STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	415 SOUTHERN BLVD CHATHAM, NJ 07928

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: 155480, 157599, 160245, 160758, 163821, 167099, 167644, 168860, 169750, 171627 Survey Date: 05/22/24 to 5/31/24 Census: 76 Sample: 24 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		7/15/24

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

Electronically Signed | 06/13/2024

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that the facility failed to ensure that residents were served their meals in a dignified manner during meal service. This deficient practice was observed for 3 of 3 meals in 1 of 2 dining rooms. The deficient practice was evidenced by the following: On 05/22/2024 at 12:24 PM, the surveyor observed in the South unit dining area during mealtime that at one table, a staff member sat and fed a resident while the other resident at the same table was not eating or being fed. A second table was observed with three residents that were served their trays and eating, while one resident at the same table did not have their meal. A third	F 550	F550 SS: D Resident Rights / Exercise of Rights Certified Nursing assistant and Nursing staff assigned to south unit dining area were educated on facility policy and procedure for Resident Dining to ensure that residents were served their meals in a dignified manner during meal service. Residents attending dining program have the potential to be affected by this finding. An audit of resident dining program was conducted to identify If others were affected. No new findings	

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F 550	Continued From page 2 table was observed with two residents that were served their trays and eating while two other residents at the same table did not have their meals. A fourth table was observed with one resident who was served their tray and was eating while two other residents at the same table were not served their trays. It was observed by the surveyor that the trays of residents eating at the same table did not arrive to the dining area on the same cart. The first cart with lunch trays arrived to the unit at 11:57 AM and the fourth cart arrived at 12:25 PM. On 05/23/2024 at 12:28 PM, the surveyor observed in the South unit dining area during mealtime that at one table three residents were served their meals and eating at approximately three minutes before another resident seated at the same table had been served. On 05/24/2024 at 08:05 AM, the surveyor observed in the South unit dining area during mealtime that at one table a resident was served their meal and eating approximately seven minutes before the tablemate was served their meal. Another table was observed with a resident who was being fed by a staff member for approximately five minutes before a family member arrived and began feeding the tablemate. On 05/24/2024 at 11:40 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that all residents sitting at one table should be eating at the same time. On 05/29/2024 at 01:18 PM, the surveyor interviewed the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) who stated that residents at the same table	F 550	The policy titled Resident Dining policy was reviewed by Director of Nursing/ADMINISTRATOR. No changes are needed. Certified Nursing assistants, Licensed Nursing Staff and Dietary staff were educated by the dietician/Director of Nursing on dining program requirements including serving residents seated at the same table had before start serving another table to ensure residents sitting at one table will be eating at the same time. Facility established a dining program mapping in coordination to level of feeding assistance needed with resident during mealtimes and to ensure food delivery and serving according to table seating and specific resident groupings based on feeding assistance needs Unit manager/Designee and Registered Dietician will oversee the dining program to ensure residents will be served their meals in a dignified manner during meal service. Unit Manager/Dietitian will audit dining program including serving residents seated at the same table had before start serving another table to ensure residents sitting at one table will be eating at the same time weekly for 4 weeks, then monthly X3. The results of the audits will be presented to the monthly Quality assurance	

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F 550	Continued From page 3 should be served together for dignity issues. The U.S. FOIA (b) (6) stated that the new U.S. FOIA (b) (6) was sending the trays to the units by room number, not according to table seating. Review of facility provided policy "Resident Dining Policy" dated 04/14/24 indicated that rounds and audits will be conducted to assess: "d. Whether residents at each table are served together." N.J.A.C. 8:39-4.1(a)12	F 550	committee for review and feedback. Responsible party: Director of Nursing	
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:	F 576		7/15/24

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F 576	Continued From page 4 (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interviews it was determined that the facility failed to provide daily delivery of mail, to include Saturdays. This deficient practice was identified for 1 of 5 residents interviewed during the resident council group meeting (Resident #61), and was evidenced by the following: On 05/24/24 at 10:03 AM, the surveyor attended a resident council group meeting with Residents #38, #45, #48, #61 and #64. The surveyor interviewed the residents regarding mail delivery and Resident #61 stated that they did not received mail from NJ Ex Order 26.4(b)(1) until NJ Ex Order 26.4(b)(1). The resident stated that he/she was expecting a letter from NJ Ex Order 2 and when they brought the concern to the U.S. FOIA (b) (6), she returned with a pile of mail including a letter that informed the resident NJ Ex Or because the date had passed. The resident stated that the facility had to write a letter in order to get their (the resident) services.	F 576	F576 Right to form of communication with privacy The Social work and activities department were educated on the policy regarding Mail delivery for residents. All residents have the potential to be affected by this finding. All residents were interviewed to ensure all have received their mails and no further findings were identified The policy titled mail delivery for residents was reviewed by Director of Nursing/ADMINISTRATOR. No changes are needed. Administrator will educate all department heads on the mail delivery process for residents.	

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F 576	Continued From page 5 On 5/30/24 at 10:11 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the process of delivering mail at the facility. The NJ Ex Ord stated that when mail was delivered to the facility, mail was dropped off with the U.S. FOIA (b) (6) The business department would sort the mail and that mail would be placed in the NJ Ex Order 26.4(b)(1) mailbox and that the U.S. FOIA (b) (6) would deliver the mail to the resident and contact family from Monday through Friday. The U.S. FOIA stated that she was on NJ Exec Order 26.4b1 from NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) and that she was aware that the covering U.S. FOIA (b) (6) was unaware about the mail delivery process and that this U.S. FO was no longer working at the facility. When a new U.S. FO started in NJ Exec Order 26.4b1, she found the mail and immediately delivered the mail to the residents. She further stated that she was aware of the situation regarding Resident #61's letter from NJ Ex Order 26.4(b)(1). She stated that the facility was able to get the resident NJ Ex Order 26.4(b)(1) On 5/30/24 at 10:40 AM, the surveyor interviewed the U.S. FOIA (b) (6) , who stated that when she received mail from the U.S. FOIA (b) (6) that she would sort out the mail. She further stated mail such as cards or magazines would be placed in the recreational department mailbox while important mail such as mail from insurance companies, bills, and checks, she would place it in the social services mailbox. She showed the surveyor the social services mailbox and stated that the mailbox had limited space, if it filled up she will bring it to the individual department. She further stated that it was the departments responsibility to deliver the mail to the residents. On 5/30/24 at 10:50 AM, the surveyor interviewed	F 576	Facility established a new process to ensure there is coverage in mail delivery in case of social worker absence to ensure residents continue to receive their mails. Mail delivery will be accessed during resident council meetings to facility provides daily delivery of mails to residents Social work/ Business office manager designee will audit mail delivery weekly x4 then monthly x3 to ensure facility provides daily delivery of mails to residents. The results of the audits will be presented to the monthly Quality assurance committee for review and feedback. Responsible party: Administrator	

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F 576	Continued From page 6	F 576		

the U.S. FOIA (b) (6) who told the surveyor that she was hired to replace the covering US FOIA who was NJ Ex [redacted] the facility. She stated that when she started on NJ Ex Order 26.4 [redacted], she found a bunch of mail that was left throughout the office and in the mailbox in the business office. She further stated that she gathered the mail and distributed the mail to all the residents. She was aware of Resident #61 and acknowledge that the resident had issues with their NJ Ex Order 26.4(b)(1). She stated that the facility worked with the resident and NJ Ex Order [redacted] to resolve all issues and the resident received NJ Ex services.

On 5/30/24 at 1:30 PM, the surveyor presented the above concerns to the administration team which included the U.S. FOIA (b) (6) [redacted] U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6).
There was no additional information provided.

A review of the facility's policy for "Mail Delivery for residents" that was undated and was provided by the US FOIA (b [redacted] that revealed the following:
"Policy statement: It is the policy of {the facility} for residents to receive and send mail in unopened envelopes in a timely manner."
"Protocol:
1. Mail is delivered to the reception desk daily.
2. The business office manager will separate from departmental mail and sort for each resident.
3. Once mail is sorted if any bills, notices for residents will be placed in social services mailbox.
4. If any cards, newsletters, magazines, letters they will be given to activity aid to distribute to resident.".

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F 576	Continued From page 7 NJAC 8:39-4.1 (a)(19)	F 576		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: COMPLAINT # 157599 Based on observations, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure a resident who was NJ Ex Order 26.4(b)(1) for activities of daily living (ADL) was consistently provided NJ Ex Order 26.4(b)(1) as needed. This deficient practice was identified for 2 of 5 residents (Resident #10 and #32) reviewed for ADLs and was evidence by the following: 1. On 05/22/24 at 12:03 PM, during the initial tour of the NJ Exec Order 26.4b1, the surveyor observed Resident #32 lying in bed. The resident's eyes were closed. On 05/23/24 at 11:07 AM, the surveyor observed the resident dressed, lying in bed. There was staff in the room assisting the resident's roommate. The surveyor reviewed the electronic medical record (EMR) for Resident #32. A review of the Resident's Admission Record (AR) (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to:	F 677	F677 SS:D Activities of daily living care provided for dependent residents CFR Resident #10 was assessed and addressed accordingly. Not negatively effected Resident # 32 was assessed and addressed accordingly Not Negatively effected. Certified nursing assistant (1) assigned was educated immediately All residents have the potential to be affected by this finding. All residents needing assistance with feeding were audited. No further findings were identified An audit of all residents meal tray delivery was conducted to ensure they all received their meals and no further findings were identified	7/15/24

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F 677	Continued From page 8 NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) ( ) NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) A review of the resident's Annual Minimum Data Set, (MDS), an assessment tool used to facilitate the management of care, dated , revealed that the resident had a Brief Interview for Mental Status (BIMS) score of out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1) A further review of the resident's MDS, Section GG for Functional Abilities and Goals, revealed that the resident was NJ Ex Order 26.4(b)(1) ( ) NJ Ex Order 26.4(b)(1). A review of the "Order Summary Report" (OSR) revealed a physician order (PO) for NJ Ex Order 26.4(b)(1), , tray only dated . A review of the resident's care plan (CP) revealed a "Focus: [name redacted] is at risk r/t (related to) NJ Ex Order 26.4(b)(1), on NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1), revised on , ...Interventions: Monitor NJ Ex Order 26.4(b)(1) and if applicable, order: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) , tray only, created ." On 05/23/24 at 12:40 pm, the surveyor observed	F 677	The policy titled resident Dining Policy was reviewed by Director of Nursing/ADMINISTRATOR. No changes are needed. Assigned nurses will monitor delivery of all resident food trays and ensure residents that require assistance with feeding are provided with assistance and to ensure all residents will receive meal trays as per their diet orders. All new diet recommendations from speech therapy will be communicated directly with primary nurse dietician, and/or leadership to ensure Medical Doctor is aware of changes Unit Mangers/Designee will oversee the meal delivery to ensure all residents will receive meal trays as per their diet orders Dietitian/ unit manager designee will audit meal delivery and assistance with feeding weekly X 4 then monthly x3 to ensure all residents will receive meal trays as per their diet orders and provided with assistance with feeding according to their plan of care. The results of the audits will be presented to the monthly Quality assurance committee for review and feedback. Responsible party: Director of Nursing	

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Resident #32 in a [NJ Exec Order 26.] chair watching television. There was a [NJ Exec Ord] tray on the bed side table, which was located near the resident. There was no staff member in the room. The surveyor observed the tray with utensils in a clear plastic wrap, that did not appear to be opened, the meal cover was intact, and the containers on the tray were not opened.

On 05/23/24 at 1:22 PM, the U.S. FOIA (b) (6) [redacted], the U.S. FOIA (b) (6) [redacted]) and the surveyor observed Resident #32's [NJ Exec Ord] tray. The surveyor asked if the utensils looked as if it was opened, the [U.S. FOIA] stated, "no." The [U.S. FOIA] removed the plate cover and both the [U.S. FOIA] and [U.S. FOIA (b)] confirmed that the food had not been touched. The [U.S. FOIA] asked Certified Nursing Assistant (CNA) #1, who was Resident #32's assigned CNA, in the presence of the surveyor, if she had asked the resident if they wanted to eat, the CNA was unable to answer the [U.S. FOIA (b)]

2. On 05/23/24 at 12:40 pm, the surveyor observed Resident #10's bedside table without a [NJ Exec Ord] tray. The surveyor asked the resident if they had [NJ Exec Orde] the resident stated, "no." The surveyor asked Resident #10 if they were [NJ Exec Order 2] the resident stated, "yes."

At 1:04 PM, the surveyor made CNA #1 aware that Resident #10 stated that they did not get a [NJ Exec Ord] tray. The CNA entered the room and went into the resident's bathroom to wash her hands. The CNA exited the room and walked down the hallway.

At 1:22 PM, Resident #10's assigned [U.S. FOIA (b) (6)] [redacted] and CNA #1 returned to the room with a tray for the resident. The [U.S. FOIA]

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and the [U.S. FOIA (b)] came to the room at that time. The [U.S. FOIA] began [NJ Exec Order 26] Resident #10.

At 1:24 PM, the surveyor interviewed the [U.S. FOIA (b)] who stated "if they (the residents) [NJ Ex Orde] they should be [NJ Ex Ord] She further stated, "this (resident not being [NJ Exec] should not occur." She stated the process was that the nurses and the aides should check to make sure the residents get their trays and that the assigned aides should make sure they [NJ Exec Orde] residents that NJ Ex Order 26.4(b)(1).

The surveyor reviewed the EMR for Resident #10.

A review of the Resident's AR revealed that the resident was admitted to the facility with diagnoses which included but were not limited to: [NJ Ex Order 26.4(b)(1)] NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) [NJ Ex Order 26.4(b)] .

A review of the resident's most recent quarterly MDS, dated [NJ Ex Order 2], revealed that the resident had a BIMS score of [NJ] out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1). A further review of the resident's MDS, Section GG for Functional Abilities and Goals, revealed that the resident required [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)] for [NJ Ex Order 26]

A review of the OSR revealed a PO for "[NJ Ex Order 26.4] , NJ Ex Order 26.4(b)(1) consistency dated [NJ Ex Order 26.4(b)]

A review of the CP revealed a "Focus: [name redacted] is at risk for [NJ Ex Order 26.4(b)] in [NJ Ex Order 26.4(b)(1)]

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F 677	Continued From page 11 NJ Ex Order 2 r/t dx (diagnosis) of NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex ( ), Revision on NJ Ex Order 2 ...Goal: [name redacted] NJ Ex Order 26.4(b)(1) at all NJ Ex Order 26 ...Interventions: NJ Ex Order 26.4(ability: NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) needed, Date Initiated: NJ Ex Order 26.4(b)(1) ." A review of the facility's undated policy "Resident Dining Policy" revealed: "Our facility audits the food and nutrition services department regularly to ensure that resident's needs are met, and that dining is a safe and pleasant experience for residents." On 05/30/24 at 12:50 PM, during a meeting with Regional Nurse #1, Regional Nurse #2, the U.S. FOIA (b) (6)), the U.S. FOIA (and the survey team, the above observations for Resident's #10 and #32 were presented. At that time, the audits for the above-mentioned "Resident Dining Policy" were requested. On 05/31/24 at 9:41 AM, during a meeting with the survey team and the U.S. FOIA (b) (the U.S. FOIA (acknowledged that no patient should be missed for meal pass. No additional information was presented for the audits as per the above mentioned "Resident Dining Policy." NJAC 8:39-27.2(e)	F 677		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		7/15/24

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F 755	Continued From page 12 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00167644 Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to a.) clarify duplicate physician's orders for an over-the-counter	F 755	F755 SS: D Pharmacy services procedures/pharmacy / records Resident #63 duplicate order was discontinued. Duplicate order was never	

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F 755	Continued From page 13 medication, NJ Ex Order 26.4(b)(1) and b). failed to obtain a medication for NJ Ex Ord This deficient practice occurred for 2 of 7 residents, (Resident #63 and #133) reviewed for medication review. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1). The surveyor reviewed the medical record for Resident #63. On 5/22/24 at 10:33 AM, the surveyor observed	F 755	given Resident #133 The resident was o NJ Exec Order 26.4b1 on NJ Ex Order 26.4(b)(1). Based on medical record review and statement obtained from the physician, the resident #133 did not NJ Ex Order 26.4(b)(1 from the medication error. Resident #133 was monitored for NJ Ex Ord and NJ Ex Or evaluation was reviewed and noted to have been medicated with NJ Ex Order 26. as needed during the time of the medications error. Resident #133 NJ Ex Ord scale was mostly a NJ on a scale of 1 to 10 with one episode of NJ and one episode of NJ 8 All residents□ physician orders were audited for duplicate orders. No concerns All residents with pain medication have the potential to be affected by the medication error. The DNS/ Designee will conduct an audit of narcotic back on Omnicell to ensure medication back up available and medications arrived accordingly. Residents with NJ Exec Ord were audited for medication availability. Residents with pain medications were audited for medication availability. No further findings were identified.	

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F 755	Continued From page 14 the resident who was seated in the NJ Exec Order 26.4b1 unit dining/recreational room. The resident was seated in their wheelchair and was participating in activities. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to: NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) . A review of the Admission Minimum Data Set (MDS), an assessment tool, used to facilitate the management of care, dated NJ Ex Order 26.4(b , reflected that the resident had a brief interview for mental status (BIMS) score of NJ Ex (which indicated that the resident was NJ Exec Order 26.4b1 . Further review of the MDS section C1000, reflected the resident's cognitive skills for decision making were a NJ Ex Order 26.4(b which indicated that the resident's cognition is NJ Ex Order 26.4(b)(1). A review of the Order Listing Report (OLR) revealed a physician order (PO): 1. A PO dated NJ Ex Order 26.4(b for NJ Ex Order 26.4(b)(1) oral solution NJ Ex Order 26.4(b)(1) by mouth one time a day for NJ Ex Order 26.4(b)(1)	F 755	The pharmacy audited all pain meds to ensure they have prescription. The Policy for medication administration schedule/policy was reviewed. No changes made. The policy for controlled substances was reviewed and revised to include: When a medication is not delivered to notify the Director of nursing immediately and place the resident on the 24-hour report for monitoring and follow-up. Licensed Nurses and Registered nurses were educated regarding the above policies by Director of Nursing/Assistant Director of Nursing Medication availability will be reviewed during morning meeting and Director of Nursing/Designee will oversee pain medication and medication availability. Pharmacy will review all residents narcotic prescriptions on routine basis to ensure timely delivery and accessibility of narcotic medications weekly X4 then monthly x 3 to ensure pain medication availability Pharmacy consultant/Designee will audit residents physician orders for duplicate orders weekly X4 then monthly x 3 to ensure there is no duplicate order. The results of all audits will be reported to monthly QAPI Meeting for review and	

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F 755	Continued From page 15 2. A PO dated NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1) give 1 tablet by mouth one time a day for supplement. A review of the NJ Ex Order 26.4(b)(1) electronic medication administration record (eMAR) revealed an order for NJ Ex Order 26.4(b)(1) oral solution NJ Ex Order 26.4(b)(1), give NJ Ex Or by mouth one time a day for NJ Ex Order 26.4(b)(1) which was signed as being administered in the eMAR on NJ Ex Order 26.4(b) at 9:00 AM. Further review, revealed an order for NJ Ex Order 26.4(b)(1), give 1 tablet by mouth one time a day for NJ Ex Order 26.4(b)(1) which was signed as being administered in the eMAR on NJ Ex Order 26.4 at 9:00 AM. On 5/28/24 at 1:10 PM, the surveyor interviewed the NJ Exec Order 26.4b1 unit U.S. FOIA (b) (6) who acknowledged that she should have discontinued the NJ Ex Order 26.4(b)(1) tablets. The U.S. FOIA did not respond to the surveyor inquiry about both NJ Ex Order 26.4(b)(1) tablets and NJ Ex Orde being signed as being administered at 9:00 AM on NJ Ex Order 26.4(b). 2). The surveyor reviewed the closed medical record for Resident #133. A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included but not limited to: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Orde , NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26. (aNJ Ex Order 26.4(b)(1) .	F 755	feedback. Responsible party: Director of Nursing	

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F 755	Continued From page 16	F 755		

A review of the Admission MDS, dated [NJ Ex Order 26.4(b)], reflected that the resident had a BIMS of [NJ] out of 15, indicating that the resident was [NJ Ex Order 26.4(b)] [redacted]

A review of the [NJ Ex Order 26.4(b)(1)] OLR revealed the following PO dated [NJ Ex Order 26.4(b)]:

1. [NJ Ex Order 26.4(b)(1)] oral capsule [NJ Ex Order 26.4], give 1 capsule by mouth one time a day for [NJ Ex Or] take with NJ Ex Order 26.4(b)(1).

2. [NJ Ex Order 26.4(b)(1)] oral capsule [NJ Ex Order 26] give 1 capsule by mouth one time a day for [NJ Ex Or] take with [NJ Ex O] [redacted]

A review of the [NJ Ex Order 26.4(b)(1)] eMAR revealed an order for [NJ Ex Order 26.4(b)(1)] oral capsule [NJ Ex Order 26.4(] give 1 capsule by mouth one time a day for [NJ Exec O] take with [NJ Ex Order 2] capsule = [NJ Ex Order 26.4] with an order date of [NJ Ex Order 26.4] and an administration time of 9:00AM. A further review of the eMAR, revealed that the resident's medication was not signed as being administered on [NJ Ex Order 2], [NJ Ex Order 2], [NJ Ex Order 2], [NJ Ex Order 2], [NJ Ex Order 26.4], [NJ Ex Order 26.4], and [NJ Ex Order 26.4(b)].

A review of the [NJ Ex Order 26.4(b)(1)] eMAR revealed an order for [NJ Ex Order 26.4(b)(1)] oral capsule [NJ Ex Order], give 1 capsule by mouth one time a day for [NJ Ex Or] take with [NJ Ex Order 26.4] capsule=[NJ Ex Order 26.4(] with an order date of [NJ Ex Order 26.4] and an administration time of 9:00AM. A further review of the eMAR revealed that the resident's medication was not signed as being administered on [NJ Ex Order 2], [NJ Ex Order 2], [NJ Ex Order 2], [NJ Ex Order 2], [NJ Ex Order 26.4], [NJ Ex Order 26.4] and [NJ Ex Order 26.4].

A review of the facility Progress Notes (PN) revealed that the facility was documenting that the resident's [NJ Ex Order 26.4(b)(1)] capsules were

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F 755	Continued From page 17	F 755		

unavailable from the pharmacy in either a medication administration notes or a nurses note from [NJ Ex Order 2] until [NJ Ex Order 26.4]. The notes revealed that the medications were unavailable and were awaiting a delivery from the pharmacy.

On 5/30/24 at 1:30 PM, the surveyor discussed the above concerns with the administration team which included the U.S. FOIA (b) (6) [redacted] U.S. FOIA (b) (6) [redacted]) and a U.S. FOIA (b) (6).

On 05/31/24 at 10:40 AM, the [U.S. FOIA (] acknowledge that the resident did not receive their [NJ Ex Order 26.4(b)(1)] [redacted] and [NJ Ex Order 26.4(b)(1)] capsules from [NJ Ex Order 2] and [NJ Ex Order 26.4]. She stated that the pharmacy needed a prescription to send out the medication and that the facility notified the physician and was awaiting a prescription from the physician.

There was no additional information provided.

A review of the facility's policy for "Medication Administration schedule/policy" that was dated 12/31/23 and was provided by the [U.S. FOIA (] that revealed the following:
"7. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for a resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or facility's medical director to discuss concerns."

A review of the facility's policy for "Physician orders" that was dated 10/31/23 and was

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F 755	Continued From page 18 provided by the [redacted] that revealed the following: "The nurses will clarify with the physician any orders needing clarifications."	F 755		
F 812 SS=E	NJAC 8:39-11.2 (b), 29.2 (d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illnesses. This deficient practice was evidenced by the following:	F 812	F812 Food procurement store/ prepare/ serve sanitary SS:E Food that was observed open and without a label was immediately discarded.	7/15/24

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F 812	Continued From page 19 On 05/22/2024 from 10:10 AM to 10:42 AM, the surveyor, accompanied by the U.S. FOIA (b) (6) [redacted], toured the kitchen, and observed the following: In the walk-in freezer, the surveyor observed a box of hamburger patties and a box of hot dogs with no labels or dates and both boxes with the inner plastic bags open to the air. The U.S. FOIA stated that there should be a received date and opened dates. She also stated that the inner bags should be closed. The surveyor also observed the fry basket with an item that resembled a french fry. The U.S. FOIA stated that nothing was fried for breakfast on this day. On 05/23/2024 in the South unit pantry, the surveyor observed 2 boxes of cereal that were outdated as follows: A box of corn flakes with a date of May0123 and a box of rolled oat cereal with a date of Feb1423. A review of facility provided policy titled "Food Receiving and Storage" revised November 2022 revealed under Refrigerated/Frozen Storage: "1.All food stored in the refrigerator or freezer are covered, labeled and dated ("use by" date)" "8. Frozen foods are maintained at a temperature to keep frozen food solid. Wrappers of frozen food must stay intact until thawing." A review of facility provided policy titled "Refrigerators Freezers" , undated revealed: "7. All food shall be appropriately dated to ensure proper rotation by expiration dates. "Received" dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. "use by" dates will be completed with	F 812	Fryer basket was cleaned Expired cereal was removed from pantry. Dietary staff and food service director were educated on proper labeling and storage of frozen foods All residents have the potential to be affected by this finding. All foods in freezer were audited. No further findings. Pantries were audited for expired food. No Further findings The policy titled Food receiving and storage was reviewed by Director of Nursing/ADMINISTRATOR. No changes are needed. All kitchen staff was educated on food receiving and storage policy to ensure to facility handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illnesses. Food Service director/Designee will review Pantries on a daily basis to ensure no expired food are kept as well as reviewing of freezers to ensure all foods are stored properly. Registered Dietician/Designee will audit Pantries and freezers weekly x 4 then monthly x 3 to ensure all foods are stored	

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F 812	Continued From page 20 expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and "use by" dates indicated once food is opened." "8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes." N.J.A.C. 18:39-17.2(g)	F 812	and labeled properly and to assure handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illnesses. The results of the audit will be presented to the monthly Quality assurance committee for review and feedback. Responsible party: Administrator	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following: On 05/22/2024 at 10:31 AM, during the initial kitchen tour with the U.S. FOIA (b) (6), the surveyor observed debris and trash around the dumpster area, including cardboard and paper. The U.S. FOIA stated that housekeeping was responsible for this area. On 05/29/2024 at 01:17 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated the dumpster area was cleaned up immediately after the debris was identified by the surveyor.	F 814	F814 SS: D Dispose garbage and refuse properly Dumpster area was immediately cleaned Maintenance and housekeeping department was educated on the waste management policy by Administrator All residents have the potential to be affected by this finding. An audit of all disposal and garbage areas was conducted and no further finding was identified The policy titled Waste management policy was reviewed by Director of	7/15/24

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F 814	Continued From page 21 Review of facility provided policy "Waste Management Policy", dated 01/03/24, included: "#3. The area around the container shall be kept clean and clear at all times." N.J.A.C. 8:39-19.3(c)	F 814	Nursing/ADMINISTRATOR. No changes are needed. U.S. FOIA (b) (6) was educated regarding above policy by Administrator. Director of maintenance/Housekeeping will monitor dumpster area to ensure the area is free of debris and garbage Administrator/Designee will audit dumpster Weekly x4 then monthly x 3 to ensure the garbage are remain from garbage and debris. The results of all audits will be presented to monthly Quality assurance committee for review and feedback. Responsible party: Administrator	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/15/24

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F 880	Continued From page 22 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: NJ #167099 Based on observations, interviews, and record review it was determined that the facility failed to ensure that staff wear the appropriate personal protective equipment (PPE) for residents on NJ Ex Order 26.4(b)(1) ([redacted] to address the risk for infection transmission, in accordance with the facility policy and acceptable standards of infection control practice. This was observed for 2 of 3 residents (Resident #41 and #18) reviewed for NJ Ex Order 26.4(b)(1) on 2 of 2 units (NJ Exec Order 26.4b1 Unit) and was evidenced by the following: 1. On 05/24/24 at 7:45 AM, during NJ Ex Order 26.4(b)(1) rounds with the U.S. FOIA (b) (6) on the South Unit, the surveyor observed an "NJ Ex Order 26.4(b)(1) [redacted] " sign outside of unsampled Resident #41's door. There was a PPE bin located under the sign. The U.S. entered the room with the surveyor and asked the resident for permission to conduct an NJ Ex Order 26.4(b)(1) check. The resident granted permission. The U.S.	F 880	F880 SS:E Infection prevention and control U.S. FOIA (b) (6) was educated on enhanced barrier precautions and the personal protective equipment requirement U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were educated on NJ Exec Order 26.4b1 [redacted] for identified rooms. All residents have the potential to be affected by this finding. All patients require enhanced barrier precautions were reviewed to ensure proper signage was placed and Enhanced Barrier Precautions are followed through. The policy titled Enhanced barrier precautions policy was reviewed by the administrator and Director of Nursing. No	

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F 880	Continued From page 24 performed hand hygiene and removed gloves from a box. She then pulled the curtain and donned (put on) the gloves. At that time, the surveyor requested to speak with the [redacted] in hallway and pointed out the signage at the door. The NJ Ex Order 26.4(b)(1) read "Stop: [redacted] Everyone Must: ... and [redacted] for the following [redacted] ... or [redacted]." The [redacted] acknowledged the signage and stated she needed to wear [redacted] and [redacted] for [redacted]. She then donned [redacted] and [redacted] and proceeded with the [redacted]. The surveyor reviewed the electronic medical record (eMR) for Resident #41. A review of the Admission Record (AR, an admission summary) revealed the resident was admitted to the facility with diagnoses which include but not limited to: [redacted]. A review of the "Order Summary Report" (OSR) revealed a physician order (PO) for [redacted] dated [redacted]. A review of the care plan (CP) revealed: "Focus: [name redacted] is on [redacted] related to being at risk for [redacted]) dated [redacted] ..."Interventions: [redacted]: wear [redacted] and [redacted] during assistance with [redacted]	F 880	changes needed All Clinical staff that are providing direct care were educated on enhanced barrier precautions policy by Director of Nursing. Infection preventionist and Unit Managers will monitor residents requiring enhanced barrier precautions were reviewed to ensure proper signage was placed and Enhanced Barrier Precautions are followed through Director of Nursing/Designee will audit residents require Enhanced barrier precautions weekly x4 then monthly x 3 to ensure proper signage was placed and Enhanced Barrier Precautions are followed through. The results of the audit will be presented to the Monthly Quality assurance committee quarterly and as needed by the Nursing department Responsible party: Director of Nursing	

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F 880	Continued From page 25 NJ Ex Order 26.4(b)NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) & NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1)." 2.) On 05/22/24 at 12:04 PM, during the initial tour of the facility, the surveyor observed Resident #18 in their room, sitting in wheelchair, by the window. The resident showed the surveyor their NJ Ex Order 26.4(b)(1) which was placed in a NJ Ex Order 26.4(b)(1) secured to the NJ Ex Order 26.4(b)(1) of the wheelchair. The surveyor did not observe any NJ Ex Order 26.4(b)(1)) signs or a PPE bin at the door. On 05/23/24 at 10:34 AM, the surveyor observed the resident #18 sitting up in their bed. No NJ Exec O sign and PPE bin noted at the door. On 05/24/24 at 07:48 AM, during NJ Ex Order 26.4(b)(1) rounds with the U.S. FOIA (b) (6) , the surveyor did not observe an NJ Exec O sign or a PPE bin at Resident#18's door. The U.S. FOIA (b) (6) and the surveyor went to the room and the U.S. FOIA (b) (6) checked the resident for NJ Ex Order 26.4(b)(1) The surveyor observed the U.S. FOIA (b) (6) wearing only gloves, no gown. The U.S. FOIA (b) (6) picked up the NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) to show the surveyor that it was attached to the NJ Exec Order 26.4(b) . The U.S. FOIA (b) (6) stated, "it (NJ Ex Order 26.4(b) was NJ Ex Order 26.4(about NJ Ex Order 26.4(b)(ago." The surveyor reviewed the eMR for Resident #18. A review of the Resident #18's AR revealed the resident was admitted to the facility with diagnoses which included, but were not limited to: NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)	F 880		

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F 880	Continued From page 26	F 880		

NJ Ex Order 26.4(b)(1) , NJ Ex O NJ Ex Order 2 , NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)

A review of the OSR revealed a PO for "NJ Ex Order 26.4(b)(1) r/t [related to] being at risk for NJ Ex Order 26.4(b)(1))" dated NJ Ex Order 26.4(b) .

A review of the CP revealed a focus of "[Name Redacted] is on NJ Ex Order 26.4(b)(1) related to being at risk for NJ Ex Order 26.4 dated NJ Ex Order 26.4(and "interventions: NJ Ex Orde wear NJ Ex Order 2 and gloves during assistance with NJ Ex Order 26.4(b)(NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(, and NJ Ex Order 26.4(b)(1) ."

On 05/24/24 at 12:05 PM, during an interview with the surveyor , the U.S. FOIA (b) (6) stated that NJ Ex Orde were used for any resident that had NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and residents with NJ Ex Order 26.4(b)(1) . The U.S. FOIA (b) (6) explained the process was first to obtain the PO, enter them in the computer, then we put the NJ Ex Ord signs on the doors and place a PPE bin at the door and inform the resident's family. The U.S. FOIA (b) (6) acknowledged that there should be a NJ Ex Ord sign on the door and the required PPE the staff should use when providing direct care to the resident. The U.S. FOIA (b) (6) further stated, "PPE is important and is required for the protection of the staff and the other residents."

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F 880	Continued From page 27 On 05/24/24 at 12:17 PM, the surveyor and the U.S. FOIA (b) (6) walked to Resident # 18's room and checked the door, the U.S. FOIA (b) (6) confirmed that there was no NJ Ex Or sign on the door. NJ Ex Or stated, "Yes, there should be a sign on the door." On 05/30/24 at 12:50 PM, during a meeting with Regional Nurse #1, Regional Nurse #2, the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6)) and the survey team, the above-mentioned observations for Resident #41 and #18 was presented. On 05/31/24 at 9:41 AM, during a meeting with the survey team and the U.S. FOIA (b) (the U.S. FOIA acknowledged that the staff did not use the proper PPE while checking resident's for NJ Ex Order 26.4(b)(1) A review of the facility's policy "Enhanced Barrier Precautions Policy" dated 4/18/24, revealed: "Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents ...3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: ...f. changing briefs or assisting with toileting ...5. EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk ...10. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required, 11. PPE is available outside of the resident rooms."	F 880		

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F 880	Continued From page 28 NJAC 8:39-19.4(a)(2)(c)	F 880		

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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: Complaint #: 163821, 167644, 157599, 168860 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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,	S 560	S560 Mandatory access to care Facility staffing coordinator was educated regarding New Jersey staffing requirement All residents have potential to be affected by this deficit practice Staffing ratio for past 30 days were audited and reviewed to ensure meeting State staffing requirements Facility has developed staffing policy to meet New Jersey Department of Health memo, minimum staffing	7/15/24

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

Electronically Signed | 06/13/24

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: 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. The survey team requested staffing for the following weeks as follows: 1. For the 2 weeks of Complaint staffing from 08/14/2022 to 08/27/2022, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -08/14/22 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -08/20/22 had 8 CNAs for 90 residents on the day shift, required at least 11 CNAs. -08/21/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -08/22/22 had 7 CNAs for 95 residents on the day shift, required at least 12 CNAs. -08/24/22 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -08/25/22 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs.	S 560	requirements for nursing homes," Facility Staffing Coordinator, Human resources, Nursing Leadership including Director of Nursing, Assistant Director, Supervisors, Unit managers were educated regarding above policy Administrator/Designee will meet and communicate with Staffing coordinator on a daily basis to ensure facility meets New Jersey staffing requirements Along with regional staffing consultant Facility has planned job fairs to recruit\ more staff Facility continues to use agency Administrator/Designee will audit staffing ratio daily to ensure it meet New Jersey State staffing requirements and Any findings will be addressed accordingly The result of the audits will be submitted to monthly Quality assurance committee for review and feedback Responsible Party: Administrator	

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S 560	Continued From page 2 -08/26/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -08/27/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. 2. For the 2 weeks of Complaint staffing from 04/16/2023 to 04/29/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -04/16/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. -04/17/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -04/18/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -04/19/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -04/20/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -04/21/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -04/22/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -04/23/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -04/24/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -04/25/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -04/26/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -04/27/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -04/28/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -04/29/23 had 7 CNAs for 88 residents on the day shift, required at least 11 CNAs. 3. For the week of Complaint staffing from	S 560		

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S 560	Continued From page 3 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -09/10/23 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs. -09/11/23 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs. -09/12/23 had 6 CNAs for 80 residents on the day shift, required at least 10 CNAs. -09/13/23 had 8 CNAs for 80 residents on the day shift, required at least 10 CNAs. -09/14/23 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. -09/15/23 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. -09/16/23 had 8 CNAs for 80 residents on the day shift, required at least 10 CNAs. 4. For the week of Complaint staffing from 10/29/2023 to 11/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/29/23 had 8 CNAs for 85 residents on the day shift, required at least 11 CNAs. -10/30/23 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -10/31/23 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -11/01/23 had 9 CNAs for 85 residents on the day shift, required at least 11 CNAs. -11/02/23 had 9 CNAs for 85 residents on the day shift, required at least 11 CNAs. -11/03/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -11/04/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. 5. For the 2 weeks of staffing prior to survey from	S 560		

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S 560	Continued From page 4 05/05/2024 to 05/18/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -05/05/24 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. -05/06/24 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. -05/07/24 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -05/08/24 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -05/09/24 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. -05/10/24 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. -05/11/24 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. -05/12/24 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs. -05/13/24 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -05/14/24 had 7 CNAs for 71 residents on the day shift, required at least 9 CNAs. -05/15/24 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs. -05/16/24 had 6 CNAs for 71 residents on the day shift, required at least 9 CNAs. -05/17/24 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs. -05/18/24 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. On 05/30/24 at 9:54 AM, the surveyor interviewed the Director of Human Resource/Staffing Coordinator (SC) who stated she was familiar with the CNA staffing ratios for each required shift. She further stated the facility was actively recruiting healthcare employees.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061407	A. BUILDING: _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	415 SOUTHERN BLVD CHATHAM, NJ 07928

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 On 05/30/24 at 10:07 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the staffing of nurses and CNAs was adjusted based on the resident census. The DON then explained she was aware of the CNA ratios required on all shifts. She stated, "Staffing was a challenge at times." A review of the facility's policy "staffing" dated 1/7/23, revealed: "Policy Statement: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment...8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing."	S 560		

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
315120 Y1	A. Building B. Wing Y2	7/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	415 SOUTHERN BLVD CHATHAM, NJ 07928

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 F0550	Correction	ID Prefix F0576	Correction	ID Prefix F0677	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(6)-(9)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	07/15/2024	LSC	07/15/2024	LSC	07/15/2024
ID Prefix F0755	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	07/15/2024	LSC	07/15/2024	LSC	07/15/2024
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/31/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061407 Y1	A. Building B. Wing Y2	7/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	415 SOUTHERN BLVD CHATHAM, NJ 07928

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 07/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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	
5/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	**415 SOUTHERN BLVD** **CHATHAM, NJ 07928**

(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 (NJDOH) on 05/23/24. The facility was found to be in substantial compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/23/24 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Chatham Hills is a one-story building constructed in 1970. It is composed of Type III (200) construction and has eight smoke compartments. The facility is fully sprinklered with a dry system. The number of occupied beds was 74 out of 108.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		7/1/24

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

Electronically Signed | 06/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 222	Continued From page 1 Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 222	Continued From page 2 permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to meet the door-locking requirements when delayed egress locking devices failed to release after 15 seconds when pressure was applied in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2. This deficient practice had the potential to affect 40 of 74 residents. Findings include: An observation on 05/23/24 at 10:33 AM of the designated exit door located by Room 54 revealed the delayed egress locking device failed to release after 15 seconds of pressure was applied to the door. Signage on the door indicated the locks would unlock 15 seconds after pressure was applied, but the doors did not unlock and open. An observation on 05/23/24 at 10:45 AM of the designated exit door located by Room 31 revealed the delayed egress locking device failed to release after 15 seconds of pressure was applied to the door. Signage on the door indicated the locks would unlock 15 seconds after pressure	K 222	The Director of Maintenance had the service vendor repair the delayed egress lock on the exit door by room 54 and room 31 back to the 15 second delayed egress. All other doors with delayed egress were inspected, no other issues were found. All work completed conforms with all applicable NFPA codes. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. The Director of Maintenance will conduct a monthly audit to ensure all doors that contain a delayed egress function as per NFPA standards. The Director of Maintenance/designee will report the findings of audit to administrator. Administrator will report findings of this audit at the monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 222	Continued From page 3 was applied, but the doors did not unlock and open. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was unaware the delayed egress locks were not functioning properly prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K 222		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide emergency lighting that was continuous in accordance with NFPA 101 (2012), Section 7.8.1.4. This deficient practice had the potential to affect 32 of 74 residents. Findings include: An observation on 05/23/24 at 10:28 AM revealed that only one bulb was provided at the exit discharge by the North Day Room. The U.S. FOIA (b) (6) was present at the time of the observation and confirmed the finding and stated the facility was not aware that two bulbs were required at designated exits.	K 281	The Director of Maintenance will replace the existing light fixture with a fixture that contains two bulbs. All other exit discharges were found within the facility to have correct light fixtures. All work conforms with all applicable NFPA standards. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. The Director of Maintenance will conduct a quarterly audit to ensure all exit discharge lighting are in compliance with NFPA standards.	7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 281	Continued From page 4 NJAC 8:39-31.1(c), 31.2(e)	K 281	The Director of Maintenance/designee will report the findings of audit to administrator Administrator will report findings of this audit at the next monthly QA meeting.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the kitchen	K 324	The Director of Maintenance field repaired the hole with the same material	7/1/24

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K 324	Continued From page 5 hood system in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition). This deficient practice had the potential to affect all 74 residents. Findings include: An observation on 05/23/24 at 10:04 AM of the kitchen revealed a three-inch unsealed hole between the grease filters divider above the deep fryer. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was not aware that the unsealed hole existed prior to the survey. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	of the hood□s constructions in compliance with NFPA 96. The hood was checked, and no other issues were found. All work done in compliance with all applicable NFPA standards. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. The Director of Maintenance will conduct a quarterly audit to ensure the kitchen exhaust hood is maintained as per NFPA standards. The Director of Maintenance/designee will report the findings of audit to administrator. Administrator will report findings of this audit at the next monthly QA meeting.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure the fire alarm system was tested and maintained in	K 345	K345 I. The Director of Maintenance	7/2/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 6 accordance with NFPA 101 Life Safety Code (2012 Edition) Section 9.6.1.3 and NFPA 72 (2010) Section 14.4.5. This deficient practice had the potential to affect all 74 residents. Findings include: A review of the facility's most recent "Fire Alarm Inspection Report," dated 12/07/23 indicated that a pull station was needed at the front Lobby exit. An observation and interview on 05/23/24 at 12:00 PM, with the U.S. FOIA (b) (6), of the Front Lobby exit revealed a pull station was not provided at the designated exit. The US FOIA (b) (6) [redacted] confirmed the finding and was not able to locate a pull station near the lobby or in the same smoke compartment. Review of the facility's "Fire Alarm Annual Inspection Reports" for the previous two years revealed sensitivity testing of the smoke detectors was not conducted. Documentation of the sensitivity test of the smoke detectors was requested on 05/23/24 at 9:30 AM, 12:00 PM, and 2:15 PM but the documentation was not provided prior to the survey exit. During an interview on 05/23/24 at 3:00 PM, the U.S. FOIA (b) (6) confirmed the finding and stated the facility was unable to locate the missing documentation. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	contacted the facility□s fire alarm vendor to (1) install a pull station within the smoke compartment (2) conduct a sensitivity test of the facility smoke heads. All documentation of the required fire alarm inspections was reviewed, no other issues were found. All work will conform with all applicable NFPA standards. II. 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. III. The Director of Maintenance will conduct a quarterly audit to ensure all required fire alarm maintenance and inspection are completed as per NFPA standards. IV. 1. The Director of Maintenance/designee will report the findings of audit to administrator. 2. Administrator will report findings of this audit at the next quarterly QA meeting. V. 1. Date of correction is 07/02/2024 2. The Director of Maintenance is responsible for the correction of this deficiency.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 7 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 74 residents who resided at the facility. Findings include: A review on 05/23/24 at 9:46 AM of the facility's untitled sprinkler system records provided by the facility revealed the facility failed to document weekly inspections of the gauges for the dry sprinkler system.	K 353	The Director of Maintenance (1) will have the facility fire sprinkler replace the missing escutcheon (2) has created a log and will document the inspection of our fire sprinkler system control valve, dry sprinkler, and system psi. The facility□s fire sprinkler system and documentation was reviewed, no issues were found. All work will conform with all applicable NFPA standards. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. The Director of Maintenance will conduct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	**415 SOUTHERN BLVD** **CHATHAM, NJ 07928**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 8 During an interview on 05/23/24 at 3:14 PM, the U.S. FOIA (b) (6) confirmed the finding and stated the facility was unable to provide documentation of the weekly inspections of the sprinkler gauges during the survey. An observation on 05/23/24 at 10:03 AM of the sprinkler in the walk-in cooler revealed the escutcheon plate was missing. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and stated the facility was unaware the escutcheon plate was missing prior to the survey. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	a quarterly audit to ensure inspections and maintenance of the fire sprinkler system is completed as per NFPA standards. The Director of Maintenance/designee will report the findings of audit to administrator. Administrator will report findings of this audit at the next monthly QA meeting.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed	K 363		7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING **01** B. WING _____	**05/31/2024**

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CHATHAM HILLS SUBACUTE CARE CENTER	**415 SOUTHERN BLVD** **CHATHAM, NJ 07928**

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K 363	Continued From page 9 when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 45 of 74 residents. Findings include: An observation on 05/23/24 at 10:43 AM of the door to resident room 41 revealed the door failed latch in the frame when the door was closed. The bottom of the door was in contact with the floor which prevented the door from fully closing and latching.	K 363	The Director of Maintenance adjusted and corrected the doors for room 41 and 35 allowing for proper closure. All other corridor doors were inspected, none were found deficient. All drills will conform with all applicable NFPA standards. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. The Director of Maintenance will conduct a quarterly audit to ensure all corridor doors function as per NFPA standards. The Director of Maintenance/designee will report the findings of audit to	

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	315120	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 363	Continued From page 10 An observation on 05/23/24 at 10:44 AM of the door to resident room 35 revealed the door failed to latch in the frame when the door was closed. The bottom of the door was in contact with the floor which prevented the door from fully closing and latching. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the findings and stated the facility he was unaware the doors were not closing and latching prior to the survey. NJAC 8:39-31.2(e)	K 363	administrator. Administrator will report findings of this audit at the next quarterly QA meeting. Attached is a picture of room 35 door closing with no issues.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with	K 372	The Director of Maintenance sealed all penetrations in (1) HVAC closet inside the activity room (2) smoke barrier located by the service corridor and rest rooms (3) smoke barrier located by the staff dining	7/1/24

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	315120	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 372	Continued From page 11 NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 74 residents. Findings include: An observation on 05/23/24 at 10:58 AM of the smoke barrier located in the heating, ventilation, and air conditioning (HVAC) closet inside the Activity room revealed a three-inch unsealed hole between two HVAC shutoff switches. An observation on 05/23/24 at 11:19 AM of the smoke barrier located by the Service Corridor and Rest Rooms revealed an unsealed two foot gap at the top of the wall near the corner of both sets of smoke doors above the hard ceiling. An observation on 05/23/24 at 11:15 AM of the smoke barrier located in the staff Dining Area by the Lobby revealed an unsealed overcut around a blue wire to the right of the vending machines below the ceiling. An observation on 05/23/24 at 11:23 AM of the smoke barrier located above the smoke doors at the South Low wing revealed an unsealed three-inch overcut around a pipe penetration. An observation on 05/23/24 at 11:25 AM of the smoke barrier located above the smoke doors at the South High wing revealed an unsealed three-inch overcut around a pipe penetration and group of wire penetrations. An observation on 05/23/24 at 11:27 AM of the smoke barrier located by the Nurses' Station and entrance to the North Hall revealed a three-inch	K 372	area (4) smoke barrier located south low wing (5) smoke barrier located south high wing (6) smoke barrier located by nurses station north hall (7) smoke barrier located north high wing (8) smoke barrier located north low wing. All smoke barriers were checked no others were found with unsealed penetration. All work will conform with all applicable NFPA standards. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. The Director of Maintenance will conduct a quarterly audit to ensure all smoke barriers are sealed and maintained as per NFPA standards. The Director of Maintenance/designee will report the findings of audit to administrator. Administrator will report findings of this audit at the next monthly QA meeting. Attached are pictures of all areas needing smoke barrier. We used 3M smoke barrier which has intumescent to make the corrections.	

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K 372	Continued From page 12 overcut around a group of wires above the ceiling and smoke doors. An observation on 05/23/24 at 11:29 AM of the smoke barrier located above the smoke doors at the North High wing revealed an unsealed two-inch overcut around a conduit penetration. An observation on 05/23/24 at 11:31 AM of the smoke barrier located above the smoke doors at the North Low wing revealed an unsealed two-inch overcut around two pipe and wire penetrations. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the unsealed gaps and penetrations. The U.S. FOIA (b) (6) stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372		
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 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	K 374		7/1/24

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K 374	Continued From page 13 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 doors to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 8.5. The deficient practice had the potential to affect all 74 residents. Findings include: An observation on 05/23/24 at 10:26 AM of the smoke doors at the North High wing revealed a four-inch gap between the smoke doors when they were closed, allowing a passage for smoke to get through. The gap appeared to be caused by a malfunctioning door coordinator installed at the top of the door frame. An observation on 05/23/24 at 10:26 AM of the smoke doors at the South Low wing revealed a five-inch gap between the smoke doors when they were closed, allowing a passage for smoke to get through. The gap appeared to be caused by a malfunctioning door coordinator installed at the top of the door frame. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was unaware of the gap between the smoke doors prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K 374	The Director of Maintenance replaced the door coordinators on the (1) north high wing smoke doors and (2) South low wing smoke doors. All work conforms with all applicable NFPA standards. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. The Director of Maintenance will conduct a quarterly audit to ensure all smoke doors function as per NFPA standards. The Director of Maintenance/designee will report the findings of audit to administrator. Administrator will report findings of this audit at the next quarterly QA meeting. Attached is a picture of fire door closing with no issues.	

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
315120 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/22/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	415 SOUTHERN BLVD CHATHAM, NJ 07928

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	07/01/2024	LSC K0281	07/01/2024	LSC K0324	07/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	07/01/2024	LSC K0353	07/01/2024	LSC K0363	07/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0372	07/01/2024	LSC K0374	07/01/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/31/2024	☐ YES ☐ NO