

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

PRINTED: 01/16/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315387	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/12/2023
NAME OF PROVIDER OR SUPPLIER ALLAIRE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 115 DUTCH LANE ROAD FREEHOLD, NJ 07728		
(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 000	INITIAL COMMENTS C #: NJ00160280 and NJ160658 Census: 145 Sample: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		8/28/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/24/2023

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 609	<p>Continued From page 1</p> <p>investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C #: NJ00160280 and NJ160658</p> <p>Based on interviews and a review of the medical records (MRs) and other facility documentation on 7/12/23, it was determined that the facility staff failed to report an injury of unknown origin to the New Jersey Department of Health (NJDOH) as required and according to the facility's policy "ABUSE INVESTIGATION AND REPORTING" for 1 of 3 sampled residents (Resident #2) reviewed for incident and accident investigation and reporting.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. According to the Admission Record (AR), Resident #2 was admitted to the facility on [REDACTED] with diagnoses which included but were not limited to: NJ EX Order. 264b1 [REDACTED]</p> <p>A Minimum Data Set (MDS), an assessment tool, dated [REDACTED] revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [REDACTED] which indicated unable to complete the interview due to a NJ EX Order. 264b1 Resident #2 needed help with activities of daily living.</p> <p>The Care Plan initiated on [REDACTED] and revised on [REDACTED]</p>	F 609	<p>" All residents are at risk to be affected by the deficient practice.</p> <p>" Resident #2's Injury of Unknown Origin was called in to the Department of Health Reportable hotline on [REDACTED].</p> <p>" All facility staff including DON and Admin were re-educated on the facility Abuse Investigation and Reporting policy.</p> <p>" DON/ADMIN will review all accidents & incident reports to ensure the policy is being followed and will report weekly to the facility's regional team. Corporate DON or designee will audit two accident & incident reports per month x 3 months for evidence of appropriate event reporting.</p> <p>" Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.</p>	

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F 609	<p>Continued From page 2</p> <p>█, indicated that Resident #2 was at risk for injuries related █ Intervention which included but was not limited to anticipate and meet the resident's needs.</p> <p>The "Un-witnessed" investigation report (UIR), dated █ at 4:15 am, indicated that assigned Certified Nursing Assistant (CNA #1) reported that resident was found lying on the floor next to his/her bed. The UIR further indicated that the resident had █ to his/her █ and █ and NJ EX Order. 264b1. The UIR indicated that the incident was not witnessed.</p> <p>Review of Resident #2's progress notes (PN), dated █ at 4:15am, documented as "Incident Note" by a Licensed Practical Nurse (LPN #1), indicated that CNA #1 reported that she found the resident laying on the floor in █ next to her/his █ The PN dated █ at 12:09 pm, documented by LPN #2 indicated that the Nurse Practitioner (NP) was called for unwitnessed █, Resident #2 was transferred to an Acute Care Hospital at 11:00 am. The PN further indicated that Resident #2 returned to the facility from the ACH and was diagnosed of █</p> <p>The surveyor was unable to interview Resident #2 due to NJ EX Order. 264b1.</p> <p>During an interview with the surveyors on 7/12/23 at 2:08 pm, the Director of Nursing (DON), in the presence of Licensed Nursing Home Administrator (LNHA). The DON and LNHA explained that one of the criteria for an allegation of abuse was "an injury of unknown origin" which were included but not limited to █." They both</p>	F 609			

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F 609	<p>Continued From page 3</p> <p>agreed that it is their responsibility to report to the NJDOH if there was an allegation of abuse. The DON and the LNHA were unable to explained why Resident #2's NJ EX Order: 264b1 on NJ EX Order: 264b1 was not reported to the NJDOH. The DON stated that it should have been reported because it was "injury of unknown origin. However, according to LNHA the incident was not reported to the NJDOH because during the investigation, resident's NJ EX Order: 264b1 was observed when he/she was found on the floor on NJ EX Order: 264b1. The LNHA confirmed that the NJ EX Order: 264b1 and how the resident acquired the NJ EX Order: 264b1 was not witness.</p> <p>The facility was unable to provide documentation that the aforementioned incident was reported to the NJDOH.</p> <p>A review of the facility's policy titled Abuse Investigation and Reporting dated 1/2023, indicated "Policy Statement All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Finding of abuse investigations will also be reported...1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual...Reporting 1. All alleged violation involving abuse, neglect, exploitation, or mistreatment will be reported by the facility administrator, or his/her designee, to the following persons or agencies. A. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State</p>	F 609			

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F 609	Continued From page 4 Ombudsman...2. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury..." NJAC 8:39-9.4(f)	F 609			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315387	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 8/29/2023	Y3
NAME OF FACILITY ALLAIRE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 115 DUTCH LANE ROAD FREEHOLD, NJ 07728		

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 F0609	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	08/28/2023	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/12/2023

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