STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD ALLENWOOD, NJ 08720**

(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 Complaint #: 171958, 176667, 181275 Survey Date: 2/25/25 Census: 133 Sample: 29 + 3 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 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability	F 645		3/25/25

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

Electronically Signed | 03/13/2025

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 645	Continued From page 1 authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an	F 645		

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F 645	Continued From page 2 intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed ensure a NJ Exec Order 26.4b1) was completed accurately for a newly admitted resident. This deficient practice was identified for 1 of 2 residents reviewed for NJ Exec Order 26.4b1 (Resident #9), and was evidenced by the following: On 2/19/25 at 11:10 AM, during the initial tour of the facility, Resident #9 was observed in the day room. A review of the Admission Record face sheet (an admission summary) indicated Resident #9 had medical diagnoses which included but were not limited to; NJ Exec Order 26.4b1 . A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 revealed the resident had a Brief Interview of Mental Status score of NJ Exec out of 15, meaning the resident had NJ Exec Order 26.4b1 A review of Section NJ Exec Order 26.4b1 revealed that the resident had diagnoses including NJ Exec Order 26 A review of the resident's individualized comprehensive care plan included a focus area dated NJ Exec Order 26.4b1, for multiple medications related to diagnoses of NJ Exec Order 26.4b1 ,	F 645	1. On 02/25/25 Resident #9's NJ Exec Order 26.4b1 was updated, and a NJ Exec Order 26 evaluation initiated if required. US FOIA was immediately re-educated on 02/25/25 by administrator ensuring NJ Exec Order 26.4b1 is accurately completed. 2. All residents who have a documented diagnosis of Mental Illness have the potential to be affected by the cited practice. 3. On 02/25/25 the US FOIA (b)(6) were re-educated by the Administrator on PASARR requirements ensuring PASRR Level 1 is accurately completed to reflect Mental Illness diagnosis as reflected in the resident medical records. The same in-service education will be provided during orientation of a newly hired social worker and admission director, annually and as deemed necessary. 4. The social worker and or designee will review new admission to assure that PASARR level 1 is accurately completed for resident with diagnosis of Mental illness as reflected in the resident medical records. The social worker will review a copy of Psychiatry consults to ensure that resident with Mental Illness diagnosis is accurately reflected in the PASSAR or if a need for new PASSAR level 1 needs to be completed to reflect resident mental illness diagnosis.	

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F 645	Continued From page 3 NJ Exec Order 26.4b1 . The ICCP included an additional focus area dated NJ Exec Order 26.4b1 that the resident utilized NJ Exec Order 26.4b1 medications related to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. On 2/21/25 at 9:15 AM, the facility provided the surveyor with the resident's NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 screening, section two titled 'NJ Exec Order 26.4b1" was marked 'NJ Exec [illegible] for the resident having a diagnosis or evidence of a NJ Exec Order 26.4b1 On 2/25/25 at 10:30 AM, during an interview with the US FOIA (b)(6)), the US FOIA (b) told the surveyor that the US FOIA (b)(6) who was responsible for the NJ Exec Order 26.4b1 was "Very good, I don't know what happened, she missed it. I think she was out of work at the time." A review of a facility's "Resident Assessment-Coordination with PASARR" policy dated revised 7/2024, included the Social Services Director shall be responsible for keeping track of each resident's PASARR evaluation report... NJAC 8:39-27.1 (a)	F 645	5. Administrator/designee will conduct weekly audits for 5 residents x 4 and then monthly x 3 on ensuring PASRR Level 1 is accurately completed to reflect Mental Illness diagnosis as reflected in the resident medical record. Negative findings will be addressed through one on one education and or progressive disciplinary measures as appropriate. Results of the audits will be reported to the QAA (Quality assurance committee) who meet quarterly and will review and determine the frequency and necessity for future audits	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		3/25/25

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F 657	Continued From page 4 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to revise an individual comprehensive care plan (ICCP) with the resident's personal preference for NJ Exec Order 26.4b1 care and the need for NJ Exec Order 26.4b1. This deficient practice was identified in 1 of 9 residents observed for NJ Exec Order 26.4b1 care (Resident #35), and was evidenced by the following: On 2/19/25 at 9:55 AM, during initial tour of the facility, the surveyor accompanied by the US FOIA (b)(6)), observed NJ Ex Order 26.4b1 for Resident #35. The surveyor observed that the resident had an NJ Exec Order 26.4b1 on with a NJ Exec Order 26.4b1 on top. At that time, the US FOIA (b informed the surveyor that it was the	F 657	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident #35 was NJ Exec Order 26.4b1 by the cited practice. Resident # 35 care plan was immediately updated on 2/19/25 to reflect the resident's preference of having NJ Exec Order 26.4b1 . The US FOIA (b)(6) involved was provided with one on one re-education on 1/19/2025 by the nurse educator regarding revisions of the Comprehensive care Plans processes to reflect appropriate interventions including resident's preferences. Element 2: Address how the facility will	

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F 657	Continued From page 5 resident's preference to wear NJ Exec Order 26.4b1 . The surveyor asked the resident if they had a preference to be NJ Exec Order 26.4b1 and the resident stated NJ Exec O due to the NJ Exec Order 26.4b1 On 2/21/25 at 11:22 AM, the surveyor reviewed Resident #35's electronic medical record (EMR) and the following was indicated: A review of the Admission Record face sheet (an admission summary) indicated that the resident was admitted to the facility with diagnosis which included but was not limited to; NJ Exec Order 26.4b1 A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool assessment dated NJ Exec Order 26.4b reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exe out of 15, which indicated NJ Exec Order 26.4b1 . The MDS further revealed that the resident was NJ Exec Order 26.4b1 on staff for NJ Exec Order 26.4b1 and was always NJ Exec Order 26.4b1 . A review of the ICCP included a focus area dated NJ Exec Order 26.4b1 , for a risk for NJ Exec O and/or have NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 . The ICCP included an update dated NJ Exec Order 26. , the same day as surveyor inquiry, that the resident preferred and requested to wear an NJ Exec Order 26.4b1 . On 2/21/25 at 11:57 AM, the surveyor interviewed the US FOIA (b)(6)	F 657	identify other residents having the potential to be affected by the same deficient practice. All residents that require incontinence care have the potential to be affected by the cited practice. Care plans of residents requiring incontinence brief were audited to ensure that double incontinence brief preference reflects the care plans. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Nurses and CNAs were re- in serviced on the facility's protocol in reporting resident's preferences with emphasis for residents who preferred to wear double incontinence brief. This in-service was initiated on 2/26/25 by the nurse educator and ongoing. Same in-service will be given during orientation of a new nurse, CNA's, annually and as deemed necessary. The nurse educator re-in serviced nurse Unit Managers, nurses and IDT members who have the responsibility in completing resident's Comprehensive Care Plan regarding care plan updates/revisions to reflect residents' preferences. This in-service was conducted on 2/26/25 and ongoing. Same in-service will be given during orientation for a newly hired nurse unit manager, IDT members, annually and as deemed necessary. Newly admitted residents' care plans will be reviewed by the IDT to ensure preferences are addressed and care	

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F 657	Continued From page 6 (US FOIA (b)(6)) in the presence of the US FOIA (b)(6) [redacted] stated that the CNA's responsibilities when it came to NJ Exec Order 26.4b1 care was to ensure the residents were checked every two hours and to treat the residents with respect. The US FOIA (b)(6) stated that residents should not, under normal circumstances, be NJ Exec Order 26.4b1 as it could NJ Exec Order 26.4b1, which could lead to NJ Exec O [redacted], as well as take away from the resident's dignity. The US FOIA (b)(6) further stated that residents had the right to prefer to NJ Exec Order 26.4b1, but nursing staff were responsible to educate and update the care plan to include the resident's preference, and the CNAs were expected to communicate with the nurses to ensure it was completed. The US FOIA (b)(6) acknowledged that Resident #35's care plan was not updated to indicate the resident's preference for NJ Exec Order 26.4b1 until after the surveyor's observation and inquiry. On 2/21/25 at 12:23 PM, the surveyor interviewed the US FOIA (b)(6) [redacted]), who stated that residents had the right to their preference in care, including to be NJ Exec Order 26.4b1, but nursing was responsible to educate the resident and family, and to update the resident's care plan timely the moment the resident's preference was known or within 24 hours. On 2/21/25 at 12:55 PM, the surveyor observed Resident #35 in their room watching television. The resident informed the surveyor that they had been at the facility for approximately NJ Exec Order 26.4b [redacted] and that they informed "the nurse that passes the medication" that they preferred to be NJ Exec Order 26 [redacted] when they were first admitted to the facility.	F 657	planned during care plan meeting or as needed. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. DON and or designee will interview 5 CNA" s and residents who requires incontinence care for incontinence brief preferences weekly x 4 and then monthly x 4 months to assure that residents preferences are reflected in the resident's plan of care. Negative findings will be addressed through one on one re-education and or progressive disciplinary measures as appropriate. Unit manager or nursing staff designee will perform an incontinent audit for 10 residents covering all shifts weekly x 4 and then monthly x 4 months to assure that residents having double incontinence brief are addressed in the resident's plan of care. Negative findings will be addressed though one on one re-education and progressive disciplinary measures as appropriate.	

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F 657	Continued From page 7 On 2/24/25 at 12:29 PM, the surveyor interviewed the [US FOIA (b)(6)] who confirmed that Resident #35 was [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] to make their [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. On 2/25/25 at 9:30 AM, the [US FOIA (b)(6)] in the presence of the survey team, acknowledged that Resident #35's care plan should have been updated prior to surveyor inquiry and observation, and that the resident's preference should have been communicated by the nursing staff. A review of the facility's "Comprehensive Care Plans" policy with a last revised date of 7/2024, included the care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed... NJAC 8:39-27.1(a)	F 657		
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: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that proper [NJ Exec Order 26.4b1] care was provided to	F 677	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice.	3/25/25

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F 677	Continued From page 8 NJ Exec Order 26.4b1 residents. This deficient practice was identified for 1 of 9 residents observed for NJ Exec Order 26.4b1 care (Resident #43), and was evidenced by the following: On 2/19/25 at 9:55 AM, during initial tour of the facility, the surveyor accompanied by the US FOIA (b)(6) [redacted], observed NJ Exec Order 26.4b1 care for Resident #43. The surveyor observed that the resident had an NJ Exec Order 26.4b1 on with a NJ Exec Order 26.4b1 [redacted]. The surveyor asked the resident if they had a preference to be NJ Exec Order 26.4b1, and the resident NJ Exec Order 26.4b1 their NJ Exec Order 26.4b1 [redacted]. On 2/19/25 at 10:09 AM, the surveyor interviewed the US FOIA (b)(6) who stated that residents should not be NJ Exec Order 26.4b1 and that residents who required NJ Exec Order 26.4b1 care should have been checked every two hours at a minimum to ensure they were NJ Exec [redacted] On 2/21/25 at 11:27 AM, the surveyor reviewed Resident #43's electronic medical record (EMR) and the following was indicated: A review of the Admission Record face sheet (an admission summary) indicated that the resident was admitted to the facility with diagnosis which included but was not limited to; NJ Exec Order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b [redacted] reflected the resident had a Brief Interview for Mental Status (BIMS) score of NJ [redacted] out of 15, which indicated the resident had NJ Exec Order 26 [redacted]	F 677	Resident # 43 was NJ Exec Order 26.4b1 impacted by the cited practice. Resident # 43 was immediately NJ Exec Order 26.4b [redacted] from a NJ Exec Order 26.4b1 brief to a NJ Exec Order 26.4b1 [redacted] by the CNA. CNAs were immediately in serviced by Nurse Educator on 2/19/25, regarding Residents' Dignity with emphasis on not utilizing NJ Exec Order 26 [redacted] and potential adverse effects unless otherwise it's in accordance with the residents' plan of care. . Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice All dependent residents for ADL care have the potential to be affected by the cited practice. Incontinence checks were conducted by nurses for residents who are ADL care dependent, no negative findings were observed. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Re-education of CNAs and other nursing staff was initiated on 2/26/25 by nurse educator and ongoing regarding Residents' Dignity and adverse effects of double incontinence //brief utilization for ADL care dependent residents. The same in-service will be given to newly hired nursing staff during orientation annually and as needed. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 677	Continued From page 9 NJ Exec Order 26.4b1. The MDS further revealed that the resident was NJ Ex Order 26.4b1 on staff for NJ Exec Order 26.4b1 and was frequently NJ Exec Order 26.4b1 of NJ Exec Order and NJ Exec Order 26.4b A review of the individualized comprehensive care plan (ICCP) included a focus area with an initiation date of NJ Exec Order 26.4b1 that the resident was at risk for activities of daily living (ADL) NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. On 2/21/25 at 11:57 AM, the surveyor interviewed the US FOIA (b)(6) the presence of the US FOIA (b)(6) stated that CNA's responsibilities when it came to NJ Exec Order 26.4b1 care was to ensure the residents were checked every two hours and to treat the residents with respect. The US FOIA (b)(6) stated that residents should not, under normal circumstances, be NJ Exec Order 26.4b1 because it could cause NJ Exec Order 26.4b1, which could lead to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 as well as take away from the resident's dignity. On 2/21/25 at 12:23 PM, the surveyor interviewed the US FOIA (b)(6)), who confirmed that residents should not be NJ Exec Order 26.4b1 as it could take away from their dignity and could cause NJ Exec Order 26.4b1. The US FOIA (b) confirmed that Resident #43 was NJ Exec Order 26.4b1 preferences and should not have been NJ Exec Order 26 On 2/25/25 at 9:30 AM, the US FOIA (b)(6) in the presence of the survey team, acknowledged that residents should not have been NJ Exec Order 26.4b1.	F 677	Unit manager or nursing staff designee will perform an incontinent audit for 10 residents covering all shifts weekly x 4 and then monthly x 4 months to assure residents are not applied with double incontinent briefs. Negative findings will be addressed though one on one re-education and progressive disciplinary measures as appropriate. The results of all audits will be submitted to the QAA committee who meets quarterly for review and will determine the necessity of future audits and recommendations.	

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F 677	Continued From page 10 After multiple requests from the surveyor, the facility was unable to provide a policy that included the NJ Exec Order 26.4b1 [redacted] care procedure. NJAC 8:39-27.1(a); 27.2(h)	F 677		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		3/25/25

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	315397	A. BUILDING _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD ALLENWOOD, NJ 08720**

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F 758	Continued From page 11 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and the review of pertinent facility documentation, it was determined that the facility failed to a.) provide supportive rational for starting a new NJ Exec Order 26.4b1 medication and b.) document NJ Ex Order 26.4b1 for a resident on NJ Exec Order 26.4b1 medication. This deficient practice was identified for 1 of 3 residents reviewed for NJ Exec Order 26.4b1 medication use (Resident #88), and was evidenced by the following: A review of the Admission Record face sheet (admission summary) indicated that Resident #88 was admitted to the facility with the diagnoses which included but was not limited to; NJ Exec Order 26.4b1 [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1	F 758	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident # 88 NJ Exec Order 26.4b1 of the cited practice. The license nurses that were involved in this cited practice were re-educated on facility's policy on NJ Ex Order 26.4b1 and documentation for residents receiving NJ Exec Order 26.4b1 medications. This Inservice was provided and completed by the nurse educator on 2/20/25. . Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents that are prescribed psychotropic medications have the potential to be affected by the cited	

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F 758	Continued From page 12 reflected that Resident #88 had NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The MDS also indicated that the resident required NJ Exec Order 26.4b1 from another person to complete activities of daily living (ADLs). On 2/19/25 at 11:06 AM, during initial tour, the surveyor observed Resident #88 sitting up in the wheelchair in the dining room, NJ Exec Order 26.4b1 The resident was unable to be interviewed due to NJ Exec Order 26.4b1. The surveyor reviewed the resident's electronic medical record (EMR) which revealed the following: A review of the Physician Order Summary Report (POSR) dated NJ Exec Order 2, reflected that Resident #88 was ordered the NJ Exec Order 26.4b1 tablet; administer 1 tablet by mouth every 12 hours as needed for NJ Exec Order 26 for 14 days. A review of the nursing Progress Note (PN) dated NJ Exec Order 26 indicated that the nurse discussed with the US FOIA (b)(6)) the resident's NJ Exec Order 26.4b1 of frequent and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and that staff were having difficulty NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1 The note reflected that the US FOIA (b) discussed with the resident's Responsible Party (RP) and ordered the NJ Exec Order 26.4b1 as needed (prn) for 14 days. A review of the the Progress Notes from NJ Exec Order 2 prior to the order for the NJ Exec Order 26 there was no supporting documentation on the evening or night shifts that the resident was exhibiting NJ Exec Order 26.4b1, and that staff were	F 758	practice. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. License nurses were provided with re-education regarding facility policy on behavior monitoring and documentation and non- pharmacological intervention utilized before administration of any PRN psychotropic medications for residents receiving psychotropic medications by the facility nurse educator on 2/27/2025 and ongoing. CNAs were re-educated on the importance of reporting behavior observed to the nurses during their shift, by the nurse educator. This re-education was initiated on 2/27/25 and ongoing. This education will be given during orientation for a newly hired license nurse and CNAs, annually and as needed. A revised facility policy on “Behavior Management, Interventions and Monitoring” was adopted on 3/4/25, a Behavior Flow sheets will be utilized for behavior monitoring and documentation. In-service/education of licensed nurses on this revised Policy and Procedure on Behavior Management, Interventions and Monitoring was started on 3/6/25 and ongoing. Same in-services will be given to newly hired nurses, cnas during orientation, annually and as deemed necessary An audit form has been developed that will be utilized in auditing behavior monitoring and documentation for residents receiving psychotropic medication.	

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F 758	Continued From page 13 having difficulty NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed that the resident received NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . A review of the corresponding PN dated NJ Exec Order 26.4b1 , included no NJ Ex Order 26.4 documentation to support the administration of the NJ Exec Order 26.4b1 medication on those dates. A review of Resident #88's individualized comprehensive care plan (ICCP) indicated that the staff focused on the use of NJ Exec Order 26.4b1 medication for the NJ Exec Order 26.4b1 such as NJ Exec Order 26.4b1 to the point of NJ Exec Order 26.4b1 Interventions included: medications were to be administered as ordered and to monitor and document for side effects and effectiveness of medications; monitor/record occurrences for NJ Exec Order 26.4b1 symptoms such as NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 toward staff and others and document as per the facility policy. A review of the NJ Ex Order 26.4b1 Monthly Review dated NJ Exec Order 26.4b1 reflected that the resident had NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 such as NJ Exec Order 26.4b1 to the point of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1 reflected that the resident was seen for a NJ Exec Order 26.4b1 follow-up and medication management. The US FOIA (b)(6) documented that the resident was re-examined and that staff had reported that the resident had periods of NJ Exec Order 26.4b1	F 758	Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Unit Managers and or nurse designee will perform a weekly audit for 10 residents x 4 weeks then monthly x 4 who receives psychotropic medications to assure that behavior is monitored and documented in the resident medical record. Negative findings will be addressed though one on one re-education and progressive disciplinary measures as appropriate. The results of all audits will be submitted to the QAA committee who meets quarterly for review and will determine the necessity of future audits and recommendations.	

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F 758	Continued From page 14 NJ Exec Order 26.4b1 and was more NJ Exec Order 26.4b1 during the daytime hours. The documentation indicated that the resident had NJ Exec Order 26.4b1, or other symptoms of NJ Exec Order 26.4b1 process that were reported. The US FOIA (b)(6) also documented that the resident had NJ Exec Order 26.4b1 that were reported and no side effects to medications. The surveyor reviewed Resident #88's progress notes which did not reflect that the resident's NJ Exec Order 26.4b1 of NJ Exec Order 2 were being documented or that the staff had attempted non-pharmacological approaches to NJ Ex Order 26.4b1 to obtaining a physician's order for the use of an NJ Exec Order 26.4b1 medication. On 2/20/25 at 12:15 PM, the surveyor interviewed the US FOIA (b)(6)), who stated that when any resident in the facility who was started on new NJ Exec Order 26.4b1 medication, the nurse assigned to the resident was required to document what NJ Exec Order 26.4b1 the resident was exhibiting. The US FOIA (b stated that NJ Ex Order 26.4b1 were documented by exception; that before a NJ Exec Order 26.4b1 medication was ordered, there should be documentation in the resident's medical records that the resident was NJ Exec Order 26.4b1 were, and non-pharmacological interventions that were attempted prior to administration of NJ Exec Order 26.4b1 medications. The US FOIA (b stated that after the resident was started on a NJ Exec Order 26.4b1 medication, the nurses were to document for 14 days after initiating the new NJ Exec Order 26.4b1 drug. On 2/20/25 at 12:19 PM, the surveyor interviewed the US FOIA (b)(6)), who stated that when a resident was on a NJ Exec Order 26.4b1 medication, that documentation	F 758		

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F 758	Continued From page 15	F 758		

included monthly [redacted] notes. The [redacted] stated that the [redacted] was updated every Friday when they came in to see the residents. The [redacted] explained that she had documented on [redacted] at 4:09 PM, that Resident #88 was having [redacted] and staff had difficulty [redacted] the resident during the night hours. The surveyor asked the [redacted] who reported those [redacted] because a review of the clinical documentation did not reflect that the resident was [redacted] any [redacted] at night prior to the [redacted] being ordered. The [redacted] stated that it was reported to her by the resident's [redacted] and not by the clinical staff. The surveyor asked the [redacted] if the resident was assessed for [redacted] or any other reasons that they may have been [redacted] and the [redacted] stated that she did not document that and could not recall. The [redacted] confirmed it would have been important to document if any non-pharmacological interventions were attempted prior to starting the resident on [redacted] The [redacted] reviewed the resident's nursing progress notes and the 24-hour report and could not find any documentation from the clinical staff that the resident was [redacted] at night [redacted] and was [redacted]. The [redacted] stated that [redacted] was done by exception, and that documentation would only occur if the resident was [redacted] The [redacted] stated that after starting any new medication, the resident was monitored for 14 days. The [redacted] reviewed the resident's medical record and could not find any documentation indicating that the use of the [redacted] medication [redacted] was being monitored for effectiveness after use.

The surveyor reviewed the facility 24-hour report

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F 758	Continued From page 16	F 758		

from NJ Ex Order 26.4b1, and there was no documentation that Resident #88 was NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 such as NJ Exec Order 2 or NJ Exec Order 26.4b1 or that the resident was NJ Exec Order 26.4b1.

On 2/21/25 at 8:49 AM, the surveyor interviewed the primary care US FOIA (b)(6)), who stated that the resident was NJ Exec Order 26.4b1 but was able to NJ Exec Order 26.4b1. The US FOIA (b) stated that the resident would NJ Exec Ord care at times, but was NJ Exec Or to NJ Exec Order 26.4b The US FOIA (b) stated that the resident NJ Exec Order 26.4b1 more NJ Exec Order 26.4b1 at night such as NJ Exec Order 26.4b1, but he did not know how often it had occurred. The US FOIA (b) continued to explain that when Resident #88 NJ Exec Order 26.4b care, he just NJ Exec Order the resident through it, and then the resident would NJ Exec Order 26.4b1 care to be performed. The US FOIA (b) also added that the resident had NJ Exec Order 26.4b1 such as NJ Exec Order 26.4b1 but did not exhibit it all the time.

On 2/25/25 at 9:32 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she had reviewed the resident's medical record and agreed that there was no documentation that the resident was NJ Exec Order 26.4b1 such as NJ Exec Order 26.4b1 at night prior to obtaining an order for the NJ Exec Order 26.4b1. The US FOIA (b) also confirmed that there was no documentation of any non-pharmacological interventions initiated prior to administration of the medication.

A review of the facility's "Use of Psychotropic Drugs" policy dated 1/2025, included that a resident who had not used psychotropic drugs were not to be given these drugs or prn psychotropic medications unless the medication was necessary to treat a specific condition diagnosed and documented in the clinical

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F 758	Continued From page 17 record...	F 758		
F 812 SS=F	NJAC 8:39-29.3(a); 33.2 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) maintain kitchen equipment in a clean and sanitary manner and b.) maintain pantry equipment in a clean and sanitary manner on 3 of 3 units. The evidence was as follows: On 2/19/25 at 9:31 AM, the surveyor toured the kitchen in the presence of the US FOIA (b)(6) [redacted] and observed the following:	F 812	The stand mixer was covered with a clear plastic bag which indicated that it was clean. The FSD removed the bag and the connecting bearing that holds the mixer attachment had hard dried white sediment on it. The Food service director was able to wipe it off with a gloved hand. The FSD acknowledge it was not properly cleaned. 1. The Mixer Was Immediately Cleaned and sanitized and re-bagged. 2. All residents have the potential to be	3/25/25

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F 812	Continued From page 18 1. The stand mixer was covered with a clear plastic bag which indicated that it was clean. The US FOIA (b) removed the bag and the connecting bearing that holds the mixer attachment had hard dried white sediment on it. The US FOIA (b) was able to wipe it off with a gloved hand. The US FOIA (b) acknowledge it was not properly cleaned. 2. The can opener blade was worn, discolored, and had a rolled pointed edge. The US FOIA (b) acknowledged it look like it had not been changed in a while and that it needed to be to prevent injury, metal splintering and cross contamination of food particles. 3. The microwave interior ceiling was covered with dried stuck on debris in a range of different colors. The US FOIA (b) acknowledged and stated, it was not cleaned according to policy. On 2/19/2025 at 9:45 AM, the surveyor interviewed the US FOIA (b) who stated the mixer, microwave, and can opener blade did not meet her's or the facility policy's expectations. The US FOIA (b) acknowledged that the equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination. On 2/21/25 at 9:28 AM, in the presence of the US FOIA (b)(6)), the surveyor observed the following: 1. The B-unit pantry had debris on the counter, in one cabinet drawer, and on two lower cabinets. The gaskets on the refrigerator door had particle buildup of white and brown debris in the gasket folds. 2. The C-unit pantry had a water dispenser that	F 812	affected by this deficient practice. 3. All Dietary Staff has been re-educated by the Administrator on 02/19/2025 on how to properly clean and sanitize dietary equipment. Re-educating will be completed monthly by administrator/designee for 3 months for all dietary employees. 4. Checking the cleanliness of the equipment has been added to the Manager's QA checklist. Food service director will audit Weekly for 1 month then monthly for 2 months. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits. The can opener blade was worn, discolored, and had a rolled pointed edge. The FSD acknowledged it look like it had not been changed in a while and that it needed to be to prevent injury, metal splintering and cross contamination of food particles. 1. The can opener was immediately cleaned and switched out. 2. All residents have the potential to be affected by this deficient practice. 3. All Dietary Staff has been re-educated by the Administrator on 02/19/2025 on how to properly clean and sanitize dietary equipment and for the need to check the can opener blade prior to use to ensure blade is not worn, discolored, or has rolled edges on. Administrator/Designee will	

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F 812	Continued From page 19 required maintenance that was indicated by the flashing wrench on the electronic screen. Two cabinet drawers had white and black sediment and debris on the interior portion. The refrigerator gaskets had debris inside of the folds. 3. The D-unit pantry had stains and debris in several cabinet drawers and on the counter. The gasket on the refrigerator door had debris in the folds, a tare in the gasket on the top of the door corner and the gasket at the base of the refrigerator door was covered with black discoloring, torn, and falling off the refrigerator. On 2/19/25 at 9:50 AM, the surveyor interviewed the [US FOIA] who acknowledged that the pantry equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination. On 2/25/25 at 09:30 AM, the survey team met with the [US FOIA (b)(6)], who both acknowledged the surveyor's concerns. No additional information was provided. A review of the facility's "General Kitchen Sanitation Policy", dated 8/2024, included clean and sanitize all food preparation areas after use...keep food contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated debris... A review of the facility's "Nursing and housekeeping and dietary Policy," dated 1/2025, revealed ensure all pantry areas in the facility are maintained in a clean and sanitary condition, in compliance with NJDOH and CMS infection control regulations, to prevent contamination and	F 812	conduct re-educating for all dietary staff monthly for 3 months. 4. Checking the Can opener has been added to the Manager's QA checklist and will be monitored by Food service director weekly for one Month and monthly for 2 months. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits. The microwave interior ceiling was covered with dried stuck on debris in a range of different colors. The FSD acknowledged and stated, it was not cleaned according to policy. 1. The microwave was immediately cleaned and sanitized per protocol, 2. All residents have the potential to be affected by this deficient practice. 3. All Dietary Staff has been in-serviced by the Administrator on 02/19/2025 on how to properly clean and sanitize dietary equipment. Re-educating will be completed monthly by administrator/designee for 3 months for all dietary employees. 4. Checking the cleanliness of the equipment has been added to the Manager's QA checklist. Food service director will audit Weekly for 1 month then monthly for 2 months. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the	

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F 812	Continued From page 20 ensure resident safety ...countertops, sinks and high touch surfaces to wiped and disinfected daily...refrigerators must be fully cleaned and sanitized...cabinets and storage shelves must be emptied, wiped and reorganized...any maintenance issues must be reported immediately to the maintenance department... NJAC 8:39-17.2(g)	F 812	frequency and necessity for future audits. 1. The B-unit pantry had debris on the counter, in one cabinet drawer, and on two lower cabinets. The gaskets on the refrigerator door had particle buildup of white and brown debris in the gasket folds. 2. The C-unit pantry had a water dispenser that required maintenance that was indicated by the flashing wrench on the electronic screen. Two cabinet drawers had white and black sediment and debris on the interior portion. The refrigerator gaskets had debris inside of the folds. 3. The D-unit pantry had stains and debris in several cabinet drawers and on the counter. The gasket on the refrigerator door had debris in the folds, a tare in the gasket on the top of the door corner and the gasket at the base of the refrigerator door was covered with black discoloring, torn, and falling off the refrigerator. 1. Al three Pantries were immediately deep cleaned as per policy a new water machine was installed on 02/26/2025 on the C unit. A new refrigerator was ordered and will be installed on 03/15/2025 for the D unit 2. All residents have the potential to be affected by this deficient practice. 3. All Housekeeping staff were	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21	F 812	re-educated by the administrator on 02/19/2025 on proper cleaning and sanitizing of pantry equipment to prevent food borne illness and contamination. Administrator/Designee will re-educated all housekeeping staff monthly for 3 months. 4. Housekeeping director/designee will conduct weekly audits of the Pantry Equipment to ensue they are properly cleaned and sanitized weekly for 1 month then Monthly for 2 months to ensure compliance and submit reports to the administrator. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits. 5. Completion date: 03/25/2026	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/25/25

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	315397	A. BUILDING _____ B. WING _____	C 02/25/2025

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F 880	Continued From page 22 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 23 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure NJ Exec Order 26.4b1 were maintained while providing direct resident care in accordance with infection control standards of practice and facility policy. The deficient practice was identified for 1 of 9 residents observed for NJ Exec Order 26.4b1 care (Resident #105), and was evidenced by the following: A review of Resident #105's Admission Record face sheet (admission summary) indicated that the resident was admitted to the facility with NJ Exec Order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, indicated that the resident had NJ Exec Order 26 and required NJ Exec Order 26.4b1 with all aspects of activities of daily living (ADLs). On 2/19/24 at 9:55 AM, the US FOIA (b)(6) accompanied the surveyor to conduct NJ Exec Order 26.4b1 rounds for	F 880	1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice.: Resident # 105 was NJ Exec Order 26.4b1 by this cited practice. US FOIA (b)(6) involved was immediately re-in serviced by Infection Preventionist on NJ Exec Or Policy and Procedure with return demonstration on don/doff of PPE on 2/19/25. 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents that are identified on EBP have the potential to be affected by this cited practice. Staff were re-educated by Nurse Educator on the Policy and Procedure on Enhanced Barrier Protection with return demonstration on how to don/doff PPE. This re-education was initiated on 2/26/25. 3: Address what measures will be put into place or systemic changes made to	

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F 880	Continued From page 24 Resident #105. Prior to entering the resident's room, the surveyor observed signage posted on the door that indicated that a resident in that room was on NJ Exec Order 26.4b1). There was also a personal protective equipment (PPE) caddy hanging on the door which contained gloves, NJ Exec Order 26.4b gowns, and masks. The resident was observed lying in bed and was NJ Exec Order 26.4b1 The surveyor observed that Resident #105 was NJ Exec Order 26.4b1 and was wearin NJ Exec Order 26.4b1 The US FOIA (b) put on gloves and proceeded to NJ Exec O the resident to check the resident's NJ Exec Order 26.4b1 and stated that the resident was NJ Exec Orde and NJ Exec O The US FOIA (b)(6) was only wearing gloves at that time. The US FOIA (b)(6) performed hand hygiene after resident care. The surveyor asked the US FOIA (b)(6) the resident was on NJ Exec Order 26.4b1 , and US FOIA (b)(6) responded that Resident #105 was on NJ Exec O due to a NJ Exec Order 26 The US FOIA (b)(6) acknowledged that she did not apply an NJ Exec Order 26.4b /protective gown prior to performing direct care for the resident. The US FOIA (b)(6) that the gown was important to apply to protect the resident from any NJ Exec Order 26.4b1 that she may have had on her clothing that could be transferred to the resident and cause an NJ Exec Order 26.4b1 On 2/21/25 at 8:54 AM, the surveyor interviewed the primary care US FOIA (b)(6)), who stated that Resident #105 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with all aspect of ADLs. The US FOIA (b) stated that the staff were required to apply (don) PPE prior to providing direct resident care. The US FOIA (b) stated that Resident #105 was on NJ Exec Order 26.4b1 because the resident had a NJ Exec Order 26 on their NJ Exec Order 26.4b1 .	F 880	ensure that the deficient practice will not recur: Staff were re-educated on EBP Policy and Procedure by IP and Nurse Educator. Competency testing of nursing staff was also initiated. These in service and competency testing will be done upon hire, annually and as needed. 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Infection Preventionist will audit 5 staff for compliance with EBP policy and procedure on residents identified on EBP weekly x 4 weeks then 10 staff monthly x 4 months. Audit tools will be presented weekly in nurse meeting and staff with negative outcome will have one on one in service with IP and may include progressive disciplinary action as needed. The results of all audits will be submitted to the QAA committee who meets quarterly for review and will determine the necessity of future audits and recommendations.	

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F 880	Continued From page 25 On 2/21/25 at 11:16 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that the US FOIA (b)(6) should have worn an NJ Exec Order 26.4b gown when performing direct care with Resident # 105. The US FOIA stated that the importance of wearing PPE while caring for a resident with NJ Exec Order 26.4b1 to the NJ Exec Order was to protect the resident from any NJ Exec Order 26.4b that could be transferred from the caregivers' clothes to the resident. A review of Resident #105's individualized comprehensive care plan (ICCP) dated NJ Exec Order 26.4b1 reflected that the resident was on NJ Exec Order related to having a NJ Exec Order 26 The interventions included that staff wore a gown and gloves when providing high contact activity such as NJ Exec Order 26.4b1 is anticipated, providing NJ Exec Order 26.4b NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 A review of the Physician's Order Summary Report dated NJ Exec Order 26.4b1 , included a physician's order (PO) to maintain NJ Exec Order due to the residents NJ Exec Order 2 every shift. A review of the Medication Administration Record (MAR) dated NJ Exec Order 26.4b1 , reflected an PO to maintain NJ Exec Order due to NJ Exec Order 26 every shift. On 2/25/25 at 9:40 AM, the US FOIA (b)(6) confirmed that all nurses should don the proper PPE that was specified by the signage on the resident's door prior to providing direct resident care for a resident that was on NJ Exec Orde A review of the facility's "Enhanced Barrier Precautions" dated 3/21/24, included EPB was utilized for the prevention of transmission of	F 880		

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F 880	Continued From page 26 targeted multi-resistant organism to keep residents safe. The policy indicated that EBP is initiated for residents meeting the criteria such as wounds and indwelling medical devices. Implementation of EBP specified that gowns and gloves be available for use during high contact activities... NJAC 8:39-19.4 (a); 27.1(a)	F 880		

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
315397 Y1	A. Building B. Wing Y2	4/9/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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 F0645	Correction	ID Prefix F0657	Correction	ID Prefix F0677	Correction
Reg. # 483.20(k)(1)-(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	03/25/2025	LSC	03/25/2025	LSC	03/25/2025
ID Prefix F0758	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/25/2025	LSC	03/25/2025	LSC	03/25/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/25/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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E 000	Initial Comments This Facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 2/21/25 and 2/24/25 and the facility 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. The building construction was stated to be 90's with no current major renovations or noted additions. It is a one-story building with Type V (111) protected construction and is fully sprinklered. The facility is divided into 14 smoke zones. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, fire pump, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The 500 KW generator powers 100 % of the building. The fire sprinkler system utilizes an electric fire pump.	K 000		

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

Electronically Signed | 03/13/2025

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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K 000	Continued From page 1 The facility has 135 certified beds. At the time of the survey the census was 133.	K 000		
K 227 SS=E	Ramps and Other Exits CFR(s): NFPA 101 Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/24/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to comply with the requirements of NFPA 101:2012 sect. 7.2.5 pertaining to exit ramps. The deficient practice was observed for 1 of 1 exit/egress ramps and was evidenced by the following: Observations at 11:00 AM with the US FOIA (b)(6) [redacted], revealed outside the utility exit/egress area of the building, broken concrete (tripping hazard) unstable unfinished wooden plywood ramp (approximately 4-foot by 5-foot), and no handrail to ensure staff or residents were protected from falling off the ramp in the event of an emergency exit. In an interview at the time of the observations, the US FOIA [redacted] confirmed the above finding's.	K 227	1. On 02/25/2025 we contracted a license Contractor to build and install a ramp with handrails to comply with NFPA 101 pertaining to exit ramps which was completed on 03/10/2025 2. All residents have the potential to be affected by the deficient practice. 3. On 02/25/2025 Administrator in service the US FOIA (b)(6) [redacted] and US FOIA (b)(6) [redacted] on the NFPA 101 pertaining to exit ramps including the requirement of ensuring Ramps, exit passageways, fire and slide escapes, alternating tread devices are maintained according to all local state and Federal regulations and requirements. 4. Maintenance director/designee will	3/25/25

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K 227	Continued From page 2 The facility's US FOIA (b)(6) was informed of the deficient practice during the Life Safety Code survey exit conference on 2/24/25 at 12:45 PM. NJAC 8:39-31.1(c)	K 227	conduct monthly audits of the outside utility for 3 months to ensure compliance and submit reports to the administrator. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/24/25 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to maintain a battery back-up emergency light above the interior fire pump transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 1 interior transfer switches, had the potential to affect all residents and was evidenced by the following: An observation at 11:15 AM with the US FOIA (b)(6) revealed in the electric fire pump room, that the transfer switch was not equipped with battery backed-up emergency lighting of at least a 90 minute duration in accordance with 7.9. 18.2.9.1 and 19.2.9.1. In an interview, the US FOIA (b)(6) stated	K 291	1. A battery backup emergency light was placed 03/07/2025 above the interior fire pump transfer switch in the event of failure of normal lighting as per NFPA 101 to maintain a battery backed-up emergency lighting of at least a 90 minute duration 2. All residents have the potential to be affected by the deficient practice. 3. On 02/24/25 Administrator in serviced US FOIA (b)(6) on regulation NFPA 101, Emergency Lighting including the requirement of, maintaining battery backed-up emergency lighting of at least a 90-minute duration. 4. Maintenance director/designee will conduct weekly audits for 3 months of the	3/25/25

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K 291	Continued From page 3 that the fire pump transfer switch did not have a battery back-up emergency lighting of at least a 90 minute duration in accordance with 7.9. 18.2.9.1, 19.2.9.1. The [redacted] was informed of the deficient practice at the Life Safety Code exit on 2/24/25 at 12:45 PM.	K 291	inferior pump emergency lighting to ensure compliance and submit reports to the administrator. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits.	
K 345 SS=F	NJAC 8:39-31.2(e) 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 and interviews on 2/21/25 in the presence of the [redacted], it was determined that the facility failed to ensure that deficiencies, damaged parts, or impairments found while performing the inspection, testing and maintenance of the fire alarm system were promptly corrected in accordance with NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that the semi-annual fire alarm inspection that was conducted on 9/4/24 identified that the following did not operate	K 345	1.1. On 02/24/2025 the maintenance director immediately confirmed that the supervisory alert On FACP for the tamper active dry system was repaired 1.2. On 02/24/2025 The Maintenance director confirmed that on 10/07/2024 (4)12v7ah total batteries needed for power supplies #1&#2.3) were installed and properly functioning. 1.3. On 02/24/2025 The Maintenance Director confirmed that on 10/07/2024 (2) 12v35ah batteries needed for main FACP battery cabinet located in security office	3/25/25

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K 345	Continued From page 4 correctly as per NFPA 72 standards: 1). Supervisory alert on FACP for tamper active. Dry air system is in the process of being repaired. 2).(4)12v7ah total batteries needed for power supplies #1&#2. 3). (2) 12v35ah batteries needed for main FACP battery cabinet located in security office across from power supplies #1 and #2. 4). Smoke detector functioning but damaged, located in the B-wing outside of the Medication Room, device 0293. 5). Smoke detector functioning but damaged, located in the B-wing outside room 221, device 0289. 6). Wall mount speaker strobe by room 321 not flashing. 7). Wall mount horn strobe in the fitness center, above the mini cooper, not functioning (system sensor). In an interview at the time, the [redacted] stated and confirmed record review from the facility vendor's semi annual inspection report dated: 9/4/24 and confirmed the corrections have not been completed. The [redacted] was informed of the deficient practices at the Life Safety Code exit conference on 2/24/25 at 12:45 PM. N.J.A.C. 8:39-31.2 (e) NFPA 25	K 345	across from power supplies #1 and #2 were installed and functioning. 1.4. On 02/24/2025 the Maintenance director scheduled an install for Smoke detector functioning but damaged, located in the B-wing outside of the Medication room device 0293 which will be installed 03/13/2025 1.5. On 02/24/2025 the Maintenance director scheduled an install Smoke detector functioning but damaged, located in the B-wing outside room 221, device0289.6 which will be installed on 03/13/2025 1.6. On 02/24/2025 the maintenance director immediately confirmed that Wall mount speaker strobe by room 321 was fixed on 10/07/2024 and was flashing. 1.7. On 02/24/2025 the Maintenance director confirmed that Wall mount horn strobe in the fitness center, above the mini cooper, was fixed on 10/07/2024 and was functioning (system sensor). 2. All residents have the potential to be affected by the deficient practice. 3. On 02/24/2025 the [redacted] were re-educated on the need to ensure 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. 4. Maintenance director/designee will conduct weekly audits of the record system weekly for one month then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING **01** B. WING _____	**02/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD** **ALLENWOOD, NJ 08720**

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K 345	Continued From page 5	K 345	monthly for 2 months to ensure compliance and submit reports to the administrator. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ 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 surveyor observation and interview on 2/21/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition in accordance with section 5.2.1.1.1 of National Fire Protection Association	K 353	1) On 02/24/25 we reached out to Confire Fire Protection schedule a 5-year internal obstruction of the pipe inspection on the dry system which was performed on 03/03/23. As per NFPA 25. 2) All residents have the potential to be	3/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING **01** B. WING _____	**02/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD** **ALLENWOOD, NJ 08720**

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K 353	Continued From page 6 (NFPA) 25. The deficient practice was for 1 of 1 (5-year internal obstruction of the pipe inspection) documentation and had the potential to affect all residents in the facility and was evidenced by the following: In interview conducted with the [redacted] during the record review, the [redacted] indicated the 5-year internal obstruction investigation of the pipe was conducted by another vendor (due to it being cheaper). The surveyor was not provided with that full 5-year report and results of the inspection. The current fire sprinkler vendor indicated on the 3/5/24 report that " leaks are present on the system". The [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 2/24/25 at 12:45 PM. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	affected by this deficient practice. 3) The [redacted] was in-serviced by the Administrator on 02/24/25, regarding NFPA 25 Standard for the Inspection Testing, and Maintaining of Water-based Fire Protection Systems and the requirement of conducting 5-year internal obstruction of the pipe inspection. 4) Maintenance director/designee will conduct monthly audit to confirm the five year test is on file monthly for 3 months to ensure compliance. Reports of audits will be presented to Quality Assurance Committee who meets quarterly. This committee will determine frequency and necessity for future audits.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		3/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING 01 B. WING _____	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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K 918	Continued From page 7 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 2/21/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to ensure the Emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test and failed to properly document the monthly testing of the emergency generator in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Sections: 8.1.1, 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7, This deficient practice had the potential to affect all residents and was evidenced by:	K 918	1. On 02/24/2025 the Maintenance Director immediately confirmed that our generator monthly load test was running at the 30% or greater of its nameplate. The Maintenance Director also created a new logbook to ensure proper recording of the tests to comply with NFPA 110 NFPA 99 in regard to of the generator and transfer switch. Including Emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90-minute annual load bank test. 2. All residents have the potential to be affected by the deficient practice.	

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	315397	A. BUILDING **01** B. WING _____	**02/25/2025**

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K 918	Continued From page 8 A record review on 2/21/25 at 9:30 AM of the emergency power generator logs revealed the facility did not record the percentage of the EPS nameplate KW rating that the generator was exercised monthly to determine if the load met the 30% of the nameplate rating requirement or perform a 90 minute annual load bank test for the last 12 months, normal operating temperature, identification of ATS(s) used to initiate the test, time delay for cool-down, oil pressure during test, operating temperature during test, engine exhaust temperature during test (if applicable), identification of unsatisfactory conditions and corrective action taken (including parts replaced) and battery system (corrosion, check specific gravity, electrolyte level and battery charger. In an interview on 2/21/25 at 11:00 AM, the US FOIA confirmed the record review findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 2/24/25 at 12:45 PM. NJAC 8:39-31.2 (e) NFPA 99, 110	K 918	3. On 02/25/2025 Administrator in service the US FOIA (b)(6) and US FOIA (b)(6) on the proper recording of the tests to comply with NFPA 110 NFPA 99 in regard to of the generator and transfer switch including the requirement to ensure and document that the emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test 4. Maintenance director/designee will conduct weekly audits of the generator logbook for 3 months to ensure compliance and submit reports to the administrator. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits	

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
315397 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/9/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0227	03/25/2025	LSC K0291	03/25/2025	LSC K0345	03/25/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0353	03/25/2025	LSC K0918	03/25/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/25/2025	☐ YES ☐ NO