STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING ______ B. WING ______	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

(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 Survey Dates: 01/23/23 to 01/27/23 Survey Census: 97 Sample Size: 27 Supplemental Residents: 0 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure reasonable accommodation of needs for one (Resident (R) 73) of one resident reviewed for accommodation of needs. Findings include: Review of R73's undated "Admission Record," located in the electronic medical record (EMR) under the " Profile" tab, indicated R73 was	F 558	Resident 73□s call bell was checked and was within her reach all residents had the potential to be affected by this practice All staff were re-inserviced on the need to ensure when they are finished providing care and leaving a resident in their room, that the call bell is left within the	3/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/17/2023

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

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F 558	Continued From page 1 admitted to the facility on NJ Exec Order 26.4b with diagnoses which included NJ Exec Order 26.4b1 and NJ Exec Order 2 Review of R73's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b, located in the EMR under the "MDS" tab, revealed a Brief Interview for Mental Status (BIMS) score of NJ Exec out of 15 which indicated R73 was NJ Exec Order 26.4b1 The MDS indicated R73 required extensive assistance with all activities of daily living (ADL). According to the MDS, R73 had no NJ Exec Order 26.4b1 that interfered with her daily functions. Review of R73's "Care Plan" updated NJ Exec Order 26.4b, located in the EMR under the "Care Plan" tab, did not address R73's keeping call light within reach. During an observation and interview on 01/23/23 at 11:31 AM, R73 was lying in bed on her left side. R73 stated her NJ Exec Order 26.4b1 She stated she did not know where her call light was to call for help. R73's call light cord was tied to right siderail with cord hanging to outside of siderail. The activation button of the call light was hanging toward and hovering approximately five inches from the floor. During an observation on 01/23/23 at 3:51 PM, R73 was lying in bed on her left side. R73 stated she had NJ Exec Order 26.4b1 She stated she did not know where her call light was to call for help. R73's call light cord continued to be tied to right siderail with cord hanging to outside of siderail. The activation button of the call light was hanging toward and hovering approximately five inches from the floor.	F 558	resident□s reach The Unit Managers or designee will conduct weekly audits on each shift for 4 weeks to ensure call bells are left within residents□ reach. They will then conduct monthly audits for 2 months to ensure call bells are left within reach of the residents. The Unit Manager or designee will report the results of these audits to the QAPI Committee on a monthly basis for 90 days, or until substantial compliance is achieved. The Administrator will ensure compliance of these audits and take corrective action as needed	

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F 558	Continued From page 2	F 558		

During an observation on 01/24/23 at 9:46 AM, R73 was calling out "Nurse! Nurse!" R73 was laying on her left side. call light cord continued to be tied to right siderail with cord hanging to outside of siderail. The activation button of the call light was hanging toward and hovering approximately five inches from the floor.

During an observation on 01/24/23 at 9:51 AM, the Administrator stopped to check on R73. The administrator left R73's room without putting the call light within R73's reach. Resident continued to call out "Nurse!"

During an observation on 01/24/23 at 9:55 AM, R73 continued to call out. The Activity Director (AD) entered R73's room. R73 stated to the AD that she had NJ Exec Order 26.4b1 The AD told R73 she would go get help and left R73's room without placing the call light within R73's reach.

During an observation on 01/24/23 at 10:02 AM. Licensed Practical Nurse (LPN) 2 entered R73's room and gave her NJ Exec Order 26.4b1. R73 was lying in bed on her left side. R73's call light cord continued to be tied to the right siderail. The cord was handing to the outside of the siderail. The activation button of the call light was touching floor. LPN2 left R73's room without placing the call light within R73's reach.

During an observation on 01/24/23 at 10:50 AM, R73 was lying in bed on her right side. R73 was calling out "Nurse!" Her call light cord was tied to the right siderail but hanging on outside of bed. The activation button was touching floor and not accessible by the resident.

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F 558	Continued From page 3	F 558		

Continued From page 3

During an observation on 01/24/23 at 04:22 PM, R73 was lying in bed on her left side. The call light cord was attached to side rail on right side behind R73. The cord was hanging to the outside of the bed. The activation button was touching the floor.

During an observation on 01/25/23 at 10:21 AM, R73 was lying in bed on her left side. Her call light was on the floor under the right side of her bed.

During an observation on 01/26/23 at 8:50 AM, R73 was lying in bed on her left side. Her call light cord was tied to the siderail on the right side of the bed. The cord was hanging on the outside of the siderail. The activation button was hovering approximately five inches from the floor.

During an observation and interview on 01/26/23 at 08:56 AM, R73 was calling "Nurse!" LPN1 went into R73's room. LPN1 verified R73's call light was not accessible to the resident. LPN1 stated R73's could use her call light if she could reach it and placed the call light across a pillow close to resident's hand.

During an interview on 01/26/23 at 10:45 AM, the Director of Nursing (DON) stated R73 could use her call light if she was able to reach it. The DON stated R73's call light should be within reach.

During an observation on 01/26/23 at 12:33 PM, R73 was lying on her back with her call light in her hand. R73 was able to activate her call light without difficulty.

Review of the facility's policy titled "Call Lights," reviewed on 10/24/22, revealed "Patients will have a call light or alternative communication

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F 558	Continued From page 4 device within their reach at all times when unattended." NJAC 8:39-31.8(c)9	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review,	F 561	Resident #63 was interviewed and her	3/3/23

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F 561	Continued From page 5 and facility policy review, the facility failed to ensure residents' choice of shower preference instead of bed baths was promoted for two residents (Residents (R) 63 and R39) of five residents reviewed for choices. Findings include: 1. Review of R63's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted NJ Exec Order 26.4b with diagnoses that included NJ Exec Order 26.4b1 Review of R63's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4, located in the EMR under the "MDS" tab, revealed a Brief Interview for Metal Status (BIMS)score of NJ Exec out of 15 which indicated R63 was NJ Exec Order 26.4b1. The MDS also revealed R63 required NJ Exec Order 26.4b1 Review of R63's "Care Plan" revised NJ Exec Order 26.4b located in the EMR under the "Care Plan" tab, indicated it was important for R63 to choose between a tub bath, shower, bed bath or sponge bath. The care plan indicated R63's ability to perform activities of daily living, including NJ Exec Order 26 Review of the Certified Nursing Assistant (CNA) "POC Documentation Report" dated NJ Exec. Order 26 2023, located in the EMR under the "Reports" tab revealed R63 last received a shower NJ Exec Order 26.4b. During an interview 01/23/23 on 12:09 PM, R63 stated she had not received a shower in over two	F 561	choice in a weekly schedule for receiving showers was updated and placed on the master schedule. Resident #63 was provided with her weekly shower schedule. Resident #39 was interviewed and her choice in a weekly schedule for receiving showers was updated and placed on the master schedule. Resident #39 was provided with her weekly shower schedule All residents had the potential to be affected by this practice Nursing administration will complete a review and audit of all residents to determine which residents have a preference for a shower. For these residents, the preference will be indicated in the tasks care record, which will trigger the shower on the CNA POC. A Master Schedule will be maintained for each nursing wing. Nurses and CNAs will be inserviced on the Master shower schedules, and making sure the residents are offered showers the days during the week that they are scheduled and that it is documented accordingly. The Unit Managers or designee will conduct weekly audits for 4 weeks to ensure residents are receiving their scheduled showers.	

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F 561	Continued From page 6	F 561		

weeks. She stated, "They don't give us showers they just take a wet cloth and wash us down." R63 stated she would like to have a shower.

During an interview on 01/25/23 at 10:25 AM, R63 was up walking in her room. She had makeup on and was dressed appropriately. R63 stated she got a shower yesterday. She stated she was told she could have a shower anytime she wanted "but they don't have enough staff for that."

During an interview on 01/25/23 at 10:30 AM, CNA5 stated residents usually got showers once a week on either Monday or Thursday. CNA5 stated sometimes they have a shower list in the assignment book, but not today. CNA5 also stated if they offered to give a resident a shower too early and the resident did not want to get up at that time then the resident would get a bed bath and not a shower.

2. Review of R39's undated "Admission Record" located in R39's EMR under the "Profile" tab indicated she was admitted on NJ Exec Order 26.4b with diagnoses which included transient NJ Exec Order 26.4b1

Review of R39's significant change " MDS" with an ARD of NJ Exec Order 26.4b in the EMR under the MDS tab revealed R39 was assessed to have a BIMS score of NJ Exec out of 15 which indicated the resident was NJ Exec Order 26.4b1 Continued review of the MDS revealed it was very important for R39 to be able to choose between a tub bath, shower, bed bath, or sponge bath. The MDS further revealed R39 required extensive assistance with NJ Exec and NJ Exec Order 26.4 and total dependence with

The UM or designee will then conduct monthly audits for 2 months

The UM or designee will report the results of these audits to the QAPI Committee on a monthly basis for 3 months or until substantial compliance is achieved .

The Administrator will ensure compliance of these audits and will take corrective action

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F 561	Continued From page 7 NJ Exec Order 26.4b and NJ Exec Order 26 Review of R39's "Care Plan" dated NJ Exec Order 26.4 in the EMR under the "Care Plan" tab revealed R39's "ability to perform ADL activities, including NJ Exec Order 26.4b1, are NJ Exec Order 26.4b1 NJ Exec O" Interventions included "I will accept necessary amount of assistance from the staff safely complete my selfcare activities" and "I will request assistance from staff if I am unable to safely complete a task independently." Review of R39's "Recreation Comprehensive Assessment" found in the EMR under the "Assessments" tab, dated NJ Exec Order 26.4b revealed "Focus: While in the facility, resident states that it is important that she has the opportunity to engage in daily routines that are meaningful relative to their preferences" and "Interventions: It is important for me to choose between a shower and a bath." Review of the undated "Shower list for North Wing" provided by the facility revealed that R39 should be getting showers twice a week on Mondays and Thursdays during the 7am - 3pm shift. During an interview on 01/23/23 at 1:48 PM, R39 stated that she had not gotten a shower in two weeks. R39 also stated that the staff tell her that they can't do it because they are by themselves. Review of the CNA task list found under the "Tasks" tab in the EMR revealed that R39 had received bed baths on 19 of the past 30 days. There was no documented evidence of any	F 561		

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F 561	Continued From page 8 showers being administered. During an interview on 01/24/23 at 3:05 PM, CNA1 stated that R39 was not scheduled for any showers today. She indicated that there's a shower schedule in the book. She didn't know if she had given her a shower yet this week. CNA1 stated that she could always get her showers done and it's documented in the computer. During an interview on 01/24/23 at 3:17 PM, CNA2 stated that "We shower twice a week, if they refuse, they get a bed bath." During an interview on 01/25/23 at 10:42 AM, CNA1 stated all residents received a shower on Monday or Thursday. CNA1 also stated for the "past few weeks" they had been short staffed and had only been giving bed baths. During an interview on 01/26/23 at 10:47 AM, the DON stated residents were supposed to get showers twice a week. The DON stated if a resident was scheduled to receive a shower, they should get one unless the resident requested otherwise. Review of the facility policy titled "Activities of Daily Living (ADL), " with a revision date of 06/01/21, read, "Purpose: To ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and the patient's choices and preferences." NJAC 8:39-4.1(a)3	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		2/17/23

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F 582	Continued From page 9 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		

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F 582	Continued From page 10 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to complete the Centers for Medicaid and Medicare Services (CMS) Form CMS-10055 "Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN)" for three of three residents (Resident (R) 257, R89, and R258) reviewed for advanced beneficiary notices. Failure to provide the form could result in the resident or their responsible party not being aware of the reason services were ending or of the options and cost to continue to receive services. Findings include: 1. Review of R257's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on NJ Exec Order 26.4b with a diagnoses which included NJ Exec Order 26.4b1 Review of R257's facility-provided document titled	F 582	Residents # 257, 89, and 258 have all been discharged from the center. All residents had the potential to be affected by this practice The Market Clinical Reimbursement/ MDS Manager re-inserviced facility staff on the Advance Beneficiary Notice Policy, and on completing Form CMS-10055 skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) The CRC will be responsible to ensure all residents or their responsible parties are provided with the SNF ABN form prior to the end of their services. The CRC or designee will conduct weekly audits for 4 weeks to ensure any residents whose services will be ending are provided with the SNF/ ABN notice within the required timeframe.	

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F 582	Continued From page 11 "SNF Beneficiary Protection Notification Review" revealed "Last covered day of Part A . . . NJ Exec Order 26.4 . . . The facility/provider initiated the discharge from Medicare Part A Services when the benefit days were not exhausted. . .. ABN, Form CMS-10055 provided to the resident? . . . No . . . The resident was discharged from the facility and did not receive non-covered services . . ." indicating the resident or family member did not receive form ABN-10055. 2. Review of R89's undated "Admission Record," located in the EMR under the "Profile" tab revealed the resident was admitted to the facility on NJ Exec Order 26.4b diagnoses which included NJ Exec Order 26. Review of R89's facility-provided document titled "SNF Beneficiary Protection Notification Review" revealed "Last covered day of Part A . . . NJ Exec Order 26.4b . . . The facility/provider initiated the discharge from Medicare Part A Services when the benefit days were not exhausted. . .. ABN, Form CMS-10055 provided to the resident? . . . No . . . The resident was discharged from the facility and did not receive non-covered services . . ." indicating the resident or family member did not receive form ABN-10055. 3. Review of R258's undated "Admission Record" located in the EMR under the "Profile" tab revealed resident was admitted to the facility on NJ Exec Order 26.4b with diagnoses which included NJ Exec Ord and NJ Exec Order 26.4b1 Review of R258 facility-provided document titled "SNF Beneficiary Protection Notification Review"	F 582	The CRC or designee will then conduct monthly audits for 2 months to ensure residents or their responsible parties are receiving the SNF/ABN form prior to their services ending. The CRC or designee will report the results of these audits to the QAPI Committee on a monthly basis for 90 days, or until substantial compliance is achieved.	

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F 582	Continued From page 12	F 582		

revealed "Last covered day of Part A . . . NJ Exec Order 26.4b . . . The facility/provider initiated the discharge from Medicare Part A Services when the benefit days were not exhausted. . .. ABN, Form CMS-10055 provided to the resident? . . . No . . . The resident was discharged from the facility and did not receive non-covered services . . ." indicating the resident or family member did not receive form ABN-10055.

During an interview on 01/25/23 at 09:30 AM, the Administrator and Associate Administrated revealed the Advance Beneficiary Notice (ABN) form CMS 10055 was not provided to any of the residents; however, we verbally tell them (residents) the cost of private, semi-private, or respite care. A contracted person was in the position, then corporate handled it remotely, but as of January 09, 2023, we have a new person, we will ensure that is fully trained.

During an interview on 01/25/23at 10:04 AM, the Social Services Director (SSD) confirmed family members were not provided the ABN form CMS-10055 because she was not aware of providing the form to residents and/or family members. The SSD confirmed she has been made aware of the CMS-10055 form and will be starting that process.

Review of facility-provided undated policy titled "Advance Beneficiary Notice" revealed "To insure an Advance Beneficiary Notice (ABN) is obtained from Medicare beneficiaries when . . . wishes to bill for . . . services that may not be covered by CMS . . . Advance Beneficiary Notice (ABN): An ABN is a written notice given to a Medicare Beneficiary . . . when . . . believes that Medicare will not pay for some or all of the services . . . and

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F 582	Continued From page 13 wishes to bill the patient for the provided services . . . The information in the ABN will assist the beneficiary in making an informed decision whether or not to receive the service and be financially responsible for the payment . . . If . . . expects payment for services to be denied by Medicare . . . employee will advise the beneficiary before services are furnished that, in our opinion, the beneficiary will personally and fully responsible for the payment . . . If . . . does not provide a proper ABN in situations where one is required, . . . will be held liable for the loss of payment if Medicare denies the claim . . . Patients must be notified well enough in advance of receiving a medical service so the patient can make a rational, informed decision . . . The ABN will clearly identify the following . . . Description of services (s) that may be denied, including procedure name, price . . . Reason why the service may be denied . . . Patient's or guarantor's signature and date . . . Witness signature and date . . . " NJAC 8:39-4.1(a)7	F 582		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		3/3/23

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F 690	Continued From page 14	F 690		

incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents received assistance to maintain NJ Exec Order 26.4b1 for one resident (Resident (R) 303) of one resident reviewed for NJ Exec Order 26.4b1 R303 was admitted with an NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 After discontinuing the NJ Exec Order 26.4b1 the facility did not assess the resident's NJ Exec Order 26.4b1 or provide measures to prevent NJ Exec Order 26.4b1 for R303.

Resident # 303 was re-assessed for NJ Exec Order 26.4b1.

Resident #303 has been placed on a NJ Exec Order 26.4b1.

Resident #303s Care Plan was reviewed by the IDCP team and updated to reflect her current NJ Exec Order 26.4b1 status.

All residents had the potential to be affected by this practice

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F 690	Continued From page 15 Findings include: Review of R303's undated Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, indicated R303 was admitted NJ Exec Order 26.4 with diagnoses which included NJ Exec Order 26.4b1 Review of R303's "Admission Assessment," dated NJ Exec Order 26.4, located in the EMR under the "Assessments" tab, revealed the section titled "NJ Exec Order 26.4b1" had NJ Exec Order 26.4b1 checked and "NJ Exec Order 26.4b1 " had NJ Exec Order 26 checked. Review of R303's "Progress Note," dated NJ Exec Order 26.4. located in the EMR under the "Progress Notes" tab revealed a physician's order had been received to discontinue R303's NJ Exec Order 26.4b1. Review of R303's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4, located in the EMR under the "MDS" tab, revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 indicating R303 was NJ Exec Order 26.4b1. The MDS also indicated R303 required extensive assistance with NJ Exec Order 26 and a NJ Exec Order 26.4b1 had not been attempted. The MDS further indicated R303 was always NJ Exec Order 26.4b1 . Review of R303's "Admission/Readmission Nursing Assessment" dated NJ Exec Order 26.4, located in the EMR under the "Assessments" tab revealed, the NJ Exec Order 26 was marked in the section titled "NJ Exec Order 26.4b1)" and new NJ Exec Order 26.4b1 was marked in the section titled "NJ Exec Order 26.4b1	F 690	Nursing administration will complete a comprehensive review and audit of all residents with urinary incontinence, and will re-assess these residents for urinary incontinence. A urinary incontinence assessment will be performed for all new admission or re-admission, and with a change in continence status. The Unit Manager or designee will conduct weekly audits for 4 weeks of all residents who have had indwelling catheters removed to ensure a trial toileting program had been attempted. They will then conduct monthly audits for 2 months of all residents who have had indwelling catheters removed to ensure a trial toileting program had been attempted to ensure compliance. The results of the audits will be presented to the QAPI Committee on a monthly basis by the Unit Manager or designee for 90 days or until substantial compliance is achieved.	

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Review of R303's "Nursing Progress Note" dated NJ Exec Order 26.4, located in the EMR under the "Progress Notes" tab, read, "New order to discontinue (D/C) NJ Exec Order 26.4b1 in AM."

Review of R303's "Admission/Readmission Nursing Assessment" dated NJ Exec Order 26.4, located in the EMR under the "Assessments" tab revealed the section titled "NJ Exec Order 26.4b1" and NJ Exec Order 26.4b1" were blank.

During an observation and interview on 01/23/23 at 10:29 AM, R303 was lying in bed receiving NJ Exec Order 26.4b1 R303 stated she had the sensation of when she needed to NJ Exec O and would like to be put on NJ Exec Order 26 but have never been asked so she had always NJ Exec Order 26.4b1." R303 stated "They [staff] always seem rushed."

During and observation on 01/26/23 at 9:25 AM, Certified Nursing Assistant (CNA) 3 and CNA7 provided R303 NJ Exec Order 26.4b1

During an interview on 01/26/23 at 9:35 AM, CNA7 stated she did not know if R303 could tell her when she needed NJ Exec Order 26.4b1 CNA7 stated she should ask but had not. She stated she had never offered R303 a NJ Exec Order 26 but had only assisted with NJ Exec Order 26.4b1

During an interview on 01/26/23 at 9:36 AM, CNA3 stated she did not know if R303 knew when she NJ Exec Order 26.4b1 CNA3 stated R303 had just moved to her hall a couple of days ago and she did not know her very well. CNA3 stated she should ask R303 but had not.

During an interview on 01/26/23 at 10:30 AM,

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LPN3 stated R303 could tell staff when she NJ Exec Order 26.4b1 but most of the time, she was NJ Exec Order 26.4b1 when she told them. LPN3 stated NJ Exec Order and NJ Exec Order 26 assessments were completed on admission and a trial voiding would be triggered on admission based on the NJ Exec Order and NJ Exec Order 26 assessment. LPN3 stated R303's November 2022 admission assessment indicated she used a NJ Exec Order 26 which meant she was NJ Exec Order 26.4b so a trial voiding would not have been completed. LPN3 stated R303 was NJ Exec O

During an interview on 01/26/23 at 10:45 AM, the Director of Nursing (DON) verified R303 should have had a NJ Exec Order and NJ Exec Order 26 assessment completed but one was not completed.

Review of R303's "Care Plan" dated NJ Exec Order 26.4b, located in the EMR under the "Care Plan" tab did not address R303's NJ Exec Order 26.4 needs.

Review of R303's "NJ Exec Order 26 Consult," dated NJ Exec Order 26.4b, located in the EMR under the "Documents" tab indicated NJ Exec Order 26.4b1

Review of the facility's policy titled " Continence Management", with a revision date of 06/15/22, read, "Patients will be assessed for the need for continence management as part of the nursing assessment process. A urinary incontinence assessment and/or bowel incontinence assessment will be completed upon admission or re-admission and with a change in condition or change incontinence status. Continence status will be reviewed quarterly as part of the care planning process."

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F 690	Continued From page 18 NJAC 8:39- 33.2(c)5	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services to maintain NJ Exec Order 26.4b1 for one of three residents reviewed for NJ Exec Order 26.4 (Resident (R) 56). Due in part to the failure to communicate R56's ongoing, significant NJ Exec Order 26.4b1 to the interdisciplinary team, implement nutritional interventions that were recommended and closely monitor the resident's	F 692	The MD and NP completed a comprehensive review of Resident #56s NJ Exec Order 26.4b1 PA who ordered additional labwork and a NJ E consult which is scheduled for NJ Exec Order 26 The RD recommended interventions for Res# 56 were ordered by MD and they have been added to the residents care	3/3/23

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weight, R56 experienced a NJ Exec Order 26.4b1 which resulted in his inability to maintain a NJ Exec Order 26.4b1

Findings include:

Review of R56's "Admission Record," located in R56's electronic medical record (EMR) under the "Profile" tab indicated he was admitted on NJ Exec Order 26.4b with diagnoses which included NJ Exec Order 26.4b1

Review of R56's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b revealed that R56 had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Ord out of 15, which indicated the resident was NJ Exec Order 26.4b1 Continued review of the MDS revealed R56 was independent with NJ Exec Order and weighed NJ Exec Order 26.4b1

Review of R56's weights under the "Weights/Vitals" tab in the EMR documented the following weights.
On NJ Exec Order NJ Exec Order 26.4b.
On NJ Exec Order NJ Exec Order 26.4b.
On NJ Exec O NJ Exec Order 26.4b1.
On NJ Exec Order NJ Exec Order 26.4b1.
On NJ Exec Order 2 NJ Exec Order 26.4b1.
On NJ Exec Order 26.4 NJ Exec Order 26.4b.
On NJ Exec Order 26.4 NJ Exec Order 26.4b.
On NJ Exec Order 26 NJ Exec Order 26.4b.
On NJ Exec Order 26 NJ Exec Order 26.4b.

Review of the "Nutrition Assessment" dated NJ Exec Order 26, found in the EMR under the "Assessments" tab revealed R56's height was NJ E

F 692

plan

The RD and Nursing administration will complete a comprehensive review and audit of all residents with weight loss. They will ensure MD orders and RD recommended interventions are care planned for weight loss.

IDCP team was re-educated by the Clinical Market Lead on the need to ensure weight loss is addressed in all care plan meetings, and that the interventions are evaluated for effectiveness, and that the MD is involved in the residents□ plan of care.

The IDCP team will meet weekly for 2 months to review residents with weight loss, to evaluate the effectiveness of current interventions. After 2 months the IDCP team will meet twice a month for 2 months, and monthly thereafter.

The Registered Dietitian or designee will audit the care plans weekly for residents with weight loss to ensure their accuracy for 2 months, then will audit care plans monthly for 2 months.

The RD will present the results of the weekly audits x 8 weeks then monthly audits X 2 months to the QAPI Committee on a monthly basis for 4 months or until substantial compliance is achieved.

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F 692	Continued From page 20 inches tall, and his body mass index (BMI) was NJ Exec O NJ Exec. Order 26:4.b.1 t.) The resident's current body weight was NJ Exec Orde pounds. He was noted to be NJ Exec Order 26.4b1 despite meeting his needs on "most days." R56 remained on a NJ Exec Order 26.4b1 diet with a good appetite. By mouth (PO) intake was reported at NJ Exec Order 26.4b1 for most meals. He had NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 He received the NJ Exec Order 26.4b1 every day. Problem/Etiology/Statement (PES) revealed a nutrition diagnosis of NJ Exec Order 26.4b1 as related to NJ Exec Order 26.4b1 as evidenced by NJ Exec Order 26.4b1 RD's [Registered Dietician] "nutrition plan" documented that she would "discuss w/[with] care team as the resident is exceeding needs on most days and should NJ Exec . RD will monitor." Review of R56's "Physician's Orders" located in R56's EMR under the "Orders" tab indicated an order for a NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 ; NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . Another order indicated a NJ Exec Order 2 one time a day, NJ Exec Order 26.4b1 activated on NJ Exec Order 26.4b Review of the R56's "Care Plan" located in the EMR under the "Care Plan" tab, initiated on NJ Exec Order 26.4b and revised on NJ Exec Order 26.4b listed a "Focus: a NJ Exec Order 26.4b1 "Goals" initiated on NJ Exec Order 26.4 were to 'NJ Exec Order 26.4b1 and "R56 will NJ Exec Order 26 as ordered" (revised on NJ Exec Order 26.4) and R56 will 'NJ Exec Order 26.4b1	F 692	The RD or designee will audit 5 residents with weight loss /per week for 4 weeks - to ensure that residents are receiving what is ordered for them. After 4 weeks the RD will audit residents monthly for 3 months to ensure that they are receiving what is ordered for them. The RD will present the results of these audits to the QAPI Committee on a monthly basis for 4 months or until substantial compliance is achieved. The Administrator will ensure compliance of these audits and will take corrective action as needed	

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F 692	Continued From page 21 per day" (NJ Exec Order 26.4b1) and "R56 will complete NJ Exec Order 26.4b1 " (revised on NJ Exec Order 26.4b) R56 interventions included: "Honor food preferences as able; Pudding at 2:00PM (Snack 2 (S2))" (initiated on NJ Exec Order 26.4b), "provide and serve NJ Exec Order 26.4b1 as ordered" (initiated on NJ Exec Order 26.4b revised on NJ Exec Order 26.4b) "provide and serve NJ Exec Order 26.4b1 as ordered" (initiated NJ Exec Order 26.4b, no revision date) and "the resident will be NJ Exec Order 26.4b 1x/month or more if necessary to NJ Exec Order 26.4b1 (initiated on NJ Exec Order 26.4b, revised on NJ Exec Order 26.4b). There were no revisions to the care plan following R56's NJ Exec Order NJ Exec Order 26.4b1 on NJ Exec Order 26.4b, a significant NJ Exec Order 26.4b1 in one month; and his NJ Exec Order 26.4b1 on NJ Exec Order 26.4b, a significant NJ Exec Order 26.4b1 in one month from NJ Exec Order 26.4b Review of R56's "Nutrition/Dietary Note," dated NJ Exec Order 26.4b located in R56's EMR under the "Progress Notes" tab indicated that the Registered Dietitian (RD) would implement a three day meal monitor to assess NJ Exec Order 26 intake. A NJ Exec Order 26.4b1 was also started at S2. There was no documentation of the three day meal monitor in the EMR and no intervention added to the care plan. Review of R56's "Nutrition/Dietary Note," dated NJ Exec Order 26.4b located in R56's EMR under the "Progress Notes" tab indicated that the RD would implement NJ Exec Order 26.4b1 one time a day. This intervention was not added to the care plan and there was no documentation in the EMR that it was added to the resident's orders. Review of a R56's "Nutrition/Dietary Note" dated NJ Exec Order 26.4 located in R56's EMR under the "Progress Notes" tab indicated that the RD would	F 692		

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F 692	Continued From page 22	F 692		

implement pudding twice a day and double portions. These interventions were not added to the care plan.

Review of R56's "Nutrition/Dietary Note" dated NJ Exec Order 26.4b located in R56's EMR under the "Progress Notes" tab indicated that the RD would address NJ Exec Order 26.4b1 with the care teams. No further follow up is documented in the progress notes.

Review of R56's "Nursing Progress Notes" dated NJ Exec Order 26.4b through NJ Exec Order 26.4b made no mention of any significant NJ Exec Order 26.4b1 noted during that time period.

Review of R56's "Physician Progress Notes" dated NJ Exec Order 26.4 through NJ Exec Order 26.4b made no mention of any significant NJ Exec Order 26.4b1 noted during that time period.

During an interview on 01/24/23 at 3:17 PM, Certified Nursing Assistant (CNA) 1 stated R56 required total care assistance, he knew everything that was going on. CNA1 stated that the resident has been here over the NJ Exec Order 26 and that with direction he can turn himself. He can tell you if he needs assistance. He has a good appetite, but he can't NJ Exec Order 26.4b1 he eats everything sometimes he even asks for snack. He can feed himself, gets a shake regularly. He got a shake at 2pm, he asks for other items like food etc. CNA1 stated that they document his intake in the computer, sometimes he complains about a NJ Exec Order 26.4b1 and she tells the nurse.

During an interview on 01/24/23 at 3:48 PM, the director of Physical Therapy stated that they had

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F 692	Continued From page 23 just picked R56 back up for NJ Exec Order 26. She stated that he was not the same functional status that he was when he was discharged from NJ Exec Order 26. She stated that he was NJ Exec Order 26.4b1, then started to decline from NJ Exec Order 26.4b1 so they were able to pick him up from their quarterly screen. During an interview on 01/26/23 at 11:14 AM, the RD stated that R56 "eats everything, the NJ Exec Order is confounding, he gets a NJ Exec Order 26.4b1." The RD stated that she was bringing it up as a medical issue now and she did not know why there has not been any follow up. The RD also stated she did not remember if she told the Nurse Practitioner (NP) or the Physician's Assistant (PA) about the NJ Exec Order 26.4b1 She indicated that she speaks to the physician on the days that he was at the facility. She had not called the physician about the NJ Exec Order 26.4b1 but asked the surveyor if she should. The RD stated that there was a NP and a PA that she would tell normally but they had not had a morning meeting. The RD stated she thought she brought it up on the NJ Exec O or the NJ Exec O of NJ Exec Order 26.4b1, and thought they said, "okay we will look at it." During a lunch observation of R56 on 01/26/23 at 12:31 PM, he was independently eating his lunch, One half a tuna salad sandwich had already been eaten. R56 stated that he "never gets double portions of food and he didn't get any today." Review of the facility's policy titled, "Nutrition/Hydration Management" revised 06/01/21 revealed "To provide safe and effective care to manage patients' nutrition and hydration needs ...Develop an interdisciplinary plan of care for enhancing oral intake and promoting adequate	F 692		

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F 692	Continued From page 24 nutrition and hydration ...Revise patient's care plan as needed." NJAC 8:39-17.1(c) NJAC 8:39-17.2(d) NJAC 8:39-27.2(e)	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		3/3/23

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F 725	Continued From page 25 by: Based on interview, record review, and review of staffing sheets, the facility failed to have sufficient nursing staff to meet resident needs and/or provide care in a timely manner for four (Resident (R) 39, R 63 R76, and 303) of 27 sampled residents. The lack of sufficient staff resulted in residents who were not bathed in accordance with their preference and/or call lights which were not answered in a timely manner. Findings include: 1. During the initial tour on 01/23/23 at approximately 10:30 AM, R303 was interviewed, and stated that staff do not answer the call light very quickly. R303 stated, "It takes maybe a half hour." R303 did not feel like staff were abusive, but stated it feels like staff are hurried when they come in to provide care. R303 stated they try to stay awake at night to catch the staff who are assigned to provide care during the evening because "I don't know when I will get taken care of again." Review of R303's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of NJ Exec Order 26.4 revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex /15, indicating the resident was NJ Exec Order 26.4b1 2. During the initial tour on 01/23/23 at approximately 12:09 PM, R63 was interviewed, and stated that the staff "don't give us showers; they just take a wet cloth and wash us down." R63 stated their preference was for a shower at least once a week. On 01/25/23 at approximately	F 725	Nursing administration Administration and/or designee reviewed and revised the plan of care based on resident preferences for showers and/or bathing for Resident #63. Resident #63 received a shower on NJ Exec Order 26 in accordance with her plan of care to maintain hygiene. Nursing Administration reviewed and revised shower and bathing schedules for Resident #63 to be consistent with residents' needs and choices to maintain hygiene by date of compliance. Residents 39, 76 and 303 were interviewed about call bell response time, with improvement noted, and call bell response time has been and will continue being audited for these residents for 3 months. All residents had the potential to be affected by this practice The Administrator, Director of Nursing, Market Director Lead for HR, Human Resources, & Staff Scheduler reviewed the master schedule pattern on 2/8/23; the requisitions for open positions we have been recruiting for were re-boosted to recruit nurses and CNAs to provide an adequate number of nursing staff to address the acuity and diagnoses of the facility's resident population in accordance with the facility assessment, resident census, and daily care required by the residents	

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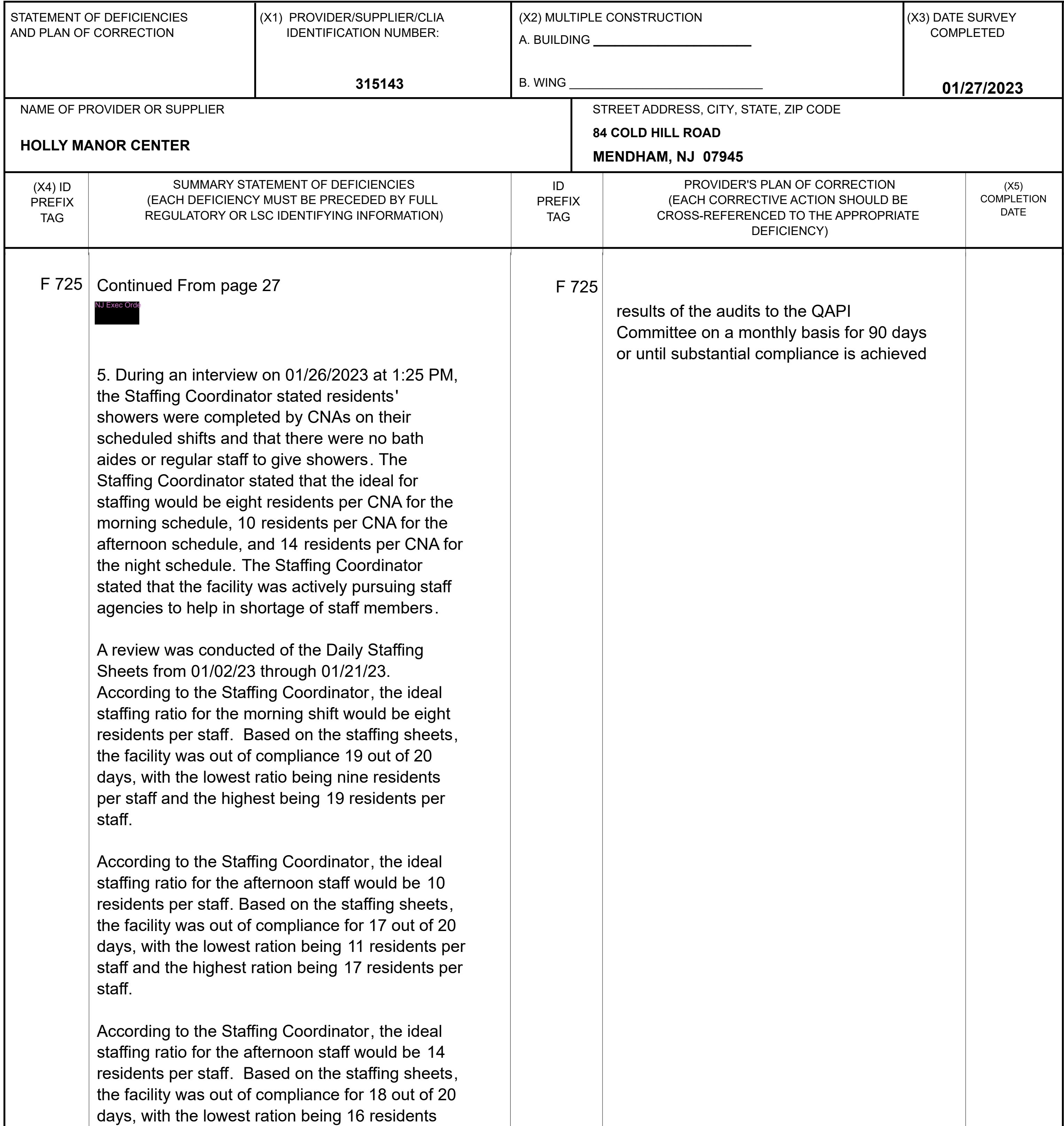
F 725	Continued From page 26 10:25 AM, R63 who was up, wearing makeup and fully dressed, stated they had received a shower yesterday. R63 stated staff said they could have a shower anytime; however, R63 added, "but I can't, because they don't have enough staff." (Please refer to F561 - Self Determination.) Review of R63's quarterly MDS, with an ARD of [NJ Exec Order 26.4], revealed the resident had a BIMS score of [NJ Ex]/15, indicating the resident was [NJ Exec Order 26.4b1] 3. During the initial tour on 01/23/23 at approximately 12:34 PM, R76 was interviewed, and stated it depends on the time of day, but staff come within a half hour after the call bell has been clicked. Review of R76's quarterly MDS, with an ARD of [NJ Exec Order 26.4] revealed the resident had a BIMS score of [NJ Ex]/15, indicating the resident was [NJ Exec Order 26.4b1] 4. During the initial tour on 01/23/23 at approximately 01:43 PM, R39 was interviewed, and stated they sometimes had [NJ Exec Order 26.], and staff would not provide care. R39 stated that the certified nursing assistant (CNA) walked out, shut the door and nobody came back. This happened a couple of months ago. R39 said if they yell for help, the staff shut the door; and if they ring the call bell, nobody responds. R39 said that this usually occurred during the evening shift. Review of R39's quarterly MDS, with an ARD of [NJ Exec Order 26.4b] revealed the resident had a BIMS score of [NJ Ex]/15, indicating the resident was [NJ Exec Order 26.4b1]	F 725	The administrator or designee will review staffing needs 5X a week and provide an adequate number of nursing staff to address the acuity and diagnoses of the facility's resident population Nursing Administration educated Nursing staff 0n 2/2/23 on providing showers and bathing in accordance with the residents preference and plan of care to maintain hygiene. Administrator or designee will audit staffing schedules 3 times a week for four weeks, then weekly for 2 months to ensure sufficient nursing staffing to meet the daily care required by the residents. The results of these audits will be resented to the QAPI Committee on a monthly basis for 3 months or until substantial compliance is achieved. Unit Manager or designee will audit bathing/shower documentation weekly for 5 residents x 4 weeks, then monthly for 2 months. The UM or designee will report the results of these audits to the QAPI Committee on a monthly basis for 3 months for until substantial compliance is achieved. The Unit Manager or designee will audit call bell response time on all 3 shifts for the next 4 weeks. This will be done for Residents # 303, 76, and 39, as well as residents on all 3 units. After 4 weeks this will be audited monthly for 2 months to ensure ongoing compliance. The Unit Manager or designee will present the	



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F 725	Continued From page 27 NJ Exec Order 5. During an interview on 01/26/2023 at 1:25 PM, the Staffing Coordinator stated residents' showers were completed by CNAs on their scheduled shifts and that there were no bath aides or regular staff to give showers. The Staffing Coordinator stated that the ideal for staffing would be eight residents per CNA for the morning schedule, 10 residents per CNA for the afternoon schedule, and 14 residents per CNA for the night schedule. The Staffing Coordinator stated that the facility was actively pursuing staff agencies to help in shortage of staff members. A review was conducted of the Daily Staffing Sheets from 01/02/23 through 01/21/23. According to the Staffing Coordinator, the ideal staffing ratio for the morning shift would be eight residents per staff. Based on the staffing sheets, the facility was out of compliance 19 out of 20 days, with the lowest ratio being nine residents per staff and the highest being 19 residents per staff. According to the Staffing Coordinator, the ideal staffing ratio for the afternoon staff would be 10 residents per staff. Based on the staffing sheets, the facility was out of compliance for 17 out of 20 days, with the lowest ration being 11 residents per staff and the highest ration being 17 residents per staff. According to the Staffing Coordinator, the ideal staffing ratio for the afternoon staff would be 14 residents per staff. Based on the staffing sheets, the facility was out of compliance for 18 out of 20 days, with the lowest ration being 16 residents	F 725	results of the audits to the QAPI Committee on a monthly basis for 90 days or until substantial compliance is achieved	

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per staff and the highest ration being 33 residents per staff.

6. a. Interview with CNA1 on 01/25/23 at approximately 10:42 AM revealed there is a shower list and CNA1 gives all of assigned residents a shower on Monday; however, for the past few weeks, the facility has been short of staff and they have been giving bed baths (instead of showers.)

b. An interview was conducted on 01/25/23 at approximately 11:15 AM with CNA8, who works the 7:00 AM - 3:30 PM shift. When asked about staffing ratios, she stated "We do the best we can. The residents come first." She also said that when the nurses are finished with doing medications, they will help. She has from time-to-time volunteered to work overtime.

c. An interview was conducted on 01/25/23 at approximately 11:30AM with CNA4, who works the 7:00 -3:30 PM shift. When asked about staffing ratios, she also stated "We do the best we can. The residents come first." She also said that when the nurses are finished with doing medications, they will help. She has from time-to-time volunteered to work overtime.

An interview was conducted on 01/25/23 at approximately 11:45 AM with CNA5, who works the 7:00 AM - 3:30 PM shift. When asked about staffing ratios, he also stated "We do the best we can. The residents come first." He also said that when the nurses are finished with doing medications, they will help. He has from time-to-time volunteered to work overtime. He stressed that they all work together to make sure

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the residents are taken care of.

An interview was conducted on 01/26/23 at approximately 9:25 AM with CNA9, who works the 7:00 AM -3:30 PM shift. When asked about staffing ratios, she also stated "We do the best we can. The residents come first." She also said that when the nurses are finished with doing medications, they will help. She has from time-to-time volunteered to work overtime. She stressed that they all work together to make sure the residents are taken care of.

An interview was conducted with CNA11 on 01/26 at approximately 10:45 AM, who volunteered today to work the 7:00 AM -3:30 PM shift. His normal schedule is double shifts on the weekends from 7:00 AM to 11:00 PM. He stressed that they all work together to make sure the residents are taken care of.

Interview with the Unit Manager (UM) on 01/25/23 at approximately 11:45 AM, who works the 7 - 3:30 shift. When asked about staffing ratios, she stated "We do the best we can. Sometimes we are short of staff and try to get the best care for the residents."

An interview was conducted on 01/26/23 at approximately 11:55 AM with CNA12, who normally works the second shift from 3:30 PM - 11:00 PM. She decided to work a double shift. When asked about staffing ratios, she also stated "We do the best we can. The residents come first."

Interview with the Director of Nursing (DON) on 01/25/23 at approximately 10:45AM revealed that scheduling of staff members depends on resident

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F 725	Continued From page 30 populations. If the facility's resident population is full (total 124), then it is maximum staffing. Per the DON, "Right now, the resident population is at 99. We use less staff members because the resident population is down." The DON stated the facility has a list of volunteers who want to work extra shifts as needed. If the DON knows that there will be a shortage of staff for the next shift, the DON will ask for volunteers to cover or stay a little longer to help out, and will use a staffing agency if the need comes up. NJAC 8:39-25.2(b)	F 725		
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;	F 758		3/3/23

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F 758	Continued From page 31 §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 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, record review, and facility policy review, the facility failed to identify target behaviors for monitoring of effectiveness of NJ Exec Order 26.4b1 for one resident (Resident (R) 55) of five residents reviewed for unnecessary medications. This failure had the potential to contribute to unnecessary NJ Exec Order 26.4b1 use for R55 who used the medication to treat the NJ Exec Order 26.4b1	F 758	R55 was reassessed by Nursing and Psych NP, and PA, and his target behaviors were identified and triggered on the Task Care record for the CNA POC. R 55's Behaviors are triggered on the MAR for the nurses to monitor. Resident 55's care Plan is updated with his current target behaviors. All residents on Psychotropic medications	

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F 758	Continued From page 32 Findings include: Review of R55's undated "Admission Record" located in the "profile" tab of the electronic medical record (EMR)revealed R55 was admitted to the facility on NJ Exec Order 26.4b with diagnoses which include NJ Exec Order 26.4b1 Review of R55's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ Exec Order 26.4b located in the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of NJ Exec Ord out of 15 indicating R55 was NJ Exec Order 26.4b1. The MDS also revealed R55 exhibited NJ Exec Order 26.4b1 of feeling NJ Exec Ord or NJ Exec Order 26.4b1. He did not exhibit any symptoms NJ Exec Order 26.4 He received NJ Exec Order 26.4b1 daily during the seven day lookback period. Review of R55's "Physician Orders" located in the EMR under the "Orders" tab revealed an order for NJ Exec Order 26.4b1 two tablets by mouth at bedtime for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4b and an order for NJ Exec Order 26.4b1 1 tablet by mouth one time a day for NJ Exec Order 26.4 with a start date of NJ Exec Order 26.4b and a discontinue date of NJ Exec Order 26.4b. Review of R55's paper "Consent" form, dated NJ Exec Order 26.4, provided by the facility, revealed R55's responsible party had consented to the use of NJ Exec Order 26.4b1 and was informed of the risks and benefits of the medications.	F 758	had the potential to be affected by this practice. Nursing administration reassessed all residents on psychotropic medications to ensure that there are targeted behaviors being monitored for the effectiveness of the medication. The behaviors for these residents have been placed on the Task Care Record for the CNA POC, and on the MAR for the nurses to monitor. Nurses, PA and attending MD were re-inserviced on the Psychotropic Medication use Policy & Procedure, and specifically on ensuring the targeted behaviors are identified and monitored for effectiveness of the medication. Nurses, CNAs, PA and MD were re-inserviced on the policy for Behaviors; Management of Symptoms. CNAs were re-inserviced on documentation of resident's targeted behaviors on the Task Care record of POC and reporting any changes to the nurse. The Unit Manager or designee will audit 5 residents per week for 4 weeks who are on Psychotropic medications to ensure the targeted behaviors are identified, are accurate and are being documented on. After 4 weeks the Unit Manager or	

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F 758	Continued From page 33 Review of R55's "Care Plan" located in the "Care Plan" tab of the EMR and dated NJ Exec Order 26.4b revealed R55 "is at risk for complications related to the use of NJ Exec Order 26.4b1." Interventions included "Complete behavior monitoring flow sheet" and "Monitor for side effects and consult physician/pharmacist as needed." Review of R55's "Care Plan" located in the "Care Plan" tab of the EMR and dated NJ Exec Order 26.4b revealed R55 had NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Interventions included "Engage resident/patient in simple, structured activities of their preference that avoid overly demanding tasks." Review of R55's EMR, including "Progress Notes" under the "Notes" tab and "Medication/Administration Records" under the "Orders" tab revealed no documentation of monitoring of NJ Exec Order 26.4b1 symptoms to evaluate the symptoms of the NJ Exec Order 26.4b1 On 01/23/23 at 12:50 PM, the resident was observed in the day room at a table. On 01/24/23 at 07:01 PM, R55 was sitting at the table in dayroom. His dinner tray was delivered with macaroni and cheese, stewed tomatoes and a dinner roll.R55 spilled his coffee and an aide took his tray away with all of his food. During an interview with Certified Nursing Assistant (CNA) 1 on 01/24/23 at 3:00 PM she stated that R55 does stand up. She stated that his mental status is NJ Exec. Order 26:4.b.1 he will start NJ Exec. Order and she stated that she has not seen any behaviors. He watches TV and sometimes plays	F 758	designee will continue to audit 5 residents per month for 2 months to ensure the targeted behaviors are identified, are accurate and are being documented on. The Unit Manager or designee will present the results of her audits to the QAPI Committee on a monthly basis for 90 days or until substantial compliance is achieved . The Administrator will ensure compliance of these audits and will take corrective action as needed	

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F 758	Continued From page 34 cards; she had not seen any family come in. During an interview with CNA2 on 01/25/23 at 12:09 PM she stated R55 does try to get up independently; however, when he does attempt to get up he NJ Exec O. CNA2 also stated that R33 does not talk to her. When he tries to get up the nurse at the desk will see him. CNA2 further stated because R55 always tries to stand up independently, we have to look at him every time we pass by the day room. During an interview with Licensed Practical Nurse (LPN) 1 on 01/25/23 at 12:18 PM she stated the staff puts R55 in the day room so they can watch him. She indicated that R55 did have some NJ Exec Order 26.4b1 a couple of weeks ago. During the NJ Exec Order 26.4b1 R55 said NJ Exec Order 26.4b1 ." She stated that he is on NJ Exec Order 26.4b1 though they were NJ Exec Order 26.4b1 LPN1 said that R55 is now on NJ Exec Order (as needed.) The facility doesn't have specific orders for the monitoring of behaviors for R55. She indicated that other residents do have this type of monitoring and that the facility must be aware of the problem." In a follow up interview with the LPN1 on 01/25/23 at 12:50 PM she stated that there was no official documentation for tracking the side effects of NJ Exec Order 26.4b1 for R55. In most cases, the EMR generates a progress note which is triggered by the MAR. R55's EMR doesn't have that functionality yet. LPN1 showed an example of how the documentation works for different resident. During an interview with the Director of Nursing (DON) on 01/26/23 at 01:34 PM, she stated she	F 758		

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F 758	Continued From page 35	F 758		

couldn't find the pharmacy recommendations to the physician. She further stated that the behavior monitoring did not get linked to the R55's EMR, so the target behaviors were not being monitored.

During an interview with the Consultant Pharmacist (CP) on 01/26/23 at 2:56 PM, she indicated that for a resident who had a NJ Exec Order 26.4b and also on an NJ Exec Order 26.4b1 , she had a checklist and looked at "the psych consult, diagnosis, gradual dose reduction [GDR] target behaviors, lab monitoring, Abnormal Involuntary Movement Scale (AIMS), target behaviors, and orthostatic blood pressure." The CP also stated she reviews the general progress notes depending on what they are looking at, sometimes including talking to nurses and looking at the MAR. Continued interview revealed for a new resident on an NJ Exec Order 26.4b1 , she makes a recommendation on a GDR twice within the first year in two separate quarters, and at least one month apart, starting a quarter from when they come in. The CP stated the recommendations then go back to the facility they have a process in place, the recommendations are sent to the DON or unit manager and they address them with the physician. The CP also stated she provides an upload for the facility to place in a binder. The CP further stated she would check on the recommendations in the software or the next time the Pharmacist go the facility they will look in the binder. They will look at the compliance rate of the facility. She indicated that were someone with NJ Exec Order 26.4b to get an NJ Exec Order 26.4b1 it would require frequent monitoring and supervision by the prescriber. When asked if worrying about medical conditions and crying were an adequate indication of use, the pharmacist stated, "It's

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F 758	Continued From page 36 difficult to say; I would defer to the clinician, depending on the patient's response, would defer to Nurse Practitioner." Review of the facility's policy titled, "Psychotropic Medication Use" revised on 10/24/22 indicated "The facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors ...All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for: Efficacy, risks, benefits and harm or adverse consequences ....Antipsychotic medications used to treat Behavioral or Psychological Symptoms of Dementia (BPSD) must be clinically indicated, be supported by an adequate rationale for use and may not be used for a behavior with an unidentifiable cause ...Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for resident's receiving psychotropic medication for organic mental syndrome with agitated or psychotic behaviors. Facility should monitor behavioral triggers, episodes and symptoms. Facility should document the number and/or intensity of symptoms and the resident's response to staff interventions." Review of the facility's policy titled, "Behaviors: Management of Symptoms" revised on10/24/22 indicated that " ...Staff will monitor for and document in the medical records any exhibited behavioral symptoms which include, but are not	F 758		

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F 758	Continued From page 37 limited to: Verbally aggressive behaviors ...Physically aggressive behaviors." NJAC 8:39-29.2(d)	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure palatable food was served to 11 (Resident (R) 88, R54, R15, R303, R19, R82, R86, R97, R37, R44, R3) of 97 total residents Specifically, the food did not look appetizing, lacked flavor and was not at an appropriate proper temperature. Findings include: 1. Interviews with residents during the survey process revealed the following complaints about food palatability: a. On 01/23/23 at 1:07 PM, R54 stated the food had, "No taste - Ask for something different-Nothing happens."	F 804	Dietary staff met with Residents 54, 15, 303, 19, 82, 97, 37. Residents # 97 and 37 were discharged home. They were interviewed regarding their food preferences, the food appearance, and their concerns with palatability- to determine how to improve their satisfaction. (Residents # 88, 86 and 44 were not on the sample list of residents provided to facility) All residents had the potential to be affected by this practice. Any food products served at inappropriate temperatures were replaced prior to resident consumption.	3/3/23

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F 804	Continued From page 38 Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26 in the electronic Medical Record (EMR) under the "MDS" tab revealed R54 was admitted to the facility on NJ Exec Order 26.4b. The MDS indicated R54 had a "Brief Interview for Mental Status (BIMS)" score of NJ Ex/15, indicating the resident was NJ Exec Order 26.4b1 b. On 01/23/23 at 1:20 PM, R88 stated "I cannot eat some of the meals because there's no taste." Review of the annual "MDS" with an ARD of NJ Exec Order 26.4b in the EMR under the "MDS" tab revealed R88 was admitted to the facility on NJ Exec Order 26.4b The BIMS score was left blank. c. On 01/23/23 at 1:11 PM R15, stated the food was, "Terrible --no taste---Ask for something different --No one listens-- What is served is what you get." Review of the annual "MDS" with an ARD of NJ Exec Order 26.4b in the EMR under the "MDS" tab revealed R15 was admitted to the facility on NJ Exec Order 26.4b. R15 was NJ Exec Order 26.4b1 with a BIMS score of NJ Ex/15. d. On 01/23/23 at 10:29 R303 stated "Food is very bland." Review of the admission "MDS" with an ARD of NJ Exec Order 26.4 in the EMR under the "MDS" tab revealed R303 was admitted to the facility on NJ Exec Order 26.4. R303 was NJ Exec Order 26.4b1 with a BIMS score of NJ Ex/15.	F 804	All meal temperatures are monitored daily to ensure all temperature recording procedures are properly followed. Cooks were re-inserviced to ensure that temperatures of all food items are recorded prior to meal service and are in the appropriate ranges, by the FSD or designee. The Dietary cooks will be able to demonstrate the correct procedure for temperature recording, they will also be able to verbalize the correct way according to policy The Food service Director or designee will hold weekly food service committee meetings with residents for 4 weeks to discuss with them the taste and appearance of food served, as well as to ask if they are provided with substitutions when asked. The Food service director or designee will audit 5 residents / week for 4 weeks to ensure the accurate menu is what the residents are being served, and to ensure residents are provided with an alternate if requested. after 4 weeks the FSD or designee will continue to audit 5 residents per month to ensure the accurate menus is what the residents are being served, and that the residents are provided with an alternate or substitution if requested. The results of these audits will be presented to the QAPI Committee on a monthly basis by the FSD or designee for 3 months, or until substantial compliance is achieved.	

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F 804 Continued From page 39 F 804

e. On 01/23/23 at 11:06 AM, R19 stated "Food is dry, tough and tasteless. I never enjoy a meal. I like the soup, but the other food is not eatable [sic]. I don't know why they can't give it taste."

Review of the annual admission "MDS" with an ARD of NJ Exec Order 26.4 in the EMR under the "MDS" tab revealed R19 was admitted to the facility on NJ Exec Order 26.4b. R19 was NJ Exec Order 26.4b1 with a BIMS score of NJ Ex/15.

f. On 01/23/23 at 12:15 PM, R82 stated "The food sometimes is terrible.

Review of the quarterly "MDS" with an ARD of NJ Exec Order 26.4b in the EMR under the "MDS" tab revealed R82 was admitted to the facility on NJ Exec Order 26.4b. R82 was NJ Exec Order 26.4b1 with a BIMS score of NJ Ex/15.

g. On 01/23/23 at 11:24 AM, R86 stated "The food is not that great. Most of the time it is cold."

Review of the quarterly "MDS" with an ARD of NJ Exec Order 26.4b in the EMR under the "MDS" tab revealed R86 was admitted to the facility on NJ Exec Order 26.4b. R86 was NJ Exec Order 26.4b1 with a BIMS score of NJ Ex/15.

h. On 01/23/23 at 01:27, PM R97 stated "The food could be better."

i. On 01/23/23 at 12:03, PM R37 stated "The food

the Food Service Director or designee will conduct audits 3 times a week on all units to ensure food temps are within range for 4 weeks. After 4 weeks the FSD or designee will continue to conduct weekly audits on food temps to ensure they are within the acceptable range.

Weekly audits of Food temperatures test trays will be presented monthly by the Food Service Director or designee at the monthly QAPI meeting for 3 months, or until substantial compliance is achieved.

The Administrator will ensure compliance of these audits and will take corrective action as needed

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is awful, very difficult to eat. Either too dry or undercooked ...a piece of pie the other night was frozen when I tried to eat. Pizza crust was like a biscuit."

Review of the admission "MDS" with an ARD of NJ Exec Order 26.4b in the EMR under the "MDS" tab revealed R37 was admitted to the facility on NJ Exec Order 26.4b. R37 was NJ Exec Order 26.4b1 with a BIMS score of NJ Ex/15.

j. On 01/23/23 at 01:34 PM, R3 stated "The food is terrible. The baked potato is hard as a rock, the French fries are not fully cooked, and the sandwich today was a piece of thin sliced turkey and a piece of cheese."

Review of the admission "MDS" with an ARD of NJ Exec Order 26.4b in the EMR under the "MDS" tab revealed R3 was admitted to the facility on NJ Exec Order 26.4b. R3 was NJ Exec Order 26.4b1 with a BIMS score of NJ Ex/15.

k. On 01/23/23 at 02:37 PM, R44 stated that "I can't eat their food. It does not taste good ...I have to buy my own food."

Review of the quarterly "MDS" with an ARD of NJ Exec Order 26.4 in the EMR under the "MDS" tab revealed R44 was admitted to the facility on NJ Exec Order 26.4b. R82 was NJ Exec Order 26.4b1 with a BIMS score of NJ Exe 15.

2. The paper "Food Committee Minutes" revealed the following comments from anonymous residents:

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F 804	Continued From page 41	F 804		

08/10/22 - Pork is not tender enough, breakfast generally served late, sometimes the food is no good.
08/29/22 - Fish is overcooked, French toast and pancakes need to be hotter, some foods are overcooked, no seasonings are used.
10/07/22 - Gravy was too thick.
10/21/22 - Vegetables are too soft, vegetables are also too hard.
11/11/22 - Pork chops were a bit tough.
11/22/22 - Vegetables are too soft at times.

3. Observations revealed concerns with meal palatability, attractiveness/appearance of food, and temperatures:

a. On 01/23/23 at 12:53 PM, lunch was observed to be a turkey sandwich and mashed potatoes that lacked color (everything in the meal was a white/beige color). Green beans were on the menu but were missing on residents' plates.

b. On 01/24/23 at 6:38 PM, a pureed test tray was obtained from the kitchen. The Registered Dietitian (RD) took the following temperatures of the test tray food items: pureed bread - 145 degrees F, pureed macaroni and cheese - 157.8 degrees F, stewed tomatoes - 141.3 degrees F, pureed broccoli - 54.9 degrees F, pureed cookies - 60 degrees F, milk 43.3 degrees F, coffee - 168.6 degrees F. The RD then brought the tray to the conference room. The RD refused to taste the test tray. The survey team then tasted the test tray. The bread, macaroni and cheese and pureed cookies tasted within acceptable palatability standards; however, the broccoli and tomatoes were found to be bland.

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F 804	Continued From page 42 c. On 01/26/23 at10:00 AM, an observation with the Dietary Manager (DM) of the pureed bread revealed it to be composed of bread crumbs and water whisked together. No additional ingredients or spices were observed to be added. d. On 01/26/23 at 10:34 AM, an observation of pureed potato salad revealed five scoops of a previously composed potato salad which the DM stated contained: chicken broth, diced potatoes, hard boiled eggs, mayonnaise, poultry seasoning, garlic and turmeric. He added that green beans are hard to puree. On 01/23/23 at 10:14 AM, the DM was interviewed during the kitchen observation. He stated that the facility does have a resident food committee and there is one coming up this month. He indicated that the RD obtains the food preferences, and they are entered in Meal Tracker, tray tickets are printed in the kitchen. During an additional interview with the DM on 01/23/23 at 1:55 PM, he stated that there is a food committee which is made-up of the residents. They meet on a monthly basis to discuss the menu for that month. They also discuss alternative meals for any resident that does not like the main meal. If there are any complaints or concerns about the meals, "we will discuss it." Although review of the "Food Committee Minutes," revealed food complaints, the DM stated that for the past six months, there have been no complaints about the food being served. On 01/23/23 at 3:15 PM the DM was interviewed again. He stated that he does get some	F 804		

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complaints about the food, usually the temperature of the food, that the vegetables are too soft and not salty enough.

During an interview with the RD on 01/26/23 at 11:14 AM she stated the food is not palatable, residents cannot cut through it because it is too hard, and staff always tried to offer something from the "always available" menu. She stated she would change it completely, adding more fruit and probably frozen broccoli. She said she is trying, and the DM is new and trying to work on the palatability of the food, with changes with the cooks.

Review of the paper "Food: Quality and Palatability" policy, dated 05/2014 and revised 09/2017, revealed "Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form and texture to meet resident's needs ...Food attractiveness refers to the appearance of the food when served to the residents ...Food palatability refers to the taste and/or flavor of the food ...Proper (safe and appetizing) temperature - Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction ...The cook prepares food in accordance with the recipes, and season for region and/or ethnic preferences, as appropriate. Cook uses proper cooking techniques to ensure color and flavor retention."

NJAC 8:39-17.4(a)2

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F 812	Continued From page 44	F 812		
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, the facility failed to ensure that the kitchen was maintained in a sanitary manner. Specifically, the kitchen was found to be unclean. Work areas were in disrepair. Dishwashing was not conducted in accordance with current professional standards of sanitation, Concerns were noted with food storage, and tray line food temperatures were not within current professional safety standards. The failure to maintain required kitchen sanitation had the potential to affect 96 of 97 residents who received food stored, prepared, and served in the kitchen. Findings include:	F 812	No residents were affected by this deficient practice All residents had the potential to be affected by this practice a) The dishwasher was repaired on 1/25/23. The stainless steel table legs were repaired. The floor under the dishwasher will be repaired by 3/13/23. b) The tile wall behind the 3 compartment sink was cleaned on 1/26/23.	3/13/23

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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 45 1. The initial kitchen inspection was conducted on 01/23/23 from 9:27 AM through 10:27 AM with the Dietary Manager (DM). The following concerns were noted: a. The dishwasher was observed to be leaking and the dish machine floor was in poor repair. Rust was noted along the bottom of the stainless steel legs. The floor under the dishwasher was noted to be crumbling. b. The tile wall behind the three-compartment sink was observed to be covered with a grimy residue. c. The ceiling was in poor condition and was missing several tiles. The ceiling fan was covered with a thick layer of dust. f. The microwave was full of crumbs and detritus. g. A clean plastic coffee mug was observed with a thick coffee stain on the inside of the mug. h. A scoop was observed inside the sugar bin. The DM read the label of sugar bin and did not remove the scoop. i. The walk-in refrigerator had a stainless floor tile missing and chunks of broken white rock/stone were observed on the floor. j. Observation of the dishwashing process revealed multiple crumbs and food debris, a rag, and a sponge located on the stainless counter of the clean side of the dish machine. Dietary Aide 1 (DA)1 was washing dishes. He was not wearing gloves. DA1 sprayed off two soiled stainless steamtable pan lids with water and then placed them on the counter where clean dishes came out of the machine. The lids that were not washed were then dried off with the towel that was on the counter and moved to the clean storage area. DA1 then touched clean plates that he removed from the dish rack after they had been washed in	F 812	c) The ceiling tiles were replaced. The ceiling vent was cleaned on 2/9/23. Future capital funds will be allocated to replace the ceiling assembly f) the microwave was removed from the kitchen on 1/23/23. g) All coffee mugs were de-stained on 1/24/23. h) Scoops were removed from bulk bins on 1/23/23 i) The walk in refrigerator floor will be repaired by 3/13/23 All Dietary staff were re-inserviced on cross contamination on 1/26/23. The dishes, pots, pans etc were re-cleaned after cross contamination. All Dietary staff were re-inserviced on proper hand washing, Completion of Daily Cleaning assignments, and proper ware-washing including appropriate cleaning materials etc. A cleaning schedule is in place and will be monitored daily by FSD or designee. The Food Service Director or Designee will conduct weekly hand hygiene audits for 4 weeks. Daily cleaning assignments will be signed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING ______ B. WING ______	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

(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 46

the dish machine. DA1 had not washed his hands/performed hand hygiene after touching the soiled steam table pans and prior to touching the clean plates. DA1 touched all the plates with contaminated hands when he stacked them. DA1 then touched the edge of the garbage can, went to the dirty side of the dish machine and sprayed off dishes/pots and loaded them into racks to be washed. DA1 touched his face mask, and then went to the clean side of the dish machine and grabbed the clean stack of plates and placed them in the plate warmer without washing his hands/performing hand hygiene after touching the garbage can, his face mask, and the soiled steamtable pan lids.

On 01/26/23 at 10:34 AM during a kitchen observation, DA1 was interviewed. He states that sometimes he may need to do the dishes by himself if they are short staffed. The person who used to assist DA1 doing the dishes no longer works there. When asked about going back and forth from the clean side to the dirty side in the dishwashing area, he stated he did not recall.

On 01/26/23 at 10:34 AM, the DM was interviewed. He explained that he was aware that DA1 had been going from the dirty to clean area and clean to dirty area and that the staff had since been in-serviced on proper dishwashing and hand hygiene practices. When asked about the wet trays stacked up on the clean side of the dishwasher, the DM stated they wipe them dry before using them for tray line.

2. During a kitchen observation on 01/24/23 at 5:00 PM the following concerns were again noted:

F 812

off by the staff at the completion of their shift and verified by the Food Service Director or designee for completion.

Staff will sign off daily on the cleaning assignments at the completion

The Food Service Director will complete weekly audits of the sanitation and food safety inspections and will report results of these weekly audits to the QAPI committee on a monthly basis for 3 months or until substantial compliance is achieved.

The FSD or designee will audit food line temps 3 times a week, and will report the results of these weekly audits to the QAPI Committee on a monthly basis for 3 months or until substantial compliance is achieved.

The Administrator will ensure compliance of these audits and will take corrective action as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING ______ B. WING ______	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

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F 812	Continued From page 47 a. The dish machine floor was still in poor repair, rust noted along bottom of stainless legs. The floor under the dishwasher was noted to be crumbling. b. The tile wall behind the three-compartment sink was observed to be covered with a grimy residue. c. The ceiling was still in poor condition, noted to be missing several tiles, and the ceiling fan was covered with a thick layer of dust. d. The walk-in refrigerator was observed to still have a stainless floor tile missing and chunks of broken white rock/stone observed on floor. e. A scoop was observed in the thickener. The DM stated, "There should not be a scoop in thickener." 3. On 01/24/23 at 5:00 PM, the DM stated that two trucks with residents' trays had already gone to the resident units for service, and he failed to obtain tray line food temperatures prior to meal service. An observation and temperature monitoring of the dinner tray line by the DM revealed a failure to maintain food holding temperatures within required parameters. The following temperatures were recorded: cole slaw - 52 degrees F, broccoli salad - 57 degrees F, pureed broccoli salad - 57 degrees F and BBQ chicken - 131.5 degrees F. On 01/24/23 at 6:06 PM, 22 trays were observed already served to residents. The trays were served prior to temperatures being taken and foods being heated/cooled to appropriate temperature range.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING ______ B. WING ______	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	**84 COLD HILL ROAD MENDHAM, NJ 07945**

(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 48 Review of the paper "Food Storage: Dry Goods" policy, dated 05/2014 and revised 09/2017, revealed "All dry goods will be appropriately stored in accordance with the FDA [Food and Drug Administration] Food Code ...Storage areas will be neat, arranged for easy identification, and date marked as appropriate ...Toxic materials will not be stored with food." Review of the paper "Food Storage: Cold Foods" policy, dated 05/2014 and revised 04/2018, revealed "All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code ...All perishable foods will be maintained at a temperature of 41 degrees F or below, except during necessary periods of preparation and service." Review of the paper "Environment: General Sanitation" policy dated 05/2014, and updated 09/2017, revealed "All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition ...The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting and ventilation. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food equipment and surfaces." Review of the paper "Equipment: Maintenance" policy dated 05/2014, and updated 09/2017. revealed "All foodservice equipment will be clean, sanitary and in proper working order ...All foodservice equipment will be clean, sanitary and in proper working order ...All equipment will be routinely cleaned and maintained in accordance	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING ______ B. WING ______	01/27/2023

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F 812	Continued From page 49 with manufacturer's directions and training materials. All staff members will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after every use. All non-food contact equipment will be clean and free of debris. The Dining Services Director will submit requests for maintenance or repairs to the Administrator and/or Maintenance Director as needed." Review of the paper "Ware washing" policy dated 05/2014, and revised 09/2017, revealed "All dishware, serviceware, and utensils will be cleaned and sanitized after each use. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishes through the dish machine and proper handling of sanitized dishware ...All dishware will be air dried and properly stored." Review of the paper "Food: Preparation" policy dated 05/2014, and revised 09/2017, revealed "All foods are prepared in accordance with the FDA Food Code ...All staff will practice proper hand washing techniques and glove use. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological and chemical contamination. All utensils, food contact equipment and food contact surfaces will be cleaned and sanitized after every use. The Dining Services Director will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees, or per state regulation ...All foods will be held at appropriate temperatures greater than 135 degrees F for hot	F 812		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	**84 COLD HILL ROAD** **MENDHAM, NJ 07945**

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F 812	Continued From page 50	F 812		

holding, and less than 41 degrees F for cold food holding."

Review of the paper "Manual Warewashing" policy dated 05/2014, and revised 09/2017, revealed "All cookware, dishware and serviceware that is not processed through the dish machine will be manually washed and sanitized ...The Dining Services staff will be knowledgeable in proper technique including: Chemical sanitizer testing and concentrations, Appropriate cleaning material (sponges, rags, etc) ...Appropriate test strips will be utilized to measure the concentration of the sanitizer solution ...All serviceware and cookware will be air dried prior to storage."

FDA Food Code 4-101.16 titled "Sponges, Use Limitation" states "Sponges are difficult, if not impossible, to clean once they have been in contact with food particles and contaminants that are found in the use environment ...Therefore, sponges area to be used only where they will not contaminate cleaned and sanitized or in-use, food-contact surfaces such as for cleaning equipment and utensils before rinsing and sanitizing."

NJAC 8:39-17.2(g)
NJAC 8:39-19.7(d)

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061406	A. BUILDING: ______ B. WING ______	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

(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 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 a review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for 13 of 14-day shifts, as well as 2 of 14 night shifts, as mandated by the state of New Jersey. This deficient practice was identified and the findings were as follows: Reference: New Jersey Department of Health (DOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	No residents were affected by this practice all residents had the potential to be affected by this practice Facility staff including Administrator, DON, HR Coordinator, Scheduling Manager, Market HR and Market recruiters will continue all recruiting functions through various forums to increase the number of nursing applicants Facility staff will Continue Weekly Staffing calls with regional support team to recruit nursing staff for open Nursing positions	3/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/17/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061406	A. BUILDING: ______ B. WING ______	01/27/2023

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S 560	Continued From page 1	S 560		

established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:

One Certified Nurse Aide (CNA) to every eight residents for the day shift.

One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and

One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.

1. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 1/08/23 through 1/14/23 and 1/15/23 through 1/21/23, revealed the staffing to residents ratio did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below.

The facility was deficient in CNA staffing for residents on 13 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows:

-01/08/23 had 10 CNAs for 107 residents on the day shift, required 13 CNAs.
-01/08/23 had 7 total staff for 107 residents on the overnight shift, required 8 total staff.
-01/09/23 had 10 CNAs for 106 residents on the day shift, required 13 CNAs.
-01/10/23 had 8 CNAs for 103 residents on the

Facility will continue to advertise for and hold Job fairs to recruit for open nursing positions

The DON, staffing coordinator and HR coordinator/designee will maintain a listing of current recruiting efforts, and document 3 days a week the results of these efforts.

The Human resources Coordinator will present the results of the current recruiting efforts to the QAPI Committee on a monthly basis for 3 months or until substantial compliance is achieved.

The Administrator will audit these efforts weekly x 4 weeks then monthly x 2 months to ensure the Center team is following up on all recruitment tasks.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061406	A. BUILDING: ______ B. WING ______	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 day shift, required 13 CNAs. -01/11/23 had 10 CNAs for 103 residents on the day shift, required 13 CNAs. -01/12/23 had 9 CNAs for 103 residents on the day shift, required 13 CNAs. -01/13/23 had 10 CNAs for 102 residents on the day shift, required 13 CNAs. -01/14/2023 had 10 CNAs for 100 residents on the day shift, required 12 CNAs. -01/14/23 had 6 total staff for 100 residents on the overnight shift, required 7 total staff. -01/15/23 had 7 CNAs for 100 residents on the day shift, required 12 CNAs. -01/16/23 had 7 CNAs for 97 residents on the day shift, required 12 CNAs. -01/17/23 had 7 CNAs for 97 residents on the day shift, required 12 CNAs. -01/18/23 had 10 CNAs for 97 residents on the day shift, required 12 CNAs. -01/20/23 had 10 CNAs for 96 residents on the day shift, required 12 CNAs. -01/21/23 had 11 CNAs for 96 residents on the day shift, required 12 CNAs.	S 560		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING ______ B. WING ______	R **03/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	**84 COLD HILL ROAD** **MENDHAM, NJ 07945**

(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 An onsite revisit was conducted for the 1/27/2023 Recertification survey on 3/17/2023. The facility was found to be in compliance with their POC.	{F 000}		

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

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.

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315143		3/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

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 F0558 Reg. # 483.10(e)(3) LSC	Correction Completed 03/03/2023	ID Prefix F0561 Reg. # 483.10(f)(1)-(3)(8) LSC	Correction Completed 03/03/2023	ID Prefix F0582 Reg. # 483.10(g)(17)(18)(i)-(v) LSC	Correction Completed 02/17/2023
ID Prefix F0690 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 03/03/2023	ID Prefix F0692 Reg. # 483.25(g)(1)-(3) LSC	Correction Completed 03/03/2023	ID Prefix F0725 Reg. # 483.35(a)(1)(2) LSC	Correction Completed 03/03/2023
ID Prefix F0758 Reg. # 483.45(c)(3)(e)(1)-(5) LSC	Correction Completed 03/03/2023	ID Prefix F0804 Reg. # 483.60(d)(1)(2) LSC	Correction Completed 03/03/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 03/13/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
1/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061406		3/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

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 03/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING **01** B. WING ______	**01/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	**84 COLD HILL ROAD** **MENDHAM, NJ 07945**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 1/24/2023. The facility was found to be in compliance with 42 CFR 483.73 .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/27/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Holly Manor Center is a one-story building with partial basement built in 1969. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 100 of 124. .	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to	K 211		3/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING 01 B. WING ______	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	**84 COLD HILL ROAD** **MENDHAM, NJ 07945**

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K 211	Continued From page 1 full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: . Based on document review, observations and interviews, the facility failed to ensure fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 100 residents. Findings include: A document review of the facility's inspection binder for 2022 provided by the Administrator revealed there was no evidence the fire door inspections were conducted. Observations from 12:20 PM to 1:45 PM on 01/27/23 revealed inspections were not conducted on any of the facilities' fire doors and the doors lacked the required inspection tags. The Maintenance Director was present at the time of observations and confirmed the doors were not inspected. NJAC 8:39-31.2(e) NFPA 80 .	K 211	No residents were affected by this practice All residents had the potential to be affected by this practice . Maintenance Staff were re-educated on the Requirements of NFPA 101 Life Safety Code7.2.1.15 regarding an annual inspection for all fire doors, and the requirements for marking the monthly inspection as complete in TELS. The Regional Property Manager was in and completed the fire door inspection by 2/22/23. The Maintenance Director will review the monthly door inspections in TELS to ensure all doors are inspected annually. The Maintenance Director will report the results of the TELS monthly door inspections to the QAPI Committee on a quarterly basis, to ensure all doors are inspected annually. The Administrator will ensure compliance of these audits and will take corrective action as needed	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		3/17/23

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	315143	A. BUILDING **01** B. WING ______	**01/27/2023**

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K 341	Continued From page 2 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		
	This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure a manual fire alarm pull station was located within 60 inches of the kitchen dock exit door in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) 17.14.6. This deficient practice had the potential to affect all 100 residents. Findings include: An observation at 12:39 PM on 01/27/23 revealed there was no manual fire alarm pull station located within 60 inches of the kitchen dock exit door. The nearest manual fire alarm pull station was located approximately 50 feet from the exit at the South center corridor exit door. At the time of the observation, the Maintenance		No residents were affected by this practice All residents had the potential to be affected by this practice . We will install a Pull station within 60 inches of the Kitchen dock Exit Door. Staff will be inserviced on proper use of the new pull station. Maintenance will conduct monthly inspections to ensure the pull station has been properly installed and staff is aware of its location. The Maintenance Director or designee will	

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K 341	Continued From page 3 Director confirmed a manual fire alarm pull station was not located within 60 inches of the kitchen dock exit door. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 341	report the results of the monthly inspections to the QAPI Committee on a monthly basis for 3 months to ensure compliance. The Administrator will ensure compliance of these audits and will take corrective action as needed	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) 8.5.2.2. This deficient practice had the potential to affect 37 residents. Findings include:	K 372	No residents were affected by this practice All residents had the potential to be affected by this practice . The penetrations found in the area adjacent to Room 7 and room 11, and in the area adjacent to the storage room will be sealed with an approved UL-	3/17/23

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K 372	Continued From page 4 An observation at 12:22 PM on 01/27/23 revealed the smoke barrier, located adjacent to Room 7 and room 11, had a two-inch sprinkler pipe which penetrated the smoke barrier and had an eight-inch by eight-inch piece of drywall patch around the sprinkler pipe. The drywall had pulled away from the wall and was not protected by a system or material capable of restricting the transfer of smoke. An observation at 12:35 PM on 01/27/23 revealed the smoke barrier, located adjacent to the storage room had a two-inch by two-inch hole which penetrated the smoke barrier and was not protected by a system or material capable of restricting the transfer of smoke. At the time of the observation, the Maintenance Director confirmed the penetrations in the smoke barriers were not protected by a system or material capable of restricting the transfer of smoke. The Maintenance Director had been employed by the facility for one month and did not know why the penetrations were not protected. NJAC 8:39-31.1(c), 31.2(e) .	K 372	rated through-wall penetration fire stop system W-L-4046 and numbered. A copy of the approved system will be kept in the life safety manual. The Maintenance Director or designee will conduct an initial audit of the smoke barrier walls and in the ceiling monthly X 3months and whenever vendors come in and work around the smoke and firewalls. To ensure continued compliance the Regional Property Manager re-in-serviced maintenance staff to ensure that all smoke and firewalls are inspected on a regular basis for fire safety reasons. The Maintenance Director or designee will present results of the audits on a monthly basis to the QAPI committee for 3 months The Administrator will ensure compliance of these audits and will take corrective action as needed	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors	K 374		4/26/23

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K 374	Continued From page 5 are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to maintain smoke barrier doors in a manner to prevent the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) 19.3.7.6. This deficient practice had the potential to affect all 100 residents. Findings include: An observation on 01/27/23 at 12:43 PM revealed a set of smoke barrier doors in the West Wing located adjacent to the dining room and room 56. The fire exit hardware was missing an end cap, had two holes in the door, the down rod was missing from the fire exit hardware and had four holes in the lower section of the door. An observation on 01/27/23 at 12:52 PM revealed a set of smoke barrier doors in the center wing corridor located adjacent to the kitchen. The panic hardware was damaged and did not operate properly.. At the time of the observations, the Maintenance Director confirmed the missing end cap and down rod to the fire exit hardware and the holes in the smoke barrier door on the West Wing and the damage to the panic hardware in the center wing	K 374	No residents were affected by this practice All residents had the potential to be affected by this practice The Regional Property Manager & Maintenance Director will conduct a fire door inspection on all smoke barrier doors by 2/22/23. Facility will continue conducting daily rounding. In the event that the fire alarm is activated, residents will be evacuated to an area behind the fire rated doors on West Wing that are in safe condition. Staff have been inserviced on this process. The smoke doors on West wing, adjacent to Room 56 and the set of barrier doors in the center wing corridor by the Kitchen as well as the West Wing doors missing panic hardware will be repaired or replaced. Any other doors identified with having issues will also be repaired or replaced. The Maintenance director will inspect all	

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K 374	Continued From page 6 corridor doors. NJAC 8:39-31.1(c), 31.2(e) .	K 374	fire smoke barrier doors on a monthly basis, to ensure compliance with NFPA 101 Life Safety Code 19.3.7.6 . The Maintenance Director will present the results of these inspections to the QAPI committee on a monthly basis. The Administrator will ensure compliance of these audits and will take corrective action as needed	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure access and working space was provided and maintained for an electrical transformer to permit ready and safe operation and maintenance of such equipment in accordance with NFPA 70 National Electrical Code (2011 Edition) section 110.26 (B). This deficient practice had the potential to affect 13	K 511	No residents were affected by this practice all residents had the potential to be affected by this practice The maintenance and Environmental services staff were inserviced on NJAC	1/30/23

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K 511	Continued From page 7 residents. Findings include: An observation on 01/27/23 at 01:35 PM revealed linen was stored in a small room in the North Wing adjacent to the pantry and was within three feet in front and below an electrical transformer. The Maintenance Director was present at the time of observation and verified that the linen was stored within three feet of the transformer. The Maintenance Director had been employed by the facility for one month and did not know why the linen was stored within three feet of the transformer. NJAC 8:39-31.2(e) NFPA 70 .	K 511	8:39-31.2 (e) NFPA 70, and specifically on the requirement that no combustible items may be stored within 3 feet of electrical equipment. The Maintenance director removed the shelving in the linen pantry to ensure there are no items stored within 3 feet of the electrical transformer on 1/30/2023. The Maintenance director will conduct weekly audits for 8 weeks, and then monthly thereafter to ensure no items are stored within 3 feet of electrical equipment. The Maintenance Director will present the results of these inspections to the QAPI committee for 4 months. The Administrator will ensure compliance of these audits and will take corrective action as needed	

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
315143 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	4/27/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

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 Reg. # NFPA 101 LSC K0211	Correction Completed 03/03/2023	ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 03/17/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 03/17/2023
ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 04/26/2023	ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 01/30/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO