STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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F 000	INITIAL COMMENTS Survey Dates: 07/17/23 - 07/20/23 Survey Census: 175 Sample Size: 39 Supplemental Residents: 0 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. One deficiency was related to Intake #NJ165572 at F609, and NJ155763 had an associated deficiency at F609. No deficiencies were issued related to Intakes: NJ162394 and NJ154298.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		8/31/23

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

Electronically Signed | 08/09/2023

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and policy review the facility failed to provide a safe, clean, and homelike environment for its residents. Specifically, two residents (Resident (R)106 and (R)40) windows were found to be dirty and broken and a request for bed replacement for R40 had not been fulfilled; and R23's room was found to have leaking insulated ceiling pipes. This deficient practice had the potential to affect three out of 175 residents. In addition, the facility failed to exercise reasonable care for the protection of a resident's (R40) property from damage or theft for one out of one resident sampled for missing items. The deficiency had the potential to	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment CFR (s): 483.10(i)(1)-(7) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice those residents that were identified as being affected by the deficient practice; windows were cleaned externally and internally, the broken handle to the window was replaced, a new mattress was issued, reimbursement of missing	

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F 584	Continued From page 2	F 584		

significantly impact the residents' quality of life, safety, and overall well-being. The lack of a safe, clean, and homelike environment compromised the residents' sense of dignity and comfort.

Findings include:

1. Review of R40's undated "Admission Record" located in R40's electronic medical record (EMR) located under the "Profile" tab indicated she was admitted on [redacted].

Review of R40's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the EMR under the MDS tab revealed R40 was assessed to have a Brief Interview for Metal Status (BIMS) score of [redacted] out of 15 which indicated the resident was [redacted]. The MDS further revealed that R40 felt it was [redacted]

During an interview on 07/17/23 at 1:19 PM R40 stated that the inside and outside of her bedroom windows were dirty and that they haven't cleaned the outside of the windows since she has been admitted to the facility.

Review of the facility "Resident Council Minutes" dated [redacted] revealed that "[R40] requested a full room cleaning." Follow Up column indicated: "[R40] scheduled for full room cleaning [redacted]"

During an interview on 07/17/23 at 1:19 PM, R40 stated she had a pair of [redacted] taken out of her room about a month ago. She stated that she reported it to nursing and she told the Administrator. She

item was issued and the leaking pipe was re insulated.

Education was immediately initiated to all housekeepers by the Director of Environmental Services on cleaning of internal windows during weekly room cleaning and as needed.

Education was immediately given to the Director of Environmental Services by the Administrator on cleaning external windows annually and as needed.

Education was immediately initiated to nursing, maintenance and housekeeping by the Director of Nursing and the Director of Environmental Services on reporting any leaking pipes and/or broken items/equipment to maintenance immediately via the Maintenance log book for immediate repair.

Education was immediately initiated to the Administrator and the Social workers by the Regional Director of Nursing and the Regional Director of Social Work on the Resolution of missing items, resolving grievances and satisfying resident requests.

The facility's policy titled "General daily cleaning" was reviewed and updated to include, External windows will be cleaned annually and as needed, documentation will be maintained of all external window cleaning.

The facility's policy titled "Personal

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F 584	Continued From page 3 stated that she went to take a shower and when she came back the [NJ Exec Order 2] were gone. Review of the facility "Resident Council Minutes" dated [NJ Exec Order 26.4] revealed that "[R40] requested follow-up on missing items and that [R40] met privately with SW [Social Worker]." Review of the facility "Grievance/Concern Tracking log" dated [NJ ex order 26.4b1] revealed a grievance for R40 which was made to SW/Administration regarding [NJ Exec Order 26.4b1]. The column titled "Resolution" was blank. On 07/19/23 at 9:53 AM during a tour of R40's bedroom window, the Director of Plant Operations (DPO) stated that cleaning of the outside windows was completed once per year. When asked for documentation that the windows had ever been cleaned, he stated "they [maintenance] don't have any paperwork to show that that they cleaned the outside of the windows. There was no schedule for cleaning the outside, only a schedule for the total room cleaning." During an interview on 07/19/23 at 10:16 AM the SW2 stated that the process for missing items was "They come speak to me and I grab a missing items log and ask them to describe it." She stated she would investigate what happened with the items. She stated that sometimes they misplaced the items. She stated she checked the inventory log, the chart, laundry, and maintenance. SW2 stated if it could not be found, they reimbursed them [the residents] or reordered the item if possible. She stated that she tried to do it within a week or so. "Ultimately it is up to the discretion of the Administrator to check on what to do next. The grievance log and missing items	F 584	Property" was reviewed and updated to include, Lost or missing property will be replaced or reimbursement will be issued if warranted per the outcome of the investigation. 2. 3 Residents in the facility were affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the same practice and corrective actions to be taken: Immediate audit was completed on all windows in the facility was completed, any windows found dirty have been cleaned, no additional broken parts noted. The missing item log has been reviewed with no outstanding resolutions. Immediate audit on leaking pipes in all resident rooms was completed with no additional leaking pipes noted. The grievance log and resident council minutes have been reviewed with no outstanding findings for equipment replacement. 3. The following measures were put into place to ensure that the deficient practice will not recur: Continued education of all housekeeping staff by the Director of Environmental Services or designee on cleaning of internal windows during weekly room cleaning and as needed. Continued education to all nursing,	

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F 584	Continued From page 4 are together in a book. The [NJ Exec Order 26] weren't in her inventory and staff stated that never saw the [NJ Exec Order 26]. Her son does come to visit." She stated she followed up with him last week. She stated when it happened, the other SW checked the room with R40 sitting there and they didn't see anything. During an interview on 07/20/23 at 9:59 AM the unit manager, Registered Nurse (RN2) stated that she looked in the inventory for the [NJ Exec Order 26] and spoke to SW2. She stated nobody had ever seen the [NJ Exec Order 26]. During an interview on 07/20/23 at 10:06 AM RN3 stated that R40 did report the missing [NJ Exec Order 26], but he had never seen them. During an interview on 07/20/23 at 10:49 R40's family member stated that R40 did have a pair of sunglasses that her grandson gave her. He stated he hadn't heard back from the facility yet about the[NJ Exec Order 26]. During an interview on 07/20/23 at 1:06 PM the Administrator stated that the process for missing items/ grievances was for the report to go to the SW. He stated R40's [NJ Exec Order 26] issue was brought to his attention, they [staff] checked and couldn't find the [NJ Exec Order 26]. He stated everyone looked for the [NJ Exec Order 26]. He stated that any valuables should have been left with nursing. He stated in the past they have replaced stuff for R40. The Administrator stated if they could prove that they came in with it, then usually he would replace it. He stated we [he and social work] spoke about it last week. He stated he was trying to make sure that she wasn't making up a story about [NJ Exec Order 26]. He stated she did not usually do that, but she	F 584	maintenance and housekeeping staff by the Director of Nursing and/or the Nursing Educator and the Director of Environmental Services or designee on reporting any leaking pipes and/or broken items/equipment to maintenance immediately via the Maintenance log book for immediate repair. Weekly audits to be done on cleanliness of windows by the Director of Environmental Services or designee. Annual and as needed external cleaning of windows to be scheduled with documentation of cleaning maintained by the Director of environmental services or designee to ensure windows are clean and facility is in compliance. Weekly audits to be done of resident rooms for leaking pipes by the Director of environmental services or designee to ensure pipes are not leaking and facility is in compliance. Weekly audits of missing item logs to be done by the Director of Social Services or designee to ensure investigation of missing items has been completed a resolution has been made and facility is in compliance. Weekly audits of the grievance log and resident council minutes will be made by the Director of Social Services and the Director of Recreation or designee to ensure any requests for equipment replacement have been satisfied.	

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F 584	Continued From page 5 misplaced things. 2. Review of R106's undated "Admission Record" located in R106's EMR located under the "Profile" tab indicated she was NJ ex order 26.4b1 . Review of R106's quarterly "MDS" with an ARD of NJ ex order 26.4b1 located in the EMR under the MDS tab revealed R106 was assessed to have a BIMS score of NJ ex out of 15 which indicated the resident was NJ Exec Order 26.4b1. Interview on 07/17/23 at 1:25 PM, R106 conveyed the following concerns: "The windows have not been cleaned inside or outside" since she has been here and the left side window in the resident's bedroom had no handle so when the resident had the window open, she was unable to close it easily without using her fingernail. R106 stated she had been NJ Exec Order 26.4b1 and she was not sure if it was NJ Exec Order 26.4b1, though they [staff] thought it was a NJ Exec Order 26.4b1. The resident had requested a new bed. The window was observed to have a film of dirt and dust which was able to be smudged with a paper towel. On 07/19/23 at 9:33 AM in a follow up interview, R106 stated that the maintenance man came and sprayed something on the bed, and it made it better. During an interview and tour of the windows in R106's bedroom on 07/19/23 at 9:47 AM, the DPO stated that "They do spot cleaning on the windows, whenever it is needed. If something spilled on the window or they can't see out of it, they will clean it right away." He stated that the air conditioner (AC) caused the film on the window. "It's not dirt ...it's not like something spilled on the window." He said they washed the screens once	F 584	4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The Director of Environmental Service or designee will complete weekly audits on all windows in the building for cleanliness. Any negative findings will be corrected immediately. Audits will be conducted weekly X 4 weeks, monthly X 3 months and quarterly X 3 quarters. All audits and findings will be reported to the QAPI committee quarterly. The Director of Environmental Service or designee will complete weekly audits on all resident rooms in the building for leaking pipes. Any negative findings will be corrected immediately. Audits will be conducted weekly X 4 weeks, monthly X 3 months and quarterly X 3 quarters. All audits and findings will be reported to the QAPI committee quarterly. The Director of Social Services or designee will complete weekly audits on the missing items log for unresolved missing items . Any negative findings will be corrected immediately. Audits will be conducted weekly X 4 weeks, monthly X 3 months and quarterly X 3 quarters. All audits and findings will be reported to the QAPI committee quarterly. The Director of Social Services and the Director of Recreation or designee will complete weekly audits on the grievance	

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F 584	Continued From page 6 a year, but he was not aware that the handle on her left side window had been broken off. He stated the process was that the resident would tell nursing and then nursing would add it to the maintenance log for the unit. The DPO stated in this case she may not have told nursing, or they may not have added it into the maintenance log. The DPO further stated that he did know that the resident wanted a new mattress but that the resident wanted to be in the room when he changed the mattress. He added that the pest control did spray R106's side of the room, and that he [pest control] didn't see anything. Review of the facility's "Maintenance Log" from 01/01/23 - 06/30/23 provided by the DPO failed to show the resident reported the problem with the window. Review of the facility's "Renaissance Room Total Cleaning Log" from 01/01/23 - 06/30/23 provided by the DPO revealed the following: In January, February, and April 2023 a total cleaning was not performed on R106's or R40's room. In March and May 2023, a total cleaning was not performed on R106's room. In June 2023, a total cleaning was performed on R106's room and was not performed on R40's room. In July 2023, a total cleaning was not performed on R106's or R40's room as of 07/17/23. During an interview on 07/19/23 at 9:39 AM, Housekeeping/Environmental Services (HSK1) stated that as part of the everyday cleaning she "cleans the bed, the bathroom, the sink and the porter does the floors." Sometimes she will clean the outside of the refrigerators. She stated that "sometimes clean the windows." She stated if she saw something was dirty, she would clean it.	F 584	log and the resident council minutes for unresolved resident requests. Any negative findings will be corrected immediately. Audits will be conducted weekly X 4 weeks, monthly X 3 months and quarterly X 3 quarters. All audits and findings will be reported to the QAPI committee quarterly.	

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F 584	Continued From page 7	F 584		

Licensed Practical Nurse (LPN)2 assisted in the interview and translated for HSK1 that "when she does a total clean, she cleans the windows and they [the facility] have a schedule for the total clean." She stated there was a schedule that she gets from the DPO.

Review of the facility's policy titled "General Daily Cleaning" effective date 07/2005, revision date 12/2022 revealed "The entire facility will be kept clean at all times. The facility is cleaned on a daily basis. The resident rooms ...need the following areas cleaned on a daily basis: Mirrors are completely cleaned, and window are [sic] spot cleaned with a glass cleaner ...All repair work must be logged in the Maintenance Log Book."

Review of the facility policy titled "Personal Property" revision date 01/20/23 revealed "Residents are permitted to retain and use personal possessions and appropriate clothing, as space permits ...The resident is encouraged to maintain his/her room in a home-like environment by bringing personal items to place on nightstands, televisions, etc. ...The facility will promptly investigate any complaints or allegations of misappropriate or mistreatment of resident property.

3. Observation on 07/17/23 at 12:10 PM in R23's room revealed a wet, stained spot on the floor near the window. Observation of the ceiling above the spot revealed a water stain, and a wet spot in the ceiling. A drop of water fell during this observation.

Observation on 07/18/23 at 10:20 AM revealed the floor and ceiling were still wet.

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F 584	Continued From page 8 Observation on 07/19/23 at 10:42 AM revealed the floor and ceiling were still wet. During an observation and interview with the Director of Environmental Services (DES) and the Administrator on 07/19/23 at 12:16 PM of R23'S room; the DES acknowledged the stain on the ceiling and moisture on the floor. The DES stated the water was due to condensation from the ac [air conditioning] unit coming from the insulated pipes. The DES stated he was unaware of the leakage in R23's room. Observation on 07/20/23 at 9:11 AM revealed the floor in R23's room was still damp.	F 584		
F 609 SS=D	NJAC 8:39-4.1(a)11 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		8/31/23

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F 609	Continued From page 9 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ165572, NJ155763 Based on interview, record review, and facility policy review the facility failed to report timely, within two hours and not later than 24 hours for initial notification to the state survey agency (SSA), a witnessed NJ Exec Order 26.4b1 for one of one sampled resident (R)21 and an NJ Exec Order 26.4b1 for R122 reviewed for facility reported incidents (FRIs). Failure to report NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 could potentially lead to continued NJ Exec Order 26.4b1. Findings include: 1. Review of R122's "Admission Record" from the facility electronic medical record (EMR) under the "Profile" tab showed an admission date of NJ ex order 26.4b1, readmission on NJ ex order 26.4b1, with medical diagnoses that included NJ ex order 26.4b1 Review of R122's EMR "Progress Notes" tab	F 609	F609 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice those residents that were identified as being affected by the deficient practice; The Administrator and Director of Nursing were immediately educated by the Regional Director of Nursing on reporting actual or allegations of abuse, mistreatment and neglect, injuries of unknown origin within 2 hours and not later than 24 hours for initial notification to the state survey agency. The facility policy Titled "Abuse, Neglect, Misappropriation" has been reviewed with no updates required. 2. 2 Residents in the facility were	

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F 609	Continued From page 10 showed a practitioner's note on NJ ex order 26.4b1 at 12:48 PM that stated, ". . .Chief Complaint . . .Patient was noted with a NJ ex order 26.4b1. I was noted this morning. Will send patient to hospital for evaluation. . . " Review of the facility investigation showed a statement by the Licensed Practical Nurse (LPN)1 on NJ ex order 26.4b1 at 8:15 AM that the Certified Nurse Aide (CNA)1 NJ ex order 26.4b1 R122's NJ ex order 26.4. The written summary of the investigation revealed th NJ ex order 26.4b1 Review of the facility reported event regarding the NJ Exec Order 2 showed an investigation with staff interviews completed on NJ ex order 26.4b1 starting at 8:15 AM determining it was an NJ Exec Order 26.4b1 and the NJ Exec Ord was reported to the State Agency on NJ ex order 26.4b1 at 12:22 PM. In response to a request for verification of the date and time of the NJ Exec Order 26.4b1 report date and time, on NJ ex order 26.4b1 at 5:20 PM the Administrator provided and confirmed the reportable form showing the NJ ex order 26.4b1 at 12:22 PM report time. When queried about the delay, the Administrator stated that he did not recognize the NJ Exec Ord as a significant event until they discussed it that morning (NJ ex order 26.4b1 in the meeting. 2. Review of a FRI, dated NJ Exec Order 26.4b, revealed a witnessed NJ Exec Order 26.4b1 NJ ex order 26.4b1 between R21 and R75 occurred on NJ ex order 26.4b1 at 4:45 PM. R75 was witnessed to " .. NJ ex order 2 ..." R21 NJ ex order 26.4b1 during a NJ Exec Order 26.4b1 between the two residents. NJ ex order 26.4b1, or noted, to R21 and the two residents were	F 609	affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the same practice and corrective actions to be taken: The accident and incident log has been reviewed; no deficient practice found. 3. The following measures were put into place to ensure that the deficient practice will not recur: The Administrator and The Director of Nursing will conduct audits of allegations of abuse, abuse mistreatment or neglect and injuries of unknown audits weekly X 4 weeks, then monthly x 3 months then quarterly x 3 quarters and to continue audits until 100% compliance is attained to assure reporting guidelines are met. Abuse or allegations of abuse, mistreatment or neglect, injuries of unknown origin will be discussed with the Director of Nursing and the Administrator who will meet to discuss finding at morning report or within 2 hours of allegation or discovery of incident, whichever comes first to discuss and assure timely reporting is maintained. 4. The facility will monitor its corrective actions to ensure that the deficient	

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	315042	A. BUILDING _____ B. WING _____	C 07/25/2023

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F 609	Continued From page 11 immediately separated. Continued review of the FRI revealed the facility identified the altercation as a "significant event" and was called in to the SSA on [NJ ex order 26.4b1] at 7:32 PM. Further review of the FRI revealed the 24-hour report was faxed to the SSA on [NJ ex order 26.4b1] at 12:18 PM. During an interview on 07/21/23 at 3:30 PM, the Regional Director of Nursing (RDON) stated the SSA required the facility to call in FRI's to a state " ...hotline ..." and then fax over the 24 hour and five-day report. The RDON was unable to provide any verification that the SSA had received the information called in on [NJ Exec Order 26.4b] at 7:32 PM. Review of the facility policy titled "Abuse, Neglect, Misappropriation Prevention Policy and Procedure," reviewed 01/25/19, showed: ". . .F. Reporting 1. Staff must immediately report any allegation or actual instance of any type of abuse, neglect, misappropriation of resident property, involuntary seclusion [sic] or injury of unknown origin to their supervisor who must report any occurrence immediately to the DON [Director of Nursing]/Administrator. 2. The Director of Nursing/Administrator/designee will report the incident to the Department of Health, Ombudsman program and law enforcement as required according to regulatory requirements if there is reason to suspect abuse, neglect [sic] or mistreatment. 3. CMS [Centers for Medicare and Medicaid Services] and NJDOH [New Jersey Department of Health] reporting guidelines will be followed since allegations or actual instances of abuse or neglect as defined above are considered potential or actual crimes and must be reported to NJDOH within one hour of occurrence.	F 609	practice is being corrected and will not recur by: The Administrator and The Director of Nursing will present all audit findings of allegations of abuse, abuse mistreatment or neglect and injuries of unknown origin to the quarterly QAPI committee meeting.	

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F 609	Continued From page 12 4. The facility will keep a copy of all documents sent to regulatory and/or law enforcement agencies and includes the name of the person, date, and time information was sent. 9. All appropriate regulatory agencies will be notified of any allegations of abuse of neglect according to required timeframes. . . " NJAC 8:39-9.4(f)	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		8/31/23

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F 623	Continued From page 13	F 623		

be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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F 623	Continued From page 14 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review, the facility failed to ensure the Resident Representative and two residents (Resident (R)122 and R154) of two residents reviewed for facility initiated emergent hospital transfer were provided with written transfer/discharge notice that stated the reason for transfer, the place of transfer, and other information required on the transfer notice. This failure has the potential to affect the resident and their Resident	F 623	F623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(C)(3)-(6)(8) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice those residents that were identified as being affected by the deficient practice;	

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F 623	Continued From page 15 Representative (RR) by not having the knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired. Findings include: 1. Review of R122's "Admission Record" from the facility electronic medical record (EMR) Profile" tab showed an NJ ex order 26.4b1 NJ ex order 26.4b1 , Review of R122's EMR "Progress Notes" tab showed a practitioner's note on NJ ex order 26.4b1 at 12:48 PM that stated, ". . .Chief Complaint . . .Patient was noted with a NJ ex order 26.4b1 . I was noted this morning. Will send patient to hospital for evaluation. . .. NJ ex order 26.4b1 13:06 [1:06 PM] . . . Seen by [Practitioner name] with orders to transfer resident to [name] Hospital for evaluation. [Name] resident daughter called left a message to voicemail and awaiting [sic] for a return call. NJ ex order 26.4b1 13:34 [1:34 PM] Note Text: @ [at] 1:34pm [name] resident daughter called back and aware of NJ ex order 26.4b1 " In response to a request for evidence of written transfer notification provision to the resident and RR, the Administrator provided a form dated NJ ex order 26.4b1 which indicated that R122 was transferred to the ER for evaluation. The form did not show any date and time of email or mailing to the RR or documentation of provision to R122. The form also did not have any information regarding the appeal of the transfer or required Ombudsman (or other agencies) contact information.	F 623	The Director of Social Services and all social workers were educated on the requirements of notice before transfer and discharge. The facility policy titled "Notice of Transfer and Discharge" was reviewed and updated to include the right to appeal on the Emergency Transfer Form. 2. 2 Residents in the facility were affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the same practice and corrective actions to be taken: Audit was completed on all transfers and discharge from the past 30 days, written transfer notifications and right to appeal including the contact information of NJ LTCO Ombudsman, Disability Rights contact information, Appeal rights, reason for transfer, effective date, location resident was transferred was sent to the resident and/or designated representative. 3. The following measures were put into place to ensure that the deficient practice will not recur: The Director of Social Services or designee will audit all facility transfers and	

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F 623	Continued From page 16 2. Review of R154's entry "Minimum Data Set (MDS)"showed an Assessment Reference Date (ARD) of [redacted] Review of R154's EMR "Progress Notes" tab showed on [redacted] at 12:54 PM R154 was complaining of [redacted] the [redacted], the physician was contacted, and an order received to send R154 to the emergency room for evaluation. On [redacted] at 3:42 PM the "Progress Note" revealed the physician ordered that R154 was to be [redacted] On [redacted] at 4:00 PM the Administrator provided emails regarding the written transfer notices for both hospitalizations. The notice does not address the Ombudsman or appeal information. The notices had evidence of provision via email to the RR. At 4:35 PM evidence of provision of the notice to R154 was made and the Administrator stated he would check with the Social Workers. No evidence of provision was provided. During an interview on 07/19/23 at 3:56 PM regarding the required contents of the written emergent transfer notice, the Chief Operating Officer (COO) stated, "The transfer form does not have all the information. They are on the involuntary discharge notice, so we will be looking at our forms." Review of the facility policy titled "Notice of a Transfer and/or Discharge," revised February 25, 2023, showed: "Policy Interpretation and Implementation . . .	F 623	discharges weekly X4 weeks then monthly X 3 months, then quarterly X 3 quarters to assure facility is in compliance. The Emergency Transfer form has been updated to include the right to appeal information and the NJLTCO Ombudsman, Disability Rights contact information. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The Director of Social Services or designee will report all audits and findings to the Quarterly QAPI Committee meeting.	

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F 623	Continued From page 17 Contents of Notice The resident and/or representative (sponsor) will be provided with the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged; d. The name, address, and telephone number of the state long-term care ombudsman; e. The name, address, and telephone number of each individual or agency responsible for the protection and advocacy of mentally ill or developmental disabled individuals (as applies); and f. The name, address, and telephone number of the person at the NJ State Department of Health & Senior Services designated to handle appeals of transfers and discharge notices. . . " NJAC 8:39-4.1(a)31 NJAC 8:39-5.3(b)	F 623		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there	F 640		8/31/23

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F 640	Continued From page 18 is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one of one	F 640	F640 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	

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F 640	Continued From page 19 resident (Resident (R)150), reviewed for not having a "Minimum Data Set ([MDS)" discharge assessment transmitted to Centers for Medicaid and Medicare Services (CMS) in a timely manner, in that the MDS was not transmitted until 120 days after the resident was discharged from the facility.. This failure has the potential to have Medicare or Medicaid services denied due to the payment system having the R149 as being a nursing facility resident. Findings include: Review of R150's "Admission Record" from the electronic medical record (EMR) showed a facility NJ ex order 26.4b1 Review of R150's EMR "Orders" tab showed an order on NJ ex order 26.4b1 to NJ ex order 26.4b1. Review of R150's EMR "MDS" tab showed a discharge return not anticipated (DCRNA) with an assessment reference date of NJ ex order 26.4b1 Review of the history of the assessment showed an "accepted" status date of NJ ex order 26.4b1. In an interview on 07/19/23 at 3:14 PM regarding the MDS history screen in the EMR, the MDS Coordinator (MDSC) stated, "It [the DCRNA] was missed. It showed up on the report, was completed on NJ ex order 26.4b1 and submitted on NJ ex order 26.4b1." During an interview on 07/20/23 at 9:55 AM, the Regional Director of Nursing (RDON) stated the facility uses the "RAI" manual regarding MDS encoding and transmitting. Review of the October 2019 "Resident	F 640	1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice those residents that were identified as being affected by the deficient practice; MDS coordinators were Educated on the RAI manual regarding DCRNA MDS assessments must be encoded by the discharge date plus 14 days and transmitted within 14 days of completion. 2. 1 Resident in the facility was affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the same practice and corrective actions to be taken: Audit of discharge residents was performed, all discharged residents assessments have been completed within RAI guidelines. 3. The following measures were put into place to ensure that the deficient practice will not recur: The MDS coordinator or designee will audit all facility discharges weekly X4 weeks then monthly X 3 months, then quarterly X 3 quarters to assure facility is in compliance with timeliness of MDS	

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F 640	Continued From page 20 Assessment Instrument [RAI] Manual," page 2-17, showed a DCRNA MDS assessment needed to be encoded by the discharge date plus 14 days and transmitted within 14 days of the MDS completion date. NJAC 8:39-11.2(e)	F 640	submissions. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The MDS coordinator or designee will report all audits and findings to the Quarterly QAPI Committee meeting.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to accurately assess] and encode the "Minimum Data Set [MDS]" related to the presence of an indwelling catheter for one of six residents reviewed for [redacted] for one of six residents (Resident (R)15) NJ ex order 26.4b1 [redacted] This failure could lead to inaccurate care planning and/or care provision for the resident. Findings include: Review of R15's "Admission Record" from the electronic medical record (EMR) showed a facility NJ ex order 26.4b1 , readmission date of	F 641	F641 Accuracy of Assessments CFR(s): 483.20(g) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice those residents that were identified as being affected by the deficient practice; MDS coordinators were Educated on the RAI manual "steps for assessment" to assure accuracy in assessments and coding. The inaccurate MDS was corrected and resubmitted	8/31/23

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F 641	Continued From page 21 NJ ex order 26.4b1, with medical diagnoses that included NJ ex order 26.4b1 Review of R15's EMR "Orders" tab showed NJ ex order 26.4b1 Review of R15's EMR "Minimum Data Set (MDS)" under the "MDS" tab showed an admission "MDS," with an assessment reference date (ARD) NJ ex order 26.4b1 that did not show a NJ Exec Order 26 coded; however, the 5-day "MDS" with an ARD of NJ ex order 26.4b1 showed R15 coded as NJ ex order 26.4b1 During an interview on 07/19/23 at 3:05 PM, the Director of Nursing (DON) reviewed the EMR "MDS" assessments and stated there was "nothing in [EMR name] about a NJ ex order 26.4b and she [R15] did not come to the facility with a NJ Exec Ord I don't know why she was coded for a NJ ex order 26.4b." In an interview on 07/19/23 at 3:13 PM, the MDS Coordinator (MDSC) stated, "It was an error. I track NJ ex order 26.4b1 and she [R15] does not have one. It was coded wrong. Sometimes the CNAs [Certified Nurse Aides] code for NJ ex order 26.4b instead of NJ ex order 26.4b1 and she [the other MDS coordinator] must not have corrected it." Review of the October 2019 "RAI Manual," page H-1 showed: "Health-related Quality of Life -It is important to know what appliances are in use." Steps for Assessment 1. Examine the resident to note the presence of any urinary or bowel appliances.	F 641	2. 1 Resident in the facility was affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the same practice and corrective actions to be taken: Residents with indwelling ostomies were audited to assure accuracy in MDS submissions, with no negative findings. 3. The following measures were put into place to ensure that the deficient practice will not recur: The MDS coordinator or designee will audit all facility MDS submissions weekly X4 weeks then monthly X 3 months, then quarterly X 3 quarters to assure accuracy in MDS coding. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The MDS coordinator or designee will report all audits and findings to the Quarterly QAPI Committee meeting.	

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	315042	A. BUILDING _____ B. WING _____	C 07/25/2023

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F 641	Continued From page 22 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances." NJAC 8:39-11.2(e)1	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to provide assistance with facial grooming, and preserve and promote the dignity of two (Residents (R)84 and R117) of two residents reviewed for activities of daily living out of 39 sampled residents. This failure resulted in residents' appearing in a manner that failed to preserve the residents' dignity. Findings include: 1. Review of R84's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed R84 was admitted to the NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1 Review of R84's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, located in the EMR under the	F 677	F677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice those residents that were identified as being affected by the deficient practice were immediately shaved, removing all facial hair present. 2. 2 Residents in the facility was affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the same practice and corrective actions to be taken:	8/31/23

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F 677	Continued From page 23 "MDS" tab, revealed R84 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, indicating NJ ex order 26.4b1 . The MDS indicated R84 NJ ex order 26.4b1 [redacted]. Review of R84's "Care Plan," last revised NJ ex order 26.4b1 and located under the "Care Plan" tab of the EMR, indicated R84 "is NJ ex order 26.4b1 [redacted] Observations on 07/18/23 at 12:03 PM in the activity room revealed R84 had a long tuft of chin hairs. Observation on 07/19/23 at 9:05 AM revealed R84 still had long facial hair, approximately half an inch. Observation on 07/20/23 at 9:05 AM revealed no facial hair. During an interview with Certified Nurse Aide (CNA)4 on 07/20/23 at 9:09 AM CNA4 stated she had been instructed to shave R84 that morning and had done so. During an interview with Licensed Practical Nurse (LPN)1 on 07/20/23 at 9:38 AM she stated it was her expectation that CNAs shave resident's facial hair every other day, or when they observe growth. When asked about R84's facial hair, LPN1 stated that she was the person who instructed CNA4 to shave R84 that morning. 2. Review of R117's "Admission Record" located under the "Profile" tab of the Electronic Medical Record (EMR) revealed R117 NJ ex order 26.4b1 [redacted] with diagnoses that included NJ ex order 26.4b1 [redacted], and	F 677	All residents were audited for facial hair and groomed as needed. Education was instituted for Nurses and CNAs regarding checking all residents for facial hair daily and groom as needed. The facility policy titled "Quality of life-Dignity" was reviewed, no updates were required. 3. The following measures were put into place to ensure that the deficient practice will not recur: The Director of Nursing or designee will audit all residents in the facility for facial hair weekly X4 weeks then monthly X 3 months, then quarterly X 3 quarters to ensure residents are provided with facial grooming. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The Director of Nursing or designee will report all audits and findings to the Quarterly QAPI Committee meeting.	

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F 677	Continued From page 24	F 677		

NJ ex order 26.4b1

Review of R117's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 located in the EMR under the "MDS" tab, revealed R117 had a "Brief Interview for Mental Status (BIMS)" score of NJ out of 15, indicating NJ ex order 26.4b1. The MDS indicated R117 NJ ex order 26.4b1

Review of R117's "Care Plan," last revised NJ ex order 26.4b1 and located under the "Care Plan" tab of the EMR, indicated R117 'NJ ex order 26.4b1 NJ ex order 26.4b1

Observation on 07/18/23 at 12:36 PM in R117's room revealed R117 had long chin hair, half an inch.
Observation on 07/19/23 at 12:02 PM revealed R117 still had chin hairs.
Observation on 07/20/23 at 9:43 AM accompanied by LPN1 revealed R117 still had long chin hairs. LPN acknowledged the presence of R117's chin hairs.

During an interview on 07/20/23 at 1:29 PM, the Director of Nursing stated it was her expectation that staff shave residents as needed as part of the AM care, that R84 and R117 should not have visible facial hair.

Review of policy titled "Quality of Life - Dignity" dated 12/22 revealed: "...
1. Residents shall be treated with dignity and respect at all times.
2.'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her

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F 677	Continued From page 25 self-esteem and self-worth. 3. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.)." NJAC 8:39-4.1(a)12 NJAC 8:39-4.1(a)22 NJAC 8:39-27.2(g)	F 677		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.	F 868		8/31/23

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F 868	Continued From page 26 §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview, review of facility documents and review of facility policy, the Quality Assurance (QA) committee failed to ensure required members of the committee attended the quarterly meetings. This failure had the potential to affect all 175 residents who currently live in the facility. Findings include: Review of the undated facility's policy titled, "Quality Assurance Performance Improvement [QAPI] Program, "revealed, " ...The Administrator, or designee is responsible for assuring that all QAPI activities and required documentation is completed and/or up-to-date [sic]." Review of the facility's policy titled, "Quality Assessment and Assurance Plan," dated December 2009, revealed, " ... ...Authority: 2. The Administrator is responsible for assuring that his facility's Quality Assessment and Assurance Program complies with federal, state, and local regulatory agency requirements." The facility was unable to provide documentation of who attended the third quarter "Quality Assurance Performance Improvement Meeting," dated 07/22/22.	F 868	F868 QAA Commitee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice those residents that were identified as being affected by the deficient practice were: 0 residents were affected by the deficient practice The Administrator was immediately educated on the requirements of QAPI committee meetings quarterly and maintaining records of attendee documentation. The facility policies titled Quality Assurance Performance Improvement Program and Quality Assessment and Assurance Plan have been reviewed, no updates required. 2. 0 Residents in the facility was affected by the deficient practice, all	

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F 868	Continued From page 27 Interview on 07/20/23 at 4:55 PM, the Administrator stated that "The QAPI committee meets quarterly and is attended by the Medical Director, Director of Nursing (DON), Administrator and department heads." The Administrator was only able to provide sign in logs for the past three quarterly meetings and was not able to provide the sign in log for the meeting held on 07/22/22. The Administrator stated, "I don't have any record of the sign in sheet for that meeting." NJAC 8:39-33.1(b)	F 868	residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the Education instituted to all QAPI committee member on the requirements of quarterly QAPI committee meeting and signing attendance of QAPI meetings. 3. The following measures were put into place to ensure that the deficient practice will not recur: The Administrator or designee will audit QAPI committee meetings Quarterly X 4 to assure QAPI attendance and documentation of QAPI meetings occurred. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The Administrator or designee will report all audits and findings to the Quarterly QAPI Committee meeting.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/31/23

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F 880	Continued From page 28	F 880		

§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:

§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,

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F 880	Continued From page 29 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 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observations, and staff interviews, the facility failed to follow appropriate infection control practices for hand hygiene and glove wearing for one (Resident (R120) of one resident observed during resident care. Findings include: Observation on 07/20/23 at 8:52 AM revealed Certified Nurse Aide (CNA)5 with R120. [redacted] due to R120	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice the CNA that were identified was immediately re-educated on hand washing and donning gloves correctly. The CNA was given a verbal discipline	

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F 880	Continued From page 30 NJ Exec Order 26.4b1. CNA5 donned a right-hand glove only and lifted R120's NJ ex order 26.4b1 [redacted] When told she was only wearing one glove, CNA5 stepped into the hallway to obtain another glove and donned it on her left hand without performing hand hygiene. On 07/20/23 at 08:57 AM, CNA5 removed her gloves, did not perform hand hygiene, and walked down the hall to R68's room. CNA5 touched R68's shoulder and hands and exited R68's room, still without performing hand hygiene. Continued observation on 07/20/23 at 9:01 AM CNA5 entered the activities/dining area and assisted R173 to drink by lifting her cup of thickened juice and touching R173's shoulder, without performing hand hygiene on 07/20/23 at 9:02 AM CNA5 walked into R116's bathroom and washed her hands at the sink. During an interview on 07/20/23 at 9:04 AM, the above observations were discussed with CNA5, and she acknowledged that she had not performed hand hygiene after removing her gloves in R120's room, and possibly coming into contact with R120's NJ ex order 26.4b1. During an interview Licensed Practical Nurse/Unit Manager (LPN)1 on 07/20/23 9:30 AM LPN1 stated it was her expectation that CNA5 should have performed hand hygiene immediately after removing her gloves. Review of the facility's policy titled, "Infection Prevention & Control Program" revised 01/21 revealed: "(7) following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC)."	F 880	regarding not performing appropriate hand washing. The facility policies titled "Infection Prevention and Control Program" and "Handwashing/Hand Hygiene" were reviewed, no updates required. 2. 4 Residents in the facility was affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the Education on hand washing and glove wearing was instituted to all staff. 3. The following measures were put into place to ensure that the deficient practice will not recur: The Director of Nursing or designee will perform random audits on the staff in the facility for hand washing and proper donning/wearing of glove weekly X4 weeks then monthly X 3 months, then quarterly X 3 quarters to ensure staff is in compliance with infection control requirements. 4. The facility will monitor its corrective actions to ensure that the deficient	

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F 880	Continued From page 31 Review of the CDC document titled "Hand Hygiene in Healthcare Settings" located at https://www.cdc.gov/handhygiene/providers/index.html, revealed "...When and How to Perform Hand Hygiene..."During Routine Patient Care: Use an Alcohol-based hand sanitizer - Immediately before touching a patient; Before moving from work on a soiled body site to a clean body site on the same patient; After touching a patient or the patient's immediate environment; After contact with blood, body fluids or contaminated surfaces; Immediately after glove removal" Review of policy titled "Handwashing/Hand Hygiene" reviewed 11/22 provided by the facility revealed: "...This facility considers hand hygiene the primary means to prevent the spread of infections...2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors... 5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions ...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) ...g. Before and after assisting a resident with meals; h. Before and after assisting a resident with personal care (e.g., oral care, bathing): 1. Upon and after coming in contact with a resident's intact skin ..." NJAC 8:39-19.4(a)1	F 880	practice is being corrected and will not recur by: The Director of Nursing or designee will report all audits and findings to the Quarterly QAPI Committee meeting.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		8/31/23

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F 883	Continued From page 32 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 33 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to ensure that five of five residents (Resident (R) R8, R9, R113, R117, and R132) NJ ex order 26.4b1 CDC guidelines out a total sample of 39. This practice had the potential to increase the risk for these residents to contract pneumonia. Findings include: 1. Review of R8's quarterly "Minimum Data Set" (MDS) located in the Electronic Medical Record (EMR) under the "MDS" tab with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 revealed R8 was admitted to the facility on NJ ex order 26.4b1 R8 was over the age NJ ex order 26.4b1 at the time of her admission to the facility. Review of R8's "immunization record" located under the "Immunization" tab of the EMR	F 883	F883 Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice those residents that were identified as being affected by the deficient practice were offered and provided the pneumonia vaccine. The IP was immediately educated on the current CDC guidelines regarding pneumococcal vaccines. 2. 5 Residents in the facility was affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING _____ B. WING _____	C 07/25/2023

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F 883	Continued From page 34 revealed R8 received a dose of the NJ ex order 26.4b1 [redacted] The record failed to reveal that R8 had received any further NJ ex order 26.4b1. There was no documentation of resident offered the NJ Exec Order 26.1 nor refusal of NJ Exec Order 26. 2. Review of R9's quarterly "MDS" with an ARD NJ ex order 26.4b1 [redacted] revealed R9 was originally NJ ex order 26.4b1 on NJ ex order 26.4b1 and NJ ex order 26.4b1 Review of R9's "immunization record" revealed R9 NJ ex order 26.4b1 [redacted] R9 was over the age of NJ ex order 26.4b1 [redacted] at the time of admission. The record failed to reveal that R9 NJ ex order 26.4b1 [redacted] There was no documentation of resident offered the NJ Exec Order 26. nor refusal of NJ Exec Order 26.4. 3.Review of R113's quarterly "MDS" with an ARD NJ ex order 26.4b1 revealed R113 was originally admitted to the facility on NJ ex order 26.4b1 and NJ ex order 26.4b1 NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1 [redacted] Review of R113's "immunization record" revealed R113 received the NJ ex order 26.4b1 [redacted] R113 was over the age of NJ ex order 26.4b1 [redacted] at the time of admission. The record failed to reveal that R113 NJ ex order 26.4b1 [redacted] There was no documentation of resident offered the NJ Exec Order 26. nor refusal of NJ Exec Order 26. 4. Review of R117's quarterly "MDS," with an ARD of NJ ex order 26.4b1 [redacted] located in the EMR under the "MDS" tab, revealed R117 was admitted to the	F 883	The following action was taken to identify other residents having the potential to be affected by the deficient practice and corrective action taken: All residents in the facility were audited for the pneumonia vaccine, those residents identified as requiring the vaccine will be offered and administered the vaccination. The facility policy titled Pneumococcal Vaccine has been reviewed, no update required. 3. The following measures were put into place to ensure that the deficient practice will not recur: Education regarding the current CDC guidelines on pneumococcal vaccination has been initiated for LPNs and RNs. The Director of Nursing or designee will perform audits on the residents in the facility for pneumonia vaccination administration weekly X4 weeks then monthly X 3 months, then quarterly X 3 quarters to ensure the residents are in compliance pneumonia vaccination requirements, Residents requiring the Pneumococcal vaccine have been offerd and administered. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:	

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F 883	Continued From page 35 facility on [redacted]. Review of R117's "immunization record" revealed R117 received the [redacted] R117 was over the age of [redacted] at the time of admission. The record failed to reveal that R113 [redacted] There was no documentation of resident offered the [redacted] nor refusal of [redacted] 5. Review of R132's admission "MDS" with an ARD [redacted] revealed R132 was admitted to the facility on [redacted] with diagnoses that included [redacted] Review of R132's "immunization record" revealed [redacted] R132 was over the age of [redacted] at the time of admission. There was no documentation of resident offered the [redacted] nor refusal of [redacted] During an interview with the facility's infection preventionist (IP) on 07/19/23 at 3:07 PM the IP acknowledged the facility's pneumococcal vaccine policy was not up to date with the latest CDC guidelines. When asked what the facility current pneumococcal practice was, the IP stated residents over sixty should receive either the Prevnar 13 or the Prevenar 23 every five years. During an interview with the Director of Nursing (DON) on 7/20/23 at 1:11 PM, the DON stated the current practice of the facility regarding pneumococcal vaccine was if residents had "received the Prevnar 23 by the age of 55 and above, then it will not be repeated, but if received below the age of 55 might be repeated". When	F 883	The Director of Nursing or designee will report all audits and findings to the Quarterly QAPI Committee meeting.	

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F 883	Continued From page 36	F 883		

told this did not reflect the current clinical practice and CDC guidelines, she acknowledged that the facility was not up to date.

The DON acknowledged that R8, R9, R113, R114 and R132 NJ ex order 26.4b1 [redacted] per CDC guidelines.

Review of the facility's policy titled "Pneumococcal Vaccine" revised 06/08 provided by the facility revealed "All residents will be offered the Pneumovax® (pneumococcal vaccine) to aid in preventing pneumococcal infections (e.g., pneumonia) ...
1. Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax® (pneumococcal vaccine), and when indicated, will be offered the vaccination within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.
2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission...
4. Pneumococcal vaccinations will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol...
6. For residents who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record.
7. Administration of the pneumococcal vaccination or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations

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F 883	Continued From page 37 at the time of the vaccination." Review of the CDC recommendations, revised on 02/13/23, indicated "...CDC recommends pneumococcal vaccination for all adults 65 years or older. . .For adults 65 years or older who have not previously received any pneumococcal vaccine +, CDC recommends you. . .Give 1 dose of PCV15 or PCV20. . .If PCV15 is used, this should be followed by a dose of PPSV23 at least 1 year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. . .If PCV20 is used, a dose of PPSV23 is NOT indicated. . . For adults 65 years or older who have only received PPSV23, CDC recommends you. . .Give 1 dose of PCV15 or PCV20. The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults 65 years or older who have only received PCV13, CDC recommends you either. . .Give 1 dose of PCV20 at least 1 year after PCV13. . .or Give 1 dose of PPSV23 at least 1 year after PCV13. . ." NJAC 8:39-19.4(i)	F 883		
F 949 SS=C	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).	F 949		8/31/23

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F 949	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on record review, interview, facility policy review and review of facility assessment, the facility failed to ensure three Certified Nurse Aides (CNAs) (CNA1, CNA2, and CNA3) of three CNAs and one Registered Nurses (RN)1 of one RN reviewed had received behavioral health training to care for residents diagnosed with mental health illnesses indicated on the facility assessment. This failure had the potential for direct care staff to lack current knowledge to work with the unique challenges mental health illnesses present. Findings include: Review of the "Facility Assessment," reviewed 02/20/23, showed: "Purpose The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. This assessment will be used to make decisions about the direct care staff needs, as well as the capabilities to provide services to our residents. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. . . 1.3 Patients with diseases/conditions that may be accepted by [Facility Name]. Psychiatric/Mood Disorders Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety	F 949	F949 Behavioral Health Training CFR(s): 483.95(i) 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: There were 0 residents affected by the deficient practice, there were 4 staff members affected by the deficient practice. The Nurse Educator was in-serviced on the requirement for Behavioral health training to be done on facility orientation and annually for all staff. The facility orientation outline has been reviewed and updated to include Behavioral Health Training Behavioral health training was immediately instituted for all staff. 2. 0 Residents in the facility was affected by the deficient practice, all residents in the facility have the potential to be affected by the deficient practice. No residents were harmed by the deficient practice. The following action was taken to identify other residents having the potential to be affected by the deficient practice and corrective action taken: 0 residents were affected by the deficient practice	

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F 949	Continued From page 39 Disorder. . ." According to the "Resident Census and Conditions of Residents" form, completed by the Director of Nursing (DON) on 07/17/23, the facility's current census included: 86 residents with signs and symptoms of depression; 36 residents with documented psychiatric diagnoses (excluding dementia and depression); and 9 residents with behavioral healthcare needs. 118 residents that are prescribed psychoactive medications; 20 residents that are prescribed antipsychotic medications; 33 residents that are prescribed anxiolytic medications; 77 residents that are prescribed antidepressant medications; and 7 residents that are prescribed hypnotic medications. Review of employee training files showed: CNA1, Date of Hire (DOH) [redacted], showed 17.5 hours of in-service training, but no behavioral health training was documented. CNA2, DOH [redacted], showed 17.5 hours of in-service training, but no behavioral health training was documented. CNA3, DOH [redacted], showed 17.5 hours of in-service training, but no behavioral health training was documented. RN1, DOH [redacted] showed dementia and abuse training, but no behavioral health training was documented. During an interview with Licensed Practical Nurse (LPN 5, LPN4 and LPN3 regarding behavioral health training for working with residents with mental health diagnoses on 07/20/23 at 4:38 PM	F 949	The facility policy titled "In-Service Training Program" was reviewed and revised to include, Behavioral Health training will be done for all employees on facility orientation and annually. 3. The following measures were put into place to ensure that the deficient practice will not recur Education for all staff will continue annually and for all new hires upon facility orientation and annually thereafter. The Director of Nursing or designee will perform audits on the all new hires in the facility weekly X4 weeks then monthly X 3 months, then quarterly X 3 quarters to ensure the staff are in compliance with Behavioral Health Training. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The Director of Nursing or designee will report all audits and findings to the Quarterly QAPI Committee meeting.	

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F 949	Continued From page 40	F 949		

LPN 5stated "We get in-services, but nothing like that." LPN4 stated she had not received that type of training before she went on the floor or since; and LPN3 stated, "No, not about those behaviors."

In an interview on 07/20/23 at 5:17 PM, regarding behavioral health training, the Chief Operating Officer (COO) stated, "I can't produce any evidence they had the training. "

During an interview on 07/20/23 at 5:56 PM, the Regional Director of Nursing (RDON) stated, "There is no separate policy [regarding behavioral health training]. We follow the Department of Health requirements for in-services." Review of the facility policy titled "In-Service Training Program," revised December 2011, stated, " . . .In-service training will be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews and per DOH guidelines." The policy only addressed CNA in-service training and did not discuss behavioral health training needs.

NJAC 8:39-Appendix B XI-5

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	061408	A. BUILDING: _____ B. WING _____	C 07/25/2023

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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: Based on 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 for day shifts reviewed. 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, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	S-560 CORRECTIVE ACTION: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, facility will utilize staffing agencies to fill any open spots in the schedule. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents have the potential to be at risk for the deficient practice. SYSTEMIC CHANGE: The Facility Administrator has Contracted with additional staffing agencies to secured supplemental facility staffing. Hiring and	8/31/23

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

Electronically Signed | 08/09/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on day shifts as follows: 1. For the week of Complaint staffing from 04/24/2022 to 04/30/2022, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -04/24/22 had 20 CNAs for 170 residents on the day shift, required 21 CNAs. -04/25/22 had 20 CNAs for 174 residents on the day shift, required 22 CNAs. -04/26/22 had 19 CNAs for 172 residents on the day shift, required 21 CNAs. -04/27/22 had 20 CNAs for 170 residents on the day shift, required 21 CNAs. -04/29/22 had 20 CNAs for 167 residents on the day shift, required 21 CNAs.	S 560	recruitment efforts including wage analysis and adjustments, pay for experience, online job listings and referral bonuses are being utilized to ensure marketplace competitiveness. In addition, the director of nursing will meet daily with the staffing coordinator to ensure appropriate staffing QUALITY ASSURANCE: The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly until compliance is met.	

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S 560	Continued From page 2 -04/30/22 had 19 CNAs for 166 residents on the day shift, required 21 CNAs. 2. For the week of Complaint staffing from 06/19/22 to 06/25/2022, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -06/19/22 had 16.5 CNAs for 180 residents on the day shift, required 22 CNAs. -06/20/22 had 20 CNAs for 177 residents on the day shift, required 22 CNAs. -06/21/22 had 20 CNAs for 177 residents on the day shift, required 22 CNAs. -06/22/22 had 21 CNAs for 177 residents on the day shift, required 22 CNAs. -06/24/22 had 19 CNAs for 178 residents on the day shift, required 22 CNAs. -06/23/22 had 19 CNAs for 176 residents on the day shift, required 22 CNAs. 3. For the week of Complaint staffing from 03/12/2023 to 03/18/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -03/12/23 had 21 CNAs for 177 residents on the day shift, required 22 CNAs. -03/13/23 had 20 CNAs for 176 residents on the day shift, required 22 CNAs. -03/14/23 had 21 CNAs for 176 residents on the day shift, required 22 CNAs. 4. For the 2 weeks of staffing prior to survey from 07/02/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -07/02/23 had 21 CNAs for 173 residents on the day shift, required 22 CNAs.	S 560		

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S 560	Continued From page 3 -07/03/23 had 21 CNAs for 173 residents on the day shift, required 22 CNAs. -07/05/23 had 19 CNAs for 172 residents on the day shift, required 21 CNAs. -07/09/23 had 18 CNAs for 170 residents on the day shift, required 21 CNAs. -07/10/23 had 20 CNAs for 170 residents on the day shift, required 21 CNAs. -07/11/23 had 20 CNAs for 170 residents on the day shift, required 21 CNAs. -07/12/23 had 20 CNAs for 170 residents on the day shift, required 21 CNAs. -07/15/23 had 20 CNAs for 170 residents on the day shift, required 21 CNAs.	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
315042 Y1	A. Building B. Wing Y2	9/20/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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	F0584	Correction	ID Prefix	F0609	Correction	ID Prefix	F0623	Correction
Reg. #	483.10(i)(1)-(7)	Completed	Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.15(c)(3)-(6)(8)	Completed
LSC		08/31/2023	LSC		08/31/2023	LSC		08/31/2023
ID Prefix	F0640	Correction	ID Prefix	F0641	Correction	ID Prefix	F0677	Correction
Reg. #	483.20(f)(1)-(4)	Completed	Reg. #	483.20(g)	Completed	Reg. #	483.24(a)(2)	Completed
LSC		08/31/2023	LSC		08/31/2023	LSC		08/31/2023
ID Prefix	F0868	Correction	ID Prefix	F0880	Correction	ID Prefix	F0883	Correction
Reg. #	483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	483.80(d)(1)(2)	Completed
LSC		08/31/2023	LSC		08/31/2023	LSC		08/31/2023
ID Prefix	F0949	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.95(i)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		08/31/2023	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	
7/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061408		9/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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 08/31/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 7/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315042	A. Building B. Wing	9/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 08/31/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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
7/25/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 07/25/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/25/23 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. Lincoln Park Renaissance Rehab and Nursing is composed of two buildings: Building 1 is the Main and Building 2 is the JDT Pavilion. Building 1 is a two-story building 1973. It is composed of Type II protected construction. The facility is divided into 21 - smoke zones. The generator does approximately 30 % of the building as per the Maintenance Director. The current occupied beds are 179 of 189. .	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by	K 000		

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

Electronically Signed | 08/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 000	Continued From page 1 Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/25/23 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. Lincoln Park Renaissance Rehab and Nursing is composed of two buildings: Building 1 is the Main and Building 2 is the JDT Pavilion Building 2 is a four-story building that was built in 2013. It is composed of Type II protected construction. The facility is divided into 21 - smoke zones. The generator does approximately 30 % of the building as per the Maintenance Director. The current occupied beds are 179 of 189.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced	K 311		9/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 311	Continued From page 2 by: . Based on observation and interview, the facility failed to ensure fire rated door assemblies for 19-stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 7.2.1.7.2. This deficient practice had the potential to affect 179 residents. Findings include: An observation on 07/25/23 at 12:00 PM to 3:30 PM revealed the stairway exit doors were equipped with panic hardware and not fire exit hardware which violated the listing of the rated fire door assemblies. During an interview at the time of observation, the Maintenance Director confirmed the stairway doors were equipped with panic hardware. NJAC 8:39-31.2(e) .	K 311	K-311 (F) Vertical Openings-Enclosure It is the practice of the facility to have fire exit doors equipped with appropriate fire exit door hardware not panic hardware. Residents were at no risk due to hardware functioning as design and building being fully sprinkled. 1. The facility will change out all panic hardware with fire exit hardware for all stairwell fire exit doors. 2. All doors will be checked to confirm proper hardware is installed. 3. Education will be completed with Maintenance staff to fire stairwell doors hardware. 4. Every month the Maintenance Director or designee will check egress doors on a random floor of the facility to confirm hardware operates as designed and proper stickers are affixed to panic hardware. This information will then be entered on a log will be presented to QAPI meeting monthly.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation	K 311		9/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 311	Continued From page 3 shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire rated door assemblies for 19-stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 7.2.1.7.2. This deficient practice had the potential to affect 179 residents. Findings include: An observation on 07/25/23 at 12:00 PM to 3:30 PM revealed the stairway exit doors were equipped with panic hardware and not fire exit hardware which violated the listing of the rated fire door assemblies. During an interview at the time of observation, the Maintenance Director confirmed the stairway doors were equipped with panic hardware. NJAC 8:39-31.2(e) .	K 311	K-311 (F) Vertical Openings-Enclosure (BUILDING 02-JDT) It is the practice of the facility to have fire exit doors equipped with appropriate fire exit door hardware not panic hardware. Residents were at no risk due to hardware functioning as design and building being fully sprinkled. 1. The facility will change out all panic hardware with fire exit hardware for all stairwell fire exit doors. 2. All doors will be checked to confirm proper hardware is installed. 3. Education will be completed with Maintenance staff to fire stairwell doors hardware. 4. Every month the Maintenance Director or designee will check egress doors on a random floor of the facility to confirm hardware operates as designed and proper stickers are affixed to panic hardware. This information will then be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 311	Continued From page 4	K 311	entered on a log will be presented to QAPI meeting monthly.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure sprinklers were located to provide protection of an area in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) section 8.5.1. This deficient practice had the potential to affect 179 residents. Findings include: An observation on 07/25/23 at 12:00 PM to 1:37 PM revealed a sprinkler head was not installed in	K 351	K-0351 (F) Sprinkler System Installation It is the practice of the facility to 100 percent sprinkler coverage throughout the building. Residents were at no risk due to occupancy of the rehab gym room and bathroom constantly supervised and proper fire safety equipment was nearby. 1. Sprinkler head will be installed in PT Gym bathroom.	9/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 351	Continued From page 5 the physical therapy restroom, located in the basement. During an interview at the time of the observation the Maintenance Director confirmed a sprinkler head was not installed in the physical therapy restroom. NJAC 8:39-31-1(c), 31.2(e) NFPA 13, 25	K 351	2. All rooms have been inspected for missing sprinkler heads on 8/1/23. 3. Education completed with Maintenance staff to monitor sprinkler heads cleanliness and placement. 4. Every month the Maintenance Director or designee will check to ensure sprinkler heads are in place on a random floor of the facility. This information will then be entered on a log and will be presented to QAPI meeting monthly.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		9/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 6 . Based on observation and interview, the facility failed to ensure sprinklers were free of paint and any sprinkler that showed signs of painting unless painted by the sprinkler manufacturer was replaced in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems (2011 edition) sections 5.2.1.1.1 and 5.2.1.1.2. This deficient practice had the potential to affect all 179 residents. Findings include: An observation on 07/25/23 at 12:36 PM revealed the cover for the concealed sprinkler head, located in the front foyer near the reception desk, was painted with white paint and not painted by the sprinkler manufacturer. During an interview at the time of the observation, the Maintenance Director confirmed the sprinkler cover was painted. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	K-0353 (F) NFPA 101- Sprinkler System Testing It is the practice of the facility to have operational sprinkler systems. The Residents were at no risk due to the area having proper sprinkler coverage and 24-hour monitoring of the lobby with proper fire extinguishing equipment nearby. 1. The sprinkler head cover in the lobby has been removed and a new sprinkler head cover free from paint has been installed. 2. All rooms have been inspected for painted or obstructed sprinkler heads on 8/1/23 3. Education completed with Maintenance staff to confirm proper operation around sprinkler heads on 8/1/23 4. Every month the Maintenance Director or designee will inspect random sprinkler heads to confirm installed as designed. This information will then be entered on a log will be presented to QAPI meeting monthly.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315042	A. Building 02 - JDT PAVILLION B. Wing	9/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 09/15/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 7/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			