STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING _____ B. WING _____	C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(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 #: NJ00172520 Survey Date: Census: 54 Sample: 15 + 1 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility documentation it was determined that the facility failed to maintain professional standards of clinical practice by not notifying the physician of a NJ Ex Order 26.4(b)(1) for 1 of 2 residents (Resident #38) NJ ex order 26.4b1. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching	F 658	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice. " The attending physician was notified of the NJ Ex Order 26.4(b)(1) for the resident affected by this practice. New orders were noted for lab work, a bedtime [redacted] and increased frequency of [redacted] due to NJ Ex Order 26.4(b)(1). " A [redacted] was complete to establish the resident's current [redacted] " The dietician was notified of the [redacted].	10/23/24

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

Electronically Signed | 10/02/2024

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F 658	Continued From page 1 program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 09/15/24 at 11:38 AM, during initial tour, the surveyor observed Resident #34 in bed. The resident did not have any complaints at that time. The surveyor reviewed Resident #34's electronic medical record (eMR). A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ ex order 26.4b1 [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b1 revealed the resident had a Brief Interview for Mental Status of [redacted] out of 15, indicating the resident was NJ Ex Order 26.4(b)(1). Further review of the MDS, revealed the resident was NJ ex order 26.4b1 [redacted] A review of the Care Plan (CP) revealed: "Focus: Potential for complications r/t (related to) NJ ex order 26.4b1, NJ Ex Orde NJ Ex Order 26.4(b)(1), Date initiated NJ Ex Order 26.4(b)(...Interventions: Administer NJ Ex Order 26.4 medication as ordered. Monitor for adverse effects r/t NJ Ex Order 26. med (medication) use (NJ Ex Order 26.4(b)(1),	F 658	" A quarterly care conference was held with the resident□s daughter. The current weight and interventions were reviewed. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: " All residents had the potential to be affected by this deficient practice. A review of current resident weights was reviewed and determined no other significant discrepancies in weights obtained from week to week over the last 4 weeks. This determined that no other residents were affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: To prevent recurrence, the facility has implemented the following measures: " All nursing staff was re-educated on the facility□s Weight Policy and Procedure. " All scales in the facility were re-calibrated for accuracy. A monthly check on scale calibration will be conducted by the Director of Maintenance. " All Certified Nursing Assistants were re-educated to zero out the scale prior to obtaining a weight. " All nurses were re-educated on the importance of notifying the resident□s Primary Care Physician, the Registered	

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F 658	Continued From page 2 NJ ex order 26.4b1 Date initiated: NJ ex order 26.4b1 Further review of the CP revealed: "Focus: Resident is at NJ ex order 26.4b1 Date Initiated: NJ ex order 26.4b1 Goal: Resident will maintain NJ ex order 26.4b1 . NJ Ex Order 26 NJ ex Date Initiated: NJ ex order 26.4b1 . Interventions: NJ ex order 26.4b1 A review of the NJ Ex Order 26.4(b)(1) weights revealed the following: NJ ex order 26.4b1 14:37 (2:37 PM) NJ ex order 26.4b1 NJ Ex Order 26.4(b)(1)) NJ ex order 26.4b1 13:57 (1:57 PM) NJ ex order 26.4b1 NJ Ex Order 26.4(b)(1) NJ ex order 26.4b1 15:05 (3:05 PM) NJ ex order 26.4b1 NJ Ex Order 26.4(b)(1) NJ ex order 26.4b1 16:26 (4:26 PM) NJ ex order 26.4b1 NJ Ex Order 26.4(b)(1) NJ ex order 26.4b1 10:13 (10:13 AM) NJ ex order 26.4b1 NJ Ex Order 26.4(b)(1) A reviewed of the NJ Ex Order 26.4(b)(1) assessment dated NJ ex order 26.4 revealed: NJ ex order 26.4b1 A review of the electronic Medication Administration Record (MAR) revealed a check for the day shift weight on NJ ex order 26.4. Further review of the MAR "Chart Codes/Follow up Codes" revealed the check=administered. No other documentation was noted for that order.	F 658	Dietitian, the Assistant Director of Nursing, and the resident□s family of any abnormalities or discrepancies with weights and to obtain a re-weight when discrepancies are noted. " All nurses were re-educated on the parameters for daily weights for residents with congestive heart failure. " Care plans for residents on increased weight monitoring were reviewed for accuracy. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: " The Assistant Director of Nursing or designee will review the Weight Summary Report in Point Click Care for any discrepancies on a weekly basis for 4 weeks to establish immediate compliance. Audits will then transition to monthly for 3 months to ensure sustained compliance. Audit findings and any corrective actions will be reviewed during quarterly Quality Assurance meeting to ensure continuous monitoring and prevent recurrence.	

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F 658		F 658		

Continued From page 3

A review of the progress notes revealed: NJ ex order 26.4b1 12:20 Nurses Note Note Text: Call received from NJ Ex Order 26 office. NJ ex order 26.4b1 [redacted]

Further review of the progress notes did not reveal a progress note that the physician was made aware of the NJ Ex Order 26.4(b)(1) from NJ ex order 26.4 [redacted] on NJ ex order 26.4b1.

Further review of the progress notes revealed: NJ ex order 26.4b1 16:25 (4:25 PM), NJ Ex Order 26.4(Note Note Text: NJ ex order 26.4b1 [redacted]

On 09/17/24 at 11:34 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated the aides do the NJ Ex Order 26.4(but the nurse enters the NJ Ex Order 26.7 in the eMR. She stated that you should look at the previous NJ Ex Order 2 and if there was a difference you should call the doctor for a certain NJ Ex Order 26.4(b)(1). She stated that on the MAR it would be checked off that the doctor was called or there would be a progress note that the NJ ex order 26.4b1. LPN#1 reviewed Resident # 34's eMR in the presence of the surveyor. She verified that she had entered Resident #34's weight on NJ ex order 26.4. She verified there was no progress note that the NJ ex order 26.4b1. She further verified that there was no documentation on the MAR that the NJ ex order 26.4b1. She then stated, NJ ex order 26.4b1, the NJ ex order 26.4b1 and it should

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F 658	Continued From page 4 have been documented." On 09/17/24 at 12:01 PM, the surveyor interviewed with the US FOIA (B) (6) who stated if there was a NJ Ex Order 26.4(b)(1), she would expect a NJ Ex Order 26.4(b) to be done. The US FOIA (B) reviewed the eMR in the presence of the surveyor for Resident #34. She reviewed the resident's NJ Ex Order 26.4 from admission and noted the NJ Ex Order 26 on NJ ex order 26.4b1 and NJ ex order 26.4b1. She stated, NJ ex order 26.4b1 [redacted] She reviewed the eMR and verified there was no documentation that the physician or the dietician was made aware of the significant NJ Ex Order 26 difference. The US FOIA (B) stated, NJ ex order 26.4b1 [redacted]." On 09/17/24 at 1:27 PM, during a meeting with the survey team, the US FOIA (B) (6) [redacted] the US FOIA (B) the US FOIA (B) (6) and the US FOIA (B) the above concerns were presented. On 09/18/24 at 9:20 AM, during a meeting with the survey team, the US FOIA (B) (6) stated the NJ ex order 26.4b1 [redacted] She stated that the resident should have been NJ Ex Order 26.4(b)(1) the US FOIA (B) (6) notified and there should have been documentation. A review of the facility, "Weight Policy" revised 10/2023, revealed: Procedure 2. Residents with weight loss or at risk for weight loss. a. Review medications and/or changes to medication regime (i.e., diuretics); b. notify physician of weight loss/gain. 4. Medical Records, a. Nursing will document in the nurse's notes the	F 658		

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F 658	Continued From page 5 communication between Physician, Dietitian, and other disciplines. A review of the facility's "Scale Accuracy for Weighing of Residents" revised 10/2023, revealed "Purpose: The purpose of this verification is to assure accurate weights. Procedure: 2. If there is a significant change in the resident's weight, the resident will be reweighed to assure accuracy. 3. If there continues to be a significant change in the resident's weight, the ADON (Assistant Director of Nursing) or designee will be notified. NJAC 8:39-13.1(d)	F 658		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the Payroll-Based Journal (PBJ) Staffing Data Report, Nurse Staffing Reports, interview, and facility documentation, it was determined that the facility failed to ensure a U.S. FOIA (b) (6)) worked 7 days a week for	F 727	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice. " No specific residents were identified	10/23/24

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F 727	Continued From page 6 at least 8 consecutive hours a day for 15 of 15 weekends reviewed. The deficient practice was evidenced by the following: A review of the PBJ staffing Data submitted for the 3rd quarter (April, May and June) of 2024 revealed the facility triggered for [redacted] coverage for 8 consecutive hours/day. Further review revealed "Infractions Dates": 04/06 (SA-Saturday); 04/07 (SU-Sunday); 04/13 (SA); 04/14 (SU); 04/20 (SA); 04/21 (SU); 04/27 (SA); 04/28 (SU) 05/04 (SA); 05/05 (SU); 05/11 (SA); 05/12 (SU); 05/18 (SA); 05/19 (SU); 05/25 (SA); 05/26 (SU) 06/01 (SA); 06/08 (SA); 06/09 (SU); 06/15 (SA); 06/16 (SU); 06/22 (SA); 06/23 (SU); 06/29 (SA); 06/30 (SU) A review of the facility provided staffing for the above-mentioned days did not reveal a registered nurse was scheduled for day, evening, or night shifts. On 09/15/24 at 8:55 AM, the survey team entered the facility. Licensed Practical Nurse (LPN) #1 assisted the survey team to the conference room. She stated there was another LPN (LPN #2) in the building. The survey team asked if there was a [redacted] in the building, she confirmed that there was not. LPN # 1 stated the US FOIA (B) (6) [redacted] was always available by phone. A review of the facility provided Nurse Staffing Report for the weeks of 9/1/24-9/7/24 and 9/8/24-9/14/24, did not revealed an [redacted] was schedule for 9/7/24, 9/8/24, or 9/14/24.	F 727	as affected by this deficient practice. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: " All residents had the potential to be affected by this deficient practice. A review of resident care records for weekend shifts from April 2024-June 2024 and September 1, 2024-September 14, 2024 was conducted. No negative outcomes, complaints or grievances related to resident care on the weekend shifts were discovered. This indicates that no residents were adversely affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: To prevent recurrence, the facility has implemented the following measures: " The US FOIA (B) (6) [redacted] were re-educated by the Regional Nurse Consultant that the RN staffing requirement is to ensure a Registered Nurse (RN) works 7 days a week for at least 8 consecutive hours a day. " The facility is actively recruiting RN staff. Strategies include offering referral and sign-on bonuses, use of an internal staff recruiter with postings on specific platforms and utilizing online advertisements and recruiting candidates from local RN programs.	

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F 727	Continued From page 7 A review of the facility provided schedule for 9/15/24 did not reveal a [US FOIA] was scheduled for the day, evening, or night shift. On 09/17/24 at 12:01 PM, during an interview, the [US FOIA (B)] stated that there was 1 other [US FOIA] at the facility, but she was prn (as needed.) She then stated if she goes on vacation or takes a day off, the US FOIA (B) (6) would have to be in the facility. The [US FOIA (B)] stated she submitted the PBJ Staffing Reports and was aware that they (the facility) did not have a [US FOIA] consistently on the weekends. She further stated she was on call 24 hours a day/7 days a week and comes in if she was needed. The [US FOIA (B)] stated the staff would call 911, if they needed to. At that time, in the presence of the surveyor, the [US FOIA (B)] reviewed the facility provided schedules for the above-mentioned weekends for the 3rd quarter. She confirmed that there was not an [US FOIA] on the weekends. She then reviewed the Nurse Staffing Report for the weeks of 9/1/24-9/7/24 and 9/8/24-9/14/24 and confirmed that there was not a RN for 9/7 (SA), 9/8 (SU), or 9/14 (SA). On 09/17/24 at 1:27 PM, during a meeting with the US FOIA (B) (6) [US FOIA (B)] the [US FOIA (B)] the US FOIA (B) (6), and the [US FOIA (B)], the above concerns were presented. A review of the facility's "Staffing Policy" reviewed 4/2024, revealed: "Goal: ...goal is to provide adequate staffing to meet needed care and services for our resident population ...Policy: ...There will be at least one registered professional nurse on duty in the facility during all day shifts. (During a temporary absence, not to exceed 72 hours, the registered professional	F 727	" The facility will request agency staffing support from multiple staffing agencies as needed to supplement weekend RN staff. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: " The Administrator, Director of Nursing or their designee will be responsible for conducting audits. Weekly RN staffing schedule audits will be conducted for 4 weeks to establish immediate compliance. Audits will then transition to monthly for 3 months to ensure sustained compliance. Audit findings and any corrective actions taken will be reviewed during quarterly Quality Assurance meetings to ensure continuous monitoring and prevent recurrence.	

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F 727	Continued From page 8 nurse may be on duty during the evening or night shift. NJAC 8:39-25.2(h)	F 727		
F 812 SS=F	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, record review and policy review, it was determined that the facility failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following:	F 812	Corrective action(s)accomplished for resident(s)affected: ¿ No residents were identified. ¿ In the food preparation area, the tan colored debris smeared on the surface of the door and on the door handles of standing refrigerator # 1, was immediately wiped down. ¿ The brown colored substance on the clear plastic packaging which contained	10/23/24

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F 812	Continued From page 9 On 9/16/24 at 9:46 AM, in the presence of the US FOIA (B) (6)), the surveyor observed the following: In the food preparation area, the surveyor observed the following: - tan colored debris smeared on the surface of the door and on the door handles of standing refrigerator # 1, - brown colored substance on the clear plastic packaging which contained styrofoam plates, -brown colored substance on the microwave oven door and door handle which was easily lifted with the U.S. FOIA (b) pen tip, -thick brown colored grease-like substance on 7 of 8 stove knobs, and brown thick grease-like substance on 1 of 2 oven handles. In the dry storage area, the surveyor observed the following: -tan colored debris smeared on the surface of the door and on the door handles of the produce standing refrigerator. The U.S. FOIA stated that this equipment should be clean and could not explain what might have happened. During an interview on 9/16/24 at 1:00 PM, the surveyor brought the above concerns to the attention of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) A review of the facility's policy, "Cleaning and Sanitation of Food Service Areas," Revised 8/4/2024, revealed: "Policy: The food service staff will maintain the sanitation of the dining and food service areas through compliance with a written	F 812	Styrofoam plates, was immediately discarded. ¿ The brown colored substance on the microwave oven door and door handle was immediately wiped down- ¿ The thick brown colored grease-like substance on 7 of 8 stove knobs, and brown thick grease-like substance on 1 of 2 oven handles was all immediately wiped down. ¿ The Food Service employees were immediately re-educated regarding the daily cleaning policies Residents identified having the potential to be affected and corrective action taken ¿ All residents residing in the facility have the potential to be affected by the deficient practice. ¿ The Administrator educated the Food Service Director on 9/26 regarding keeping the kitchen clean at all times. The Regional Food Service Director will re-educate the FSD again next quarter. ¿ The Food Service employees were immediately re-educated regarding following the daily cleaning schedules and signing after completion. Measures will be put into place to ensure the deficient practice will not recur: ¿ On 10/01 the Food Service Director (FSD) re-educated Dietary staff regarding the importance of following daily cleaning schedule and signing once their assigned tasks are completed. ¿ The management opening and closing check list was updated to reflect identified areas to ensure compliance.	

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F 812	Continued From page 10 and comprehensive cleaning schedule. Procedure: 1. The food service manager (or designee) will record all cleaning and sanitation tasks needed for the department." NJAC 8:39-17.2(g)	F 812	Corrective actions will be monitored to ensure the deficient practice will not recur: ¿ FSD/Designee will ensure staff are signing daily once their assigned tasks are completed and report the findings from the opening and closing check lists logs to the administrator monthly for six months. ¿ FSD/designee will report trends to the QA committee the next two quarters to assure compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint: #NJ00172520 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to ensure that one administrative staff member and one direct care staff member employed at the facility completed the general training for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program. This deficient practice was evidenced by the	S 560	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice. " No specific residents were identified as affected by this deficient practice. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: " All residents had the potential to be affected by this practice.	10/23/24

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

Electronically Signed | 10/02/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061331	A. BUILDING: _____ B. WING _____	C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 following: Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C. 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on	S 560	3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: " The Administrator and Director of Nursing were re-educated by the Regional Nurse Consultant on the Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care facilities; N.J.S.A. 26:2G-12.101-107 and that the facility must designate two employees, including one employee representing management at the facility and one employee representing direct care staff at the facility. " The Administrator has designated a second employee to complete training for the LGBTQI+ Resident Rights Designated Representative course by the New Jersey Hospital Association and will assure that there are always at least two employees trained, one representing administration and one representing direct care staff. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: " The Administrator will be responsible for ensuring that two representatives from the facility are trained for the LGBTQI+ Resident Rights Designated Representative course. If one of the representatives terminates employment for any reason, a second representative will be established and required to complete the appropriate training. The Administrator will report any changes in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061331	A. BUILDING: _____ B. WING _____	C 09/18/2024

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S 560	Continued From page 2 gender, subject to the provisions of 42 C.F.R. 483.10(e)(5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that	S 560	representatives and corrective action taken during the quarterly Quality Assurance meeting for the next two quarters to ensure continuous monitoring and prevent recurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061331	A. BUILDING: _____ B. WING _____	C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

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S 560	Continued From page 3	S 560		

resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.

Confidentiality
The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed.

Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties.

Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility.

Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care

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S 560	Continued From page 4 provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061331	A. BUILDING: _____ B. WING _____	C 09/18/2024

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S 560	Continued From page 5 mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. On 09/15/24 at 10:33 AM, during entrance conference, the surveyor requested the certifications of the 2 staff members who were trained in LGBTQI+. On 09/16/24 at 1:36 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) stated the 2 certified staff members were the social worker, who no longer works at the facility, and the current Director of Nursing (DON). He then stated, "We are going to be deficient in this." On 09/17/24 at 1:20 PM, during a meeting with the survey team, the LNHA, the DON, the Infection Preventionist, and the Regional Nurse Manager, the above concern was presented. On 09/17/24 at 1:31 PM, the LNHA provided the DON's certification for LGBTQI+ training. On 09/18/24 at 10:05, in the presence of the survey team, the DON confirmed that the facility did not have a policy on LGBTQI+. She stated that all staff were educated on the subject upon hire and yearly.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315069		10/25/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 10/23/2024	ID Prefix F0727 Reg. # 483.35(b)(1)-(3) LSC	Correction Completed 10/23/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 10/23/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061331		10/25/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/23/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
9/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING **01** B. WING _____	**09/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	**1506 GULLY ROAD** **WALL, NJ 07719**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Tower Lodge was found to be 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 9/16/24 and 9/17/24, Tower Lodge Care Center 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 Tower Lodge Care Center is a 1-story building that was built in 60's. It is composed of Type II protected construction. The facility is divided into 4- smoke zones. The 100 KW exterior natural gas generator does 100% of the building. The facility has 60 licensed beds currently at 54.	K 000		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		10/23/24

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

Electronically Signed | 10/02/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING **01** B. WING _____	**09/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	**1506 GULLY ROAD** **WALL, NJ 07719**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/16/24 in the presence of the US FOIA (B) (6) and US FOIA (B) (6) it was determined that the facility failed to maintain the resident room through wall air conditioning units in a safe condition by maintaining air filters in accordance with NFPA 101: 2012 edition, Sections 19.5.2.1, 9.2, NFPA 90 A: 2012 Edition. This deficient practice was identified for 5 of 5 units, had the potential to effect 54 residents, and was evidenced by the following: Observations on 09/16/24 from 01:31 PM to 03:00 PM of the resident rooms air conditioning unit filters opened by the US FOIA, revealed the filters were dirty containing a layer of filtered material for the following rooms: 18, 20, 15, 7 and 3. The US FOIA and US FOIA confirmed the observations at the time. The US FOIA (B) (6) was notified of the findings at the Life Safety Code exit conference at 1:47 PM on 09/17/24. N.J.A.C. 8:39-31.2(e)	K 521	I. Corrective action(s) accomplished for resident(s) affected: Air condition filters were cleaned for residents in rooms 18, 20, 15 ,7 and 3. II. Residents identified having the potential to be affected and corrective action taken: This deficient practice had the potential to affect all residents residing in this facility. No residents were negatively affected by this practice. On 9/17/2024 the deficient practice was corrected for residents in room 18, 20 15, 7 and 3. The maintenance director cleaned the filters for all other residents on 9/18/2024. III. Measures will be put into place to ensure the deficient practice will not recur: The US FOIA (B) (6) was educated by the Administrator on the importance of cleaning the filters monthly as per the manufacturers specifications when they are being used. Maintenance Director will conduct a monthly inspection of all air conditioner filters in resident rooms to ensure they are all clean. Results of this inspection and any corrective actions will be presented at the following Quality Assessment and Assurance (QAA) Committee meeting. IV. Corrective actions will be monitored to ensure the deficient practice will not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315069	A. BUILDING **01** B. WING _____	**09/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 521	Continued From page 2	K 521	The Director of Maintenance will report the results of the monthly inspections of all resident room filters and any corrective actions to the Quality Assessment and Assurance (QAA) Committee when conducted. The QAA Committee will determine the need for any additional monitoring for filter cleanliness.	

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
315069 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/25/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 10/23/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO