of Room 207 was hitting the door frame and failed to latch. An observation on 09/29/23 at 9:43 AM revealed the corridor door of Room 210 was hitting the door frame and failed to latch. An observation on 09/29/23 at 9:44 AM revealed the corridor door of Room 200 was hitting the door frame and failed to latch. An observation on 09/29/23 at 10:58 AM revealed the corridor door of Room 105 failed to latch in the door frame. During an interview at the time of the observations, the Maintenance Director confirmed the doors failed to latch in the frames. He stated the facility was unaware the doors were not latching. NJAC 8:39-31.2(e) .	K 363	Element 4: The Door Audit will be monitored by the Maintenance Director or designee once a week for four months then once every other week for four weeks, and then once a month for four months. Identified issues will be corrected as they are discovered, results will be reported to the Administrator, and will be reviewed at quarterly QAPI meetings.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		10/19/23

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K 372	Continued From page 8 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 145 residents. Findings include: An observation on 09/29/23 at 10:15 AM revealed the smoke barrier, located above the corridor smoke doors by Room 308, had a four-inch unsealed gap around a grouping of five wires which penetrated the wall. An observation on 09/29/23 at 10:17 AM revealed the smoke barrier, located inside the Bathroom of Room 309, had a three-inch unsealed gap along the top of the wall along the metal deck. An observation on 09/29/23 at 10:30 AM revealed the smoke barrier, located in the Therapy Office, had an unsealed gap above the ceiling tile, six-inches by 18-inches in size. An observation on 09/29/23 at 10:40 AM revealed the smoke barrier, located above the West Wing corridor smoke doors, had two unsealed wire penetrations above the ceiling tile, two inches in diameter.	K 372	Element 1: The deficiency was corrected by closing off all unsealed gaps in the smoke barriers with UL rated products. Element 2: All residents have the potential to be affected by this deficiency. Element 3: A Smoke Barrier Audit will be conducted to ensure the smoke barriers are properly maintained in accordance with NFPA 101. Element 4: The Smoke Barrier Audit will be monitored by the Maintenance Director or designee once a week for four months, then once every other week for four weeks, and then once a month for four months. Identified issues will be corrected as they are discovered, results will be reported to the Administrator, and will be reviewed at quarterly QAPI meetings.	

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K 372	Continued From page 9 An observation on 09/29/23 at 10:45 AM revealed the smoke barrier, located above the corridor smoke doors by Room 212, had a three-inch unsealed gap around a conduit penetration and a two-inch unsealed gap around a wire penetration. An observation on 09/29/23 at 10:50 AM revealed the smoke barrier, located inside the Korean Office, had a six-inch unsealed gap around the top of the wall above the ceiling. During an interview at the time of the observations the Maintenance Director confirmed the unsealed gaps and penetrations. He stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e) .	K 372		

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
315177 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	11/8/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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).

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ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 10/19/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 10/19/2023	ID Prefix Reg. # LSC	Correction Completed
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9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO