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 10/10/2024

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
F 000	INITIAL COMMENTS Complaint #s NJ 173810, 174365, 174581, 175435, 176286, 177537, 177694 STANDARD SURVEY: 10/1-10/8/24 CENSUS: 176 SAMPLE SIZE: 35+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 2 of 38 residents reviewed for accommodation of needs (Resident #59 and #127), and was evidenced by the following: On 10/1/24 at 11:34 AM, the surveyor observed Resident #59 in bed on a [NJ Ex Order 26.4(d)] mattress, with his/her eyes open. Resident #59 did not respond	F 558	558 Call Bells/ Call Light Use I. Corrective action accomplished for the resident found to have been affected by the deficient practice: Upon notification of the deficient practice, the two residents identified as being affected by the deficient practice were immediately attended to and their call bells were placed within their reach. Education was immediately initiated for all Nurses and CNAs by the DON and Nurse	12/10/24

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

Electronically Signed | 11/04/2024

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F 558	Continued From page 1 to the surveyor's greeting. The surveyor observed the resident's call bell (a bell used to summon staff for assistance) was intertwined with their roommates call bell cord and entangled in the bed electrical cords, not within his/her reach. The surveyor reviewed the medical record for Resident #59. A review of Resident #59's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]. A review of Resident #59's Annual Minimum Data Set (MDS) an assessment tool dated [redacted] revealed Resident #59 had a NJ Exec Order 26.4b1 [redacted] The MDS further revealed that the resident was dependent on staff for [redacted] and he/she was always [redacted]. A review of Resident 59's individualized comprehensive care plan (ICCP) initiated on [redacted], with a revision date of [redacted] included the resident had a communication problem r/t history of NJ Exec Order 26.4b1 [redacted]. The interventions included but were not limited to; NJ Exec Order 26.4b1 [redacted]. On 10/1/24 at 11:34 AM, the surveyor observed	F 558	Supervisor on Call Bell Placement. 2. Two residents [redacted] by the deficient practice; all residents have the potential to be affected by the deficient practice. An immediate audit was completed on all residents in the facility by DON to ensure all call bells were in reach. The facility policy on "Call Light Use" was reviewed and revised to add "Call bell must not be intertwined with other residents call bell" 3. The following measures were put into place to ensure that the deficient practice will not recur: Education of Nursing Staff on Proper Placement of Call Bells. Audits on Call Bell Placement throughout the building by the DON or Designee to ensure call bells are in proper placement and in compliance. 4. The facility will monitor its corrective actions to ensure that the deficient practice is been corrected and will not recur by: The DON or Designee will perform audits on Call Light Use Weekly X 4 weeks, then monthly X 3 months, then Quarterly X 3 quarters to ensure that residents call lights are within reach and answered promptly. The DON or Designee will report all audits and findings in the quarterly QAPI committee meeting. 5. Completion Date: 12/10/24	

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F 558	Continued From page 2 Resident #127 in bed. The resident did not respond to the surveyor's greeting. The surveyor observed the resident's call bell was intertwined with their roommates call bell and twisted together in the bed electrical cords not within his/her reach. A review of Resident #127's Admission Record reflected that the resident was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1 [redacted] A review of the most recent quarter MDS dated NJ Exec Order 26.4 revealed the resident had a brief interview for mental status (BIMS) score of NJ Exec Order [redacted] which indicated a NJ Exec Order 26.4b1 [redacted]. A further review indicated they required NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) from staff for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) A review of the ICCP initiated NJ Ex Order 26.4(b) revised NJ Exec Order 26.4b reflected, resident has potential for NJ Ex Order 26.4(b)(1) [redacted] r/t NJ Ex Order 26.4(b)(1) secondary to NJ Ex Order 26.4(b)(1) with interventions that included but not limited to: encourage resident to use bell to call for assistance. On 10/4/24 at 8:00 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) who had Resident #59 and Resident #127 on their assignment on NJ Exec Order 26 [redacted]. The U.S. FOIA (b) [redacted] acknowledged that the call bells should be kept within the resident's reach at all times and could not speak to why she did not ensure that the resident's call bells were within their reach. On 10/7/24 at 10:35 AM, the U.S. FOIA (b) (6)	F 558		

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F 558	Continued From page 3 U.S. FOIA (b) (6) in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) acknowledged that all residents should have their call bells within reach. A review of the facility's "Call Light Use" policy revised 1/5/24 included ...the purpose is to respond promptly to resident's call for assistance ...when providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light ...be sure call lights are placed on the bed as all times never on the floor or bed side. A review of the facility's Certified Nursing Assistant job description included ...answers all call bells and places them in reach of the resident ...	F 558		
F 640 SS=D	NJAC 8:39- 31.8 (c)(9) 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		12/10/24

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F 640	Continued From page 4 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 interview and record review, it was determined that the facility failed to start, complete and transmit the Minimum Data Set	F 640	F-640 Identification of at-Risk Residents: All residents that have expired in the	

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F 640	Continued From page 5 (MDS) for NJ Ex Order 26.4(b) in facility and a Discharge Return not Anticipated in accordance with federal guidelines. This deficient practice was identified for two (2) of 38 residents reviewed for Resident Assessment (Resident #144, and 54) and was evidenced by the following: 1. The surveyor reviewed the closed medical record for Resident #144. A review of the resident's Admission Record (an admission summary) reflected that Resident #144 was admitted to the facility with diagnoses that included but was not limited to NJ Exec Order 26.4b1 On 10/7/24 at 10:14 AM, the surveyor reviewed the electronic Medical Record, Minimum Data Set (MDS) tab that reflected NJ Ex Order 26.4(b) in the facility tracking discharge was not completed and was NJ Ex Order 26.4(b)(1) overdue. On 10/7/24 at 10:28 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) stated that the facility had 14 days to submit the NJ Ex Order 2 in the facility tracking. At that time the U.S. FOIA (b) (6) confirmed Resident #144 NJ Ex Order 26.4(on NJ Exec Order 26.4 and the NJ Ex Order 2 in the facility was not started, and was over NJ Ex Order 26.4(b)(1 overdue. A review of the facility provided policy Resident Assessment Instrument (RAI), dated 1/3/24, reflected that the Assessment Coordinator was responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: within 14 days of the resident's admission; when there is a significant	F 640	facility and have been discharged have the potential to be affected by this deficient practice. The residents affected by this deficient practice are no longer in the facility. Corrective Action for Residents Affected: MDS Coordinator will review an accurate daily census and schedule appropriate MDS assessments on the same day to prevent missing any required assessments. Systematic Changes: The U.S. FOIA (b) (6) has been in-serviced on the process to review daily census and schedule assessments to ensure there are no missing scheduled assessments. Quality Assurance/Performance Improvement: A second MDS coordinator or designee will review the census and scheduled assessments daily after MDS Coordinator #1 has completed his/her review to ensure that all necessary assessments have been scheduled. A log with a signature will be completed daily (Monday through Friday) for two months to ensure no missing assessments exist. After two months, a random audit of three residents per week will be performed by MDS Coordinator #2 weekly for one month to ensure compliance. Audit results will be reviewed by the Quality Assurance Committee. Completion Date: December 10, 2024	

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F 640	Continued From page 6 change; at least quarterly, and once every 12 months. 2. Resident #54 was discharged from the facility to home on [redacted] as noted in a [redacted] electronic Nurses Note and the electronic Census. The resident was not expected to return to the facility. A review of the completed MDS assessments revealed the following submissions: A [redacted] Entry and a [redacted] Admission/Medicare 5 Day assessment. The surveyor interviewed the [redacted] on [redacted]. She stated the MDS Discharge/Return Not Anticipated assessment should be done within 14 days of the discharge date. She stated the assessment was not done and was late. On 10/7/24 at 10:44 AM, during a meeting with the survey team, the [redacted] and the [redacted] and the [redacted], the surveyor discussed the concern Regarding the [redacted] in the facility tracking discharge for Resident #144 that was not started and was [redacted] overdue. A review of facility policies regarding resident MDS assessments failed to address discharge assessment, however the [redacted] stated the facility follows the Resident Assessment Instrument (RAI) 3.0. NJAC 8:39 - 11.1	F 640		

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F 641 F 641 SS=D	Continued From page 7 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 observation, interview, and record review it was determined that the facility failed to accurately assess: a) a resident's [redacted]; b) a resident's use of a [redacted]; c) a resident's use of an [redacted]; and d) a resident's [redacted] in the Minimum Data Set (MDS) assessment tool. The deficient practice was identified for 4 of 38 residents reviewed for MDS accuracy (Resident #88, 77, 129, 25) and evidenced by the following. 1. The surveyor interviewed Resident #88 on 10/2/24 at 9:53 AM. The resident was observed with [redacted] The surveyor interviewed the [redacted]) on 10/4/24 at 8:46 AM regarding the resident's [redacted]. The [redacted] referred the surveyor to the [redacted] admission evaluation. The surveyor reviewed the [redacted] Evaluation and Plan of Treatment. In the document, the [redacted] noted '[redacted] The [redacted] Admission MDS assessment, Section [redacted] Status failed to identify [redacted]. The surveyor interviewed the [redacted]	F 641 F 641	F-641 Identification of at-Risk Residents: All residents have the potential to be affected by this deficient practice. Of the residents that the deficient practice was identified for, all assessments were modified and resubmitted for both the residents that remain in the facility and the residents no longer residing in the facility. Corrective Action for Residents Affected: An MDS Coordinator, different from the coordinator completing the assessment will review each assessment for accuracy in coding prior to submitting. Systematic Changes: All nurses in the MDS department have been in-serviced on the properly coding assessments. Quality Assurance/Performance Improvement: A second MDS coordinator or designee will review all completed MDS assessments for accuracy and address and discrepancies or omissions prior to submission. An audit log will be kept for all assessments and the results of the review for one month. For month two a random audit will be performed by the MDS Coordinator or designee twice per week to ensure accuracy in coding.	12/10/24

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F 641	Continued From page 8 U.S. FOIA (b)(6) on 10/4/24 at 12:00 PM. She stated the NJ Exec Order 26.4b1 should have been triggered in the Admission MDS. 2. The surveyor observed Resident #77 on NJ Exec Order 26.4b1 The resident had a NJ Exec O NJ Exec Order 26.4b1 on the over bed table. A review of the electronic medical record revealed a NJ Exec Order 26.4 physician's order for a NJ Exec Order 26.4b1 roll with a U.S. FOIA (b)(6) (an NJ Exec Order 26.4b1 The NJ Ex Order 26 Annual MDS assessment, Section NJ Exec Special Treatments, Procedure, and Programs failed to address the daily placement of a NJ Exec Order 26.4b . The surveyor interviewed the U.S. FOIA (b)(6) on 10/04/24 at 12:00 PM. She stated the splint should have been identified in Section NJ Exe 3. Resident #129 was admitted to the facility with an NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) as noted by the nurse in the NJ Exec Order 2 electronic Admission Summary Note. The NJ Ex Order 26 Admission MDS assessment Section NJ failed to identify that the resident used an NJ Exec Order 26.4b1 . The surveyor interviewed the U.S. FOIA (b)(6) on 10/4/24 at 12:00 PM. She stated the NJ Exec Order 26.4 should have been coded in the Admission MDS. The facility policy titled Certifying Accuracy of the	F 641	For month three a random weekly audit will be performed by the MDS Coordinator or designee to ensure accuracy in coding. Audit results will be reviewed by the Quality Assurance Committee. Completion Date: December 10, 2024	

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F 641	Continued From page 9	F 641		

Resident Assessment, revised 12/2009, contained the following Policy Statement: "All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment."

4. On 10/1/24 at 11:45 AM, during the initial tour, Resident #25 was not in their room. A staff member identified Resident #25 in the dayroom asleep, NJ Ex Order 26.4(b)(1) the surveyor's voice, seated on a NJ Exec Order 26.4b1 [redacted] with NJ Exec Order 26.4b1 [redacted]

The surveyor reviewed the medical record for Resident #25

According to the electronic Medical Record, Resident #25 had diagnoses which included, but were not limited to, NJ Exec Order 26.4b1 [redacted]

Review of the quarterly Minimum Data Set, an assessment tool dated U.S. FOIA (b)(6) reflected a Brief Interview for Mental Status (BIMS) score of NJ Exec Ord [redacted], which indicated a NJ Exec Order 26.4b1 [redacted]. Further review of the qMDS revealed Resident #25 had an NJ Exec Order 26.4b1 [redacted] that was not present upon admission.

Review of the Admission MDS dated NJ Exec Order 26.4b [redacted] under section NJ Exec Order 26.4b1 revealed the resident had NJ Exec Order 26.4b1 that was present

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F 641	Continued From page 10 upon admission. Review of the NJ Exec Order 26.4b1 Note dated NJ Exec Order 26.4b reflected Resident #25 had an NJ Exec Order 26.4b1 . On 10/4/24 at 12:37 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated she signed the submissions for the MDS and that the signature was an attestation that she had checked all the areas for accuracy to the best of her knowledge. At that time, the surveyor and the U.S. FOIA (b) (6) reviewed Resident #25's medical record. The U.S. FOIA (b) (6) confirmed that the MDS submitted was inaccurate and that the accuracy of the MDS was important because the assessment can affect the care given to the resident. On 10/4/24 at 1:26 PM, during a meeting with the survey team, the U.S. FOIA (b)(6) the surveyor discussed the concern regarding the inaccuracy of the MDS for Resident #25. On 10/7/24 at 10:44 AM, during a meeting with the survey team, the U.S. FOIA (b)(6) , stated the MDS coding should be accurate. A review of the facility provided policy, Certifying Accuracy of the Resident Assessment, dated /revised on 1/5/24 included: All personnel who complete any portion of the MDS assessment, tracking form or correction request form must sign a hard copy of such assessment certifying the accuracy of that portion of that assessment.	F 641		

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F 641	Continued From page 11 NJAC 8:39-11.2(e)1	F 641		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility's documentation, it was determined that the facility failed to ensure a.) the Professional Standards of Practice to assess a resident's [NJ Ex Ord] at least each shift for significant changes in levels of [NJ Exec Order 26.4b1], b.) a physician order for administration with parameters was followed (Resident #131) and c.) a [U.S. FOIA (b)(6)] was administered when documented as administered (Resident #367). The deficient practice was identified for one (1) of one (1), Resident #14, reviewed for [NJ Exec O] t, one (1) of (4) four residents administered by one (1) of four (4) nurses observed during the medication administration, and for one (1) of (5) medication carts observed during the medication storage and labeling inspection. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and	F 658	F# 658 Meet Professional Standards REVISED 1.Corrective actions accomplished for those residents found to have been affected by the deficient practice. Upon notification of the deficient practices : 1:1 education provided to the nurses by the Director of Nursing In-service nurses immediately on Narcotic administration, taking Parameters as ordered prior to drug administration and Pain assessment on all residents for Pain evaluation and monitoring every shift. A PAIN ASSESSMENT WAS IMMEDIATELY PERFORMED ON THE RESIDENTS AFFECTED WITH NO NEGATIVE FINDINGS 2. Three residents were affected by the deficient practice; all residents have the potential to be affected by the deficient practice. The facility policy titled "Medication Pass Policy" was reviewed and no revision were required.	12/10/24

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	315042	A. BUILDING _____ B. WING _____	C 10/10/2024

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
F 658	Continued From page 12 treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." The evidence was as follows: 1.) On 10/01/24 at 11:20 AM, the surveyor observed Resident#14 lying in bed, alert, awake and oriented able to make needs known. The resident did not appear to be in NJ Exec Order 26.4b1 The resident complained of NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 On 10/03/24 at 10:00 AM, the surveyor reviewed the following records: Review of Admission Records revealed the following Diagnosis which include but not limited to NJ Exec Order 26.4b1 Review of Quarterly Pain Interview Assessment record dated NJ Exec Order 26.4b1 revealed NJ Exec Order 26.4b1 . A review of U.S. FOIA (b)(6) Summary revealed that there were only NJ Exec Order 26.4b1 done on the following month of NJ Exec Order 26.4b1 month of NJ Exec Order 26.4b1, and month of NJ Exec Order 26.4b1 Review of Care plan for U.S. FOIA (b)(6), initiated on NJ Exec Order 26.4b1 and revised on NJ Exec Order 26.4b1, revealed	F 658	3. The following measures were put into place to ensure that the deficient practice will not recur: A "parameter review" audit has been created for residents with parameters to ensure blood pressure monitoring has been done prior to administering blood pressure medications An immediate audit on all residents in the facility by the DON on Pain Management which Includes pain assessment and administration of Narcotics and Parameters. The DNS/designee will provide Inservice to the licensed nursing staff regarding first taking the B/P prior to administering medications per physician orders, monitoring pain of all residents and administering and documenting narcotics per facility policy. This Inservice will also be provided to the licensed nursing staff during the new hire facility orientation and will be provided to all agency staff hire packet. 4. The facility will monitor its corrective actions to ensure the deficient practice are being corrected and will not recur by: The DON or Designee will perform audits on Pain Management, Narcotic Administration and Following Parameter orders weekly X 4 weeks, then monthly X 3 months, then Quarterly X 3 quarters to ensure residents are assessed and medicated for pain as needed and parameters are follows as ordered. The DON or designee will report all audits and findings in the Quarterly QAPI Committee Meeting.	

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F 658	Continued From page 13 that Resident # 14 had NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 . Review of Medication Order for Resident # 14 revealed the following NJ Exec Order 26.4b1 which included but was not limited to NJ Exec Order 26.4b1) give NJ NJ Exec Order 26.4b1 every NJ E hours as needed for NJ Exec Order NJ Exec Order 26.4b1 give NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b . NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 , give NJ Exec Order 26. . NJ Exec Order 26.4b1 , give for NJ Exec Order 26.4b On 10/02/24 at 10:30 AM, the surveyor interviewed the U.S. FOIA (b)(6)) working full time in the facility about NJ Exec Order 26.4b1 for Resident #14. She described the Resident # 14 is on NJ Exec Order 26.4b due to NJ Exec Order 26.4b1 . She further explained that the floor nurses were the ones doing NJ Exec O and were responsible for monitoring the effectiveness of the NJ Exec Order 26.4b1 . When the surveyor requested documentation related to NJ Ex Order the U.S. FOIA (b)(6) showed the surveyor a list of NJ Ex Ord levels which were not consistent and did not show U.S. FOIA (b)(6) done every shift. On 10/7/24 at 11:05 AM, the surveyor discussed the concern with the U.S. FOIA (b)(6)),	F 658	5. Completion Date: 12/10/2024	

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who acknowledged that the NJ Exec Order 26.4b1 were not done every shift.

The surveyor reviewed the Pain Assessment and Management Protocol policy, revised on 6/24/2024, which revealed "to assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain."

2.) On 10/3/24 at 8:23 AM, the surveyor observed the U.S. FOIA (b)(6) prepare medications for Resident #131 that included a physician order for NJ Exec Order 26.4b1 Hold for NJ Ex Order 26.4(b)(1)) U.S. FOIA (b)(6) .

On 10/3/24 at 8:36 AM, the surveyor observed the U.S. FOIA (b)(6) and the U.S. FO use an alcohol-based hand rub (ABHR), then put on their personal protective equipment prior to entering the resident's room. The U.S. FO informed, the surveyor that they will adjust the resident to a seated position prior to the administration of the medications. The surveyor observed the U.S. FO enter the resident's room with the resident's medication in a medication cup. The resident was adjusted to a seated position, the U.S. FO was about to administer the medications, and the surveyor requested to speak with the U.S. FO outside the room.

At 8:37 AM, during an interview with the surveyor, the U.S. FO stated she took Resident #131's NJ Exec Orde reading at 8:00 AM and confirmed she did not take the NJ Ex Orde prior to entering the resident's room for medication administration. At that time, the U.S. FOIA stated that the parameters

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should have been taken immediately prior to the medication administration of the U.S. FOIA (b)(6) [redacted]

3.) On 10/4/24 at 11:04 AM, the surveyor and U.S. FO #2 began the NJ Exec Order 26.4b medication inspection, which was stored in a mounted, double locked portion of the medication cart (NJ Exec Order 26.4b1) located in [redacted]. RN #2 stated her cart was called NJ Ex split.

At that time, in the presence of RN #2, the surveyor observed Resident #367's bingo card (blister packet which contains the medication) with a pharmacy label for NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) [redacted]). The bingo card contained two (2) tablets.

At that time, in the presence of RN#2 the surveyor compared the bingo cared against Resident #367's NJ Ex Order 26.4(b)(1) [redacted] (NJ Ex Order 26.4(b)(1) [redacted]) for U.S. FOIA (b)(6) The NJ Ex Order 26.4 log reflected a documented quantity of one (1).

At that time, during an interview with the surveyor, RN #2 stated that she did not administer the medication but had signed the NJ Ex Order 26.4(b [redacted] The surveyor and the U.S. FO reviewed Resident #367's electronic Medication Administration Record (eMAR) which revealed the U.S. FOI's initials attesting the resident had consumed the medication.

On 10/4/24 at 11:15 AM, the surveyor and the U.S. FO entered Resident #367's room. The resident

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informed, the surveyor that she had [NJ Ex Ord] every day and stated that she took her [NJ Exec Order 26.4b1] that morning and was feeling a little better. The [U.S. FO] informed the resident that she made an error and had not administered the [NJ Exec Order 26.4b1] and informed the resident that she would be administering it at that time. The surveyor and the [U.S. FO] exited the resident's room.

On 10/4/24 at 11:20 AM, during a follow-up interview with the surveyor the [U.S. FO] stated that she would call the physician and inform her supervisor.

The surveyor reviewed the medical record for Resident #367.
According to the Admission Record, Resident #367 was admitted to the facility with diagnosis that included but was not limited to [NJ Exec Order 26.4b1] [redacted]

Review of the incomplete Admission Minimum Data Set (MDS), an assessment tool with an Assessment Record Date of [NJ Exec Order 26], reflected a Brief Interview for Mental Status (BIMS) score of [NJ Exec Order 26.4b1] which indicated that the resident was NJ Exec Order 26.4b1. The [NJ Ex Ord] asssessment section of the MDS was incomplete.

Review of the eMAR for Resident #367 included a physician order for NJ Exec Order 26.4b1 [redacted]. The administration was scheduled at 9:00 AM and 21:00 [9:00 PM].

On 10/8/24 at 1:45 PM, during an interview with the surveyor, the U.S. FOIA (b) (6) stated that the

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MDS for Resident #367 was incomplete, the section for [U.S. FOIA (b)] assessment was incomplete and the comprehensive person-centered care plan for [NJ Ex Ord] was also incomplete.

On 10/4/24 at 1:26 PM, in the presence of the survey team, the U.S. FOIA (b)(6) the [U.S. FOIA (b)] and the U.S. FOIA (b)(6), the surveyor discussed the concern regarding RN #1 who failed to obtain a parameter for Resident #131 prior to administration of the NJ Exec Order 26.4b1 in accordance with the physician's order and professional standards of practice. At that time, the surveyor also discussed the concern regarding Resident #367's routine [NJ Exec Order 26.4b1] physician's order that was documented as administered, but was not and was documented removed from the [NJ Ex Order 26.4(b)] but was not.

On 10/7/24 at 10:44 AM, during a meeting with the survey team, the U.S. FOIA (b)(6), and the U.S. FOIA (b)(6), the [U.S. FOIA (b)] stated that education was given to the nurses for medication administration, parameters, and an investigation was conducted for the missed administration of the [NJ Exec Order 26.4b1]. The resident was assessed, and the physician was notified.

A review of the provided facility policy, Medication Pass dated/revised 6/24/24, included the following:

-Medication Preparation; Hold parameters: Check blood pressure and/or pulse rate immediately prior to pouring.

-Signing for Medications; Sign the MAR/eMAR

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F 658	Continued From page 18 immediately after the administration of the medication to each resident.	F 658		
F 677 SS=D	NJAC 8:39-27.1(a), 29.2(d) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that NJ Exec Order 26.4b1 was provided to dependent residents in a timely manner for 3 of 10 residents (Resident #59, #82 and #29), observed for NJ Exec Order 26.4b1 on 1 of 2 units (B1 Unit). This deficient practice was evidenced by the following: On 10/1/24 at 11:34 AM, the surveyor observed Resident #59 in bed on a NJ Exec Order 26.4b1, with his/her eyes open. Resident #59 did not respond to the surveyor's greeting. The surveyor observed a NJ Exec Order 26.4b1 in the resident's room. On 10/1/24 at 11:40 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who had been assigned to Resident #59's care for the 7AM-3:00 PM shift. During the interview, the U.S. FOIA (b) stated that she had 10 residents on her assignment and that this was the first opportunity	F 677	F# 677 Incontinent Care REVISED #2 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice the three residents that were identified as being affected by the deficient practice were immediately washed, cleansed and dried. 1:1 education was given immediately to the U.S. FOIA (b) by the DON on how to care and handle the assigned residents by upon receiving assignment at the start of the shift, checked residents for safety and for incontinence then provide care to those that need it first and other toileting. 2. Three residents were affected by the deficient practice; all residents have the potential to be affected by the deficient practice. The facility policy titled “Urinary and Fecal Incontinence Care Policy” was reviewed and no revisions were required.	12/10/24

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F 677	Continued From page 19 she had to provide care to Resident #59. The surveyor asked the [redacted] how often she provided NJ Exec Order 26.4b1 to the residents on her assignment. The [redacted] replied she would usually provide NJ Exec Order 26.4b1 3 x daily, but today it would be only twice since it was already so late. On 10/1/24 at 11:45 AM, the [redacted] exposed Resident #59's NJ Exec Order 26.4b1 The surveyor and [redacted] observed that the Resident's NJ Exec Order 26.4b1 [redacted] The adult [redacted] under the resident were all [redacted] A review of Resident #59's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident #59's Annual Minimum Data Set (MDS) an assessment tool dated [redacted] revealed Resident #59 had a NJ Exec Order 26.4b1 [redacted] The MDS further revealed that the resident was dependent on staff for [redacted], and he/she was always [redacted]. A review of Resident 59's Individualized Care Plan (ICP) initiated on [redacted], with a revision date of [redacted] included the resident was totally dependent on staff with NJ Ex Order 26.4(b)(1)	F 677	An immediate audit on all residents in the facility was completed by the DON to ensure that all residents must be cleaned after each episode of incontinence. 3. The following measures were put into place to ensure that the deficient practice will not recur: In-service on Incontinent Care was provided to all nursing staff and agency nursing staff to ensure that residents are provided with incontinent care after each episode of incontinence by checking residents at a minimum of every two hours. Incontinent care policy was forwarded to all active agencies to add to our policy package for all nursing staff to review the expectations of our policy. Incontinent care policy has been included in the orientation package for all new nursing staff new hires to review the expectations of our policy. Audits on Incontinent Care throughout the building by the DON or Designee to ensure residents are kept clean and dry. 4. The facility will monitor its corrective actions to ensure the deficient practice has been corrected and will not recur by:The DON or Designee will perform audits on Incontinent Care weekly X 4 weeks, then monthly X 3 months, then quarterly X 3 quarters to ensure that incontinent care is provided after each episode of incontinence. The DON or Designee will report all audits and findings in the quarterly QAPI Committee meeting . 5. Completion date :12/10/2024	

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F 677	Continued From page 20 NJ Ex Order 26.4 with Interventions which included but were not limited to: providing NJ Exec Order 26.4b1 every NJ and as needed. On 10/4/24 at 7:20 AM, the surveyor completed an NJ Exec Order 26.4b1 tour on the B1 Unit and observed the following: On 10/4/24 at 7:26 AM, the surveyor accompanied by the U.S. FOIA P observed Resident #82 in bed. The surveyor and U.S. FOIA P noted a strong NJ Exec Order 26.4b1 in the resident's room. The surveyor observed that Resident #82's NJ Exec Order 26.4b1 The pad under the resident was also NJ Exec Order 26.4b1 The U.S. FOIA (b acknowledged the NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 and stated that the resident could not have received NJ Exec Order 26.4b1 recently due to the extent of the NJ Exec Order 26.4b1 A review of Resident #82's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited NJ Exec Order 26.4b1 A review of Resident #82's Quarterly MDS dated NJ Ex Order 26 revealed Resident #82 had a had a long and NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 . The MDS further revealed that the resident required staff assistance NJ Ex Order 26.4(b)(1), and he/she was always NJ Exec Order 26.4b1 . A review of Resident 82's ICP initiated on NJ Ex Order 26.4(, with a revision date of NJ Ex Order 26.4(, revealed the resident had an NJ Ex Order 26.4(b)(1) with interventions which included but were not	F 677		

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F 677	Continued From page 21 limited to the resident required extensive assistance of [redacted] for NJ Ex Order 26.4(b)(1); and to NJ Ex Order 26.4(b)(1). On 10/4/24 at 7:38 AM, the surveyor accompanied by the [redacted] observed Resident #29 in bed with a NJ Exec Order 26.4b1 in the resident's room. The [redacted] exposed Resident #29's NJ Exec Order 26.4b1 [redacted]. At that time when the [redacted] NJ Exec Order 26.4b1 [redacted] the surveyor observed that the Resident's NJ Exec Order 26.4b1 [redacted]. The [redacted] stated that the resident could not have received NJ Exec Order 26.4b1 care at 5:00 AM, due to the NJ Exec Order 26.4b1 [redacted]. On 10/4/24 at 7:40 AM, the U.S. FOIA (b)(6) accompanied the surveyor to Resident #29's room. The U.S. FOIA (b) (6) acknowledged that the resident was NJ Exec Order 26.4b1 [redacted] and stated that it was unacceptable. A review of Resident #29's Admission Record revealed Resident #29 was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]. A review of Resident #29's Annual MDS dated [redacted] revealed Resident #29 had a Brief Interview for Mental Status (BIMS) of [redacted] indicating a NJ Exec Order 26.4b1 [redacted]. MDS further assessed Resident #29 was dependent on staff for personal hygiene and was always NJ Exec Order 26.4b1 [redacted]. A review of Resident #29's ICP initiated on [redacted] with a revision date of [redacted] revealed	F 677		

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that the resident had an NJ Ex Order 26.4(b)(1) and required extensive assistance of staff for NJ Ex Order 26.4(b)(1).

On 10/4/24 at 12:35 PM, the survey team met with the administration to discuss the above observations and concerns.

On 10/7/24 at 6:50 AM, the surveyor attempted an interview with the assigned 11 PM-7 AM U.S. FOIA (b) for Resident's #82 and #29. The U.S. FOIA (b)(6) stated that the 11-7 U.S. FOIA (b) had called out. The surveyor attempted a phone interview and left a message, with no return call. The surveyor asked the U.S. FOIA (b)(6)) to contact the U.S. FOIA (b)

On 10/7/24 at 7:00 AM, the surveyor interviewed the U.S. FO who stated that the U.S. FOIA (b)(6) should perform NJ Exec Order 26.4b1 and provide NJ Exec Order 26.4b1 care 3 times per shift at 11:30 PM, 2:30 AM and again between 4:30-5:00 AM. The U.S. FOIA (b)(6) stated that on 10/4/24 one of the U.S. FOIA (b)(6) left their shift early around 6:00 AM and there was only 1 U.S. FOIA (b) on the floor from 6:00 AM-7:00 AM.

On 10/7/24 at 10:35 AM, in the presence of the survey team, the U.S. FOIA (b) stated that despite the number of residents the U.S. FOIA (b)(6) have on their assignments, NJ Exec Order 26.4b1 should be provided to the residents 3 times on the night shift and every 2 hours on the day shift.

On 10/7/24 at 11:30 AM, the U.S. FOIA (b) stated that the 11-7 U.S. FOIA (b) did not return her call and therefore was not available for an interview.

A review of the facility's " Urinary and Fecal Incontinence Care" policy dated as revised

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	315042	A. BUILDING _____ B. WING _____	C 10/10/2024

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
F 677	Continued From page 23 6/24/24 reflected...residents must be cleaned after each episode of incontinence.	F 677		
F 684 SS=D	NJAC 8:39-27.1 (a), 27.2 (h) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint NJ 177694, NJ 176286 Based on interviews and record review and review of pertinent facility documentation, the facility failed to ensure an NJ Ex Order 26.4(b)(1) lab result was communicated to the physician, received treatment and care, in a timely manner, and in accordance with professional standards of practice that meet the resident's physical, mental and psychosocial needs. This deficient practice was identified for one (1) of two (2) residents reviewed for NJ Ex Order 26 and NJ Ex Order 26.4(b) (Resident #319) and was evidenced by the following: The surveyor reviewed the closed record for Resident #319. According to the Admission Record, Resident	F 684	684 -Quality of Care 1. Corrective action accomplished for the resident found to have been affected by the deficient practice: Upon notification of the deficient practice, one resident NJ Ex Order 26.4(b)(1) by the deficient practice. The resident NJ Ex Order 26.4(b)(1) in the facility. All residents have the potential to be affected by the deficient practice. The NP was given 1:1 education to follow up his lab results and referral for recommendations and treatment. Education was immediately initiated for all nurses by the DON and the nurse supervisor on notifying MD/NP regarding lab results and document. 2. An immediate audit was completed on	12/10/24

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F 684	Continued From page 24 #319 was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]). Review of the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26 [redacted], reflected the resident's Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's cognition was NJ Exec Order 26.4b1. Further review of the MDS revealed the resident did not exhibit behaviors associated with NJ Exec Order 26.4b [redacted] Resident #319 had NJ Exec Order 26.4b1 [redacted] Review of Resident #319's person-centered care plan (CP) included a focus that the resident had a potential for NJ Exec Order 26.4b1 related to impaired NJ Exec Order 26.4b1 [redacted] awareness. The interventions included to provide NJ Ex Order 26.4(b)(1) needs for NJ Exec Order 26.4b1, that was initiated on NJ Exec Order 26.4b [redacted] Further review of the CP for activities of daily living reflected the resident required a NJ Exec Order 26.4b1 [redacted]) with two (2) to three (3) staff member assistance. The CP did not reflect an intervention to monitor for signs and symptoms of NJ Exec Order 26.4b1 [redacted] Review of the facility provided, NJ Exec Order 26.4b1 Order Listing Report for NJ Exec Order 26.4b1, reflected Resident #319 had a physician order on NJ Exec Order 26.4b1 for a facility acquired NJ Exec Order 26.4b1 [redacted]	F 684	all residents with abnormal lab results by the DON to ensure that recommendations and treatments are done. The facility policy on "Test Results" was reviewed and no revisions were required. 3. The following measures were put into place to ensure that the deficient practice will not recur: All nurses were in-serviced on reporting abnormal lab results to MD/NP and documenting notification in the electronic medical record. 4. The facility will monitor its corrective actions to ensure that the deficient practice has been corrected and will not recur by: The DON or designee will perform audits on abnormal labs results reporting weekly X 4 weeks, then monthly X 3 months, then quarterly X 3 quarters so that all abnormal lab results are referred to the MD/NP for recommendations and treatments. The DON or designee will report all audits and findings in the quarterly QAPI committee meeting.	

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F 684	Continued From page 25 Review of the Nurse's progress notes (NPN), dated [redacted] at 12:22 PM, included that a [redacted] from Resident #319. Review of the NPN, dated [redacted] at 1:03 AM, reflected Resident #319 received [redacted] and that the [redacted] was pending. Review of the NPN note dated [redacted] at 2:36 PM included that the [redacted] was still pending. Review of the [redacted] lab report, with a reported date of [redacted] included a preliminary report of [redacted], and [redacted]. Review of the final [redacted] for [redacted] with a final report date on [redacted] included the following: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted] identification: [redacted] Review of the Infectious Disease Note, dated [redacted] at 4:22 PM, included that the resident was seen for [redacted] evaluation of reported [redacted] The assessment plan included an order for [redacted] On 10/8/24 at 8:45 AM, during an interview with the surveyor, the [redacted]) stated that	F 684		

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F 684		F 684		

Continued From page 26

if a resident had NJ Ex Order 26.4(b)(1), with or without [redacted], and an NJ Ex Order 26.4(b)(1), a [redacted] was ordered by the physician. When the [redacted] result showed NJ Ex Order 26.4(b)(1) [redacted] and either NJ Ex Order 26.4(b)(1) [redacted]. The physician usually orders an [redacted] when the NJ Ex Order 26.4(b)(1) report is available.

At that time, the [redacted] also stated that any abnormal labs were reported to the physician, by any of the nurses or the supervisors. The standard of practice was to document the communication into the electronic medical record (eMR).

On 10/8/24 at 9:24 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) [redacted] could not provide evidence that the physicians were made aware of the final NJ Ex Order 26.4(b)(1) lab report for [redacted] result that returned on [redacted] The communication was not documented in the eMR. The [redacted] stated she would look into the matter further, discuss with the supervisors and care team regarding the surveyor's concern.

On 10/8/24 at 11:49 PM, during an interview with the surveyor, the [redacted] stated that he did not treat [redacted] until the NJ Exec Order 26.4b1 came back. In the case of Resident #319, who had [redacted], the [redacted] stated he had to involve the U.S. FOIA (b)(6) [redacted] or the [redacted] to renally dose the resident.

At that time, the [redacted] stated that the expectation was the [redacted] prescriber would see the resident within 2 to 3 days of the requested consult. The [redacted] was asked if it was an acceptable standard of

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F 684	Continued From page 27 practice for Resident #319 NJ Exec Order 26.4b1 [redacted] The U.S. FOIA stated that it was not an acceptable standard of practice however he had no control of when the ID prescriber saw the resident. On 10/8/24 at 12:52 PM, during a follow-up interview with the surveyor, the U.S. FOIA (b)(6) stated that she was on vacation prior to U.S. FOIA (b)(6) and was the one who called the U.S. FOIA (b)(6) to see Resident #319 that day. At that time, the U.S. FOIA (b)(6) stated that the nurses or the supervisors should have followed-up preliminary result and communicated with the U.S. FO when the finalized NJ Exec Order 26.4b1 [redacted] results was available and documented into the eMR. Review of the provided policy, Facility Assessment dated 8/1/24, reflected: It is the policy of [name redacted] to conduct, document and annually review a facility-wide assessment, which included both resident population and the resources the facility needs to care for the residents. Review of the provided policy, Test Results dated 2/5/24, included that Attending physicians will be notified promptly of the the test results provided to the facility.	F 684		
F 688 SS=D	NJAC 8:39-27.1 (a) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		12/10/24

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F 688	Continued From page 28 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to consistently follow a physician's order for placement of an NJ Exec Order 26.4b1 for 1 of 3 residents reviewed for NJ Ex Order 26.4(b)(1), Resident #77. The deficient practice is evidenced by the following. The surveyor observed the door to Resident #77's room was closed on 10/1/24 at 11:19 AM. The surveyor knocked and entered the room to see the resident had completed receiving morning care from the NJ Exec Order 26.4b1 [redacted] The NJ Exec Orde stated she was done with care and left the room. The surveyor observed a NJ Ex Order [redacted] placed on the over bed table. The surveyor returned to the resident's room later the same day at 1:03 PM. The U.S. FOIA (b) was	F 688	F 688 Splint Use 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice, the one resident that was identified as being affected by the deficient practice was immediately attended and NJ Ex Order was applied. 1: 1 education was immediately given by the Director of Nursing to the U.S. FOIA (b) (and U.S. FOIA (on application of the splint after AM care and nurse to sign the E-TAR after checking the splint application. Education was initiated for all nursing staff regarding application of splint/orthotic device, checking placement and skin impairment. 2. One resident was affected by the	

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F 688	Continued From page 29 observed on the over bed table. The resident was seated in a [NJ Exec Order 26.4b1] at the bedside. A review of the electronic medical record revealed the following information. An Admission Record noting the resident was admitted with a diagnosis of a [NJ Exec Order 26.4b1] A [NJ Ex Order 26.4( ] Physician's Order for the application of a [NJ Exec Order 26.4b1] to be placed on the resident during AM care and removed during PM care daily. A [NJ Ex Order 26.4( ] Treatment Administration Record (TAR) contained a nurse signature indicating the [NJ Exec Orde] was placed at AM care and removed at PM care on [NJ Ex Order 26.4(b)]. The surveyor interviewed the nursing [U.S. FOIA] on [NJ Ex Order 26.4( ] at 8:36 AM. She stated if the [NJ Exec Orde] was not put on the resident during AM care, the nurse should not have documented that it was in place. The [U.S. FOIA (b)(6)] stated on [NJ Ex Order 26.4( ] at 11:04 that if the nurse documented the placement of the [NJ Exec Orde], it should have been [NJ Ex O] The facility policy titled Orthotic Devices, revised 4/2007, included the Standard as follows: "Residents receive appropriate services and interventions in response to physical and functional needs."	F 688	deficient practice; all residents have the potential to be affected by the deficient practice. The facility policy titled " Orthotic Device" was reviewed and no updates were required. An immediate audit was completed on all residents by the DON to ensure that Orthotic Device is applied as scheduled. 3. The following measures were put into place to ensure that the deficient practice will not recur: 4. Audits in Splint/Orthotic Device by the DON or Designee to ensure that splint/orthotic device is applied. 5. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The DON or Designee will perform audits on Splint Use weekly X4 weeks, then monthly X3 months, then Quarterly X3 quarters to ensure splints are applied. The DON or designee will perform audits on splint use weekly x 4weeks, then monthly x 3 months, then quarterly x 3 quarters to ensure splints are applied as ordered .	

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F 688	Continued From page 30 NJAC 8:39-27.1(a)	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer NJ Exec Order 26.4b1 according to the physician's order for 2 of 4 residents, (Resident #29 and #136). This deficient practice was evidenced by the following: 1. On 10/1/24 at 12:46 PM, the surveyor observed Resident #29 in bed. The resident did not respond to the surveyor. The surveyor observed Resident #29 wearing a [redacted] on and the NJ Ex Order 26 was set at NJ Exec Order 26.4b1). On 10/4/24 at 7:38 AM, the surveyor observed Resident #29 in bed with the head of the bed positioned at approximately NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 running via a machine at NJ Exec Order 26.4b1 [redacted]. The resident did not respond to the surveyor. The surveyor observed Resident #29 was wearing a NJ Exec Order 26.4b1	F 695	F#695 -Oxygen Therapy 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice, those 2 residents that were identified as being affected by the deficient practice were immediately attended to and their oxygen flow rate were corrected as ordered by the Physician. The nursing staff taking care of those residents were immediately educated by the DON on the proper administration of Oxygen Therapy with the prescribed flow rate. 2. Two Residents were affected by the deficient practice; all residents have the potential to be affected by the deficient practice. An immediate audit was conducted on all residents by the DON or designee to ensure correct administration of oxygen The facility policy on "Oxygen	12/10/24

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F 695	Continued From page 31 tank on and the gauge was set at [redacted]. A review of Resident #29's Admission Record revealed Resident #29 was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of Resident #29's Annual Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed Resident #29 had a Brief Interview for Mental Status (BIMS) of [redacted]" indicating a [redacted]. A review of the resident's comprehensive person-centered care plan initiated on [redacted] reflected that Resident #29 had altered [redacted]) The interventions included [redacted]. A review of the September 2024 Order Summary Report (OSR) revealed an active physician order (PO) with an order date of [redacted] On 10/4/24 7:40 AM, the surveyor asked the [redacted] to accompany her to Resident #29's room. The surveyor and the [redacted] entered Resident #29's room, and both observed the resident in the bed at approximately [redacted] running via a machine. The resident was wearing a [redacted] and the [redacted] was on with the [redacted]. The [redacted] confirmed the [redacted] was on and the [redacted]. On that same day at the same time, the surveyor	F 695	Administration" was reviewed and no updates were required. 3. The following measures were put into place to ensure that the deficient practice will not recur: Education of the nurses on Proper Administration of Oxygen Therapy. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The DON or designee will perform audits on residents in the facility for Oxygen Therapy weekly X 4 weeks then monthly X 3 months, then quarterly X 3 quarters to ensure that oxygen is administered with the correct rate of flow as ordered at all times. The DON or designee will report all audits and findings during the Quarterly QAPI committee meeting. COMPLETION DATE 12.10.24	

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F 695	Continued From page 32	F 695		

and the [U.S. FOIA (b)(6)] reviewed the electronic medical record (EMR) for the resident's order for oxygen. The [U.S. FOIA (b)(6)] stated that the resident's PO was for [NJ Ex Order 26.4(b)(1)] and she did not know who changed the [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA (b)(6)] acknowledged the order should have been followed.

On 10/4/24 at 12:35 PM, the survey team met with the administration to discuss the above observations and concerns.

2. On 10/1/24 at 10:53 AM, the surveyor observed Resident #136 in bed asleep, wearing a [NJ Exec Order 26.4b1) set at [NJ Exec Order 26.4b1) and the head of the bed was elevated.

On 10/2/24 at 9:12 AM, the surveyor observed Resident #136 asleep, who did not rouse from the surveyor voice. The resident was wearing a [NJ Exec Ord] was on and set to [NJ Exec Order 26.4b1]

The surveyor reviewed the medical record for Resident #136.

According to the Admission Record, an admission summary, the resident was admitted to the facility with diagnoses that included but was not limited to [NJ Exec Order 26.4b1].

The significant change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4], reflected a Brief Interview for Mental Status (BIMS) score

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F 695	Continued From page 33	F 695		

that was [NJ Exec Order], and that the resident was NJ Exec Order 26.4b1. Further review of the SCMDS reflected the resident required respiratory treatment.

A review of the residents comprehensive person-centered care plan reflected Resident #136 had NJ Exec Order 26.4b1 [redacted]). The interventions included NJ Exec Order 26.4b1 [redacted], initiated on [NJ Exec Order 26.] . The goal reflected that the resident would maintain NJ Ex Order 26.4(b)(1) as evidenced by NJ Ex Order 26.4(b)(1), [NJ Ex Order 26.4(b)(1)] [redacted] and NJ Ex Order 26.4(b)(1) [redacted] through the review date.

A review of the Treatment Administration Record (TAR) reflected an order for [NJ Exec Order 26.4b1] included a physician's order for NJ Exec Order 26.4b1 [redacted] every shift. The [NJ Exec O] order start date was on [NJ Ex Order 26.4(] . Further review of the TAR revealed the administration of [NJ Exec Order 26.4] was signed on all three shifts on [NJ Ex Order 26.4(b)] and on the day shift of [NJ Ex Order 26.4(b)(1)]

On 10/2/24 at 12:40 PM, during an interview with two surveyors, the U.S. FOIA (b)(6) [redacted] informed the surveyors that he was assigned to Resident #136. The [U.S. FOIA] stated that Resident #136 was on [NJ Exec Order 26.4b] and had a [U.S. FOIA (b)(6)] [redacted], but the aid did not provide care involving the resident's [NJ Exec Order 26.4b]. The [redacted] also stated that he checked the resident's [NJ Exec Order 26.] that morning and ensured the head of the bed was elevated.

On 10/2/24 at 12:42 PM, the surveyor and the [U.S. FOIA] entered the Resident #136's room who was asleep and observed the NJ Exec Order 26.4b1 was on

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	315042	A. BUILDING _____ B. WING _____	C 10/10/2024

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and set at [redacted]. The [redacted] observing the [redacted] was set at [redacted], the surveyors and the [redacted] exited the resident's room.

On 10/2/24 at 12:44 PM, the surveyor and the LPN reviewed the electronic medical record for Resident #136 which reflected the physician's order for [redacted]. At that time, the [redacted] acknowledged the order should have been followed.

On 10/2/24 at 12:47 PM, the surveyor and the [redacted]) entered Resident #136's room. Resident #136 was [redacted] conversant and [redacted]. The [redacted] adjusted the setting on the [redacted] while speaking with the resident. The [redacted] explained to the resident that she needed to use a [redacted] to measure the amount of [redacted] in their blood. The resident was agreeable, and [redacted] reading was [redacted], which indicated the [redacted] was normal.

On 10/2/24 at 12:55 PM, the [redacted] stated the physician's order should have been followed. The [redacted] informed the surveyor that she would check the functionality of the machine and provide education to the nurses. All nurses on all shifts were responsible to ensure the [redacted] for Resident #136 was correct.

A review of the facility provided policy for Oxygen Administration, dated/revised on 5/13/24, included the following: The purpose of this procedure is to provide guidelines for safe oxygen administration.

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F 695	Continued From page 35 NJAC 8:39-27.1(a)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to assess residents' vital signs and dialysis [NJ Ex Order 26.4] for complications upon return from the [U.S. FOIA (b)]) center for 2 of 2 residents reviewed for dialysis care, Resident #90 and 134. Evidence of the deficient practice is as follows. 1. The surveyor interviewed Resident #90 on 10/1/24 at 1:09 PM. The resident stated they had [U.S. FO] appointments on Monday, Wednesday, and Friday at 5:30 AM. The resident stated they are not assessed promptly when returning from [U.S. FOIA] A review of the electronic medical record revealed the following information. The [NJ Ex Order 26.4(b)] quarterly Minimum Data Set (MDS) assessment tool, Section NJ Exec Order 26.4b1, indicated the resident was NJ Exec Order 26.4b1 (Brief Interview for Mental Status score [NJ Exec Order 26.4]). Section I - Active Diagnoses triggered for [NJ Exec Orde] Section NJ Exec Order 26.4b1, Procedures, and Programs indicated the resident received [U.S. FO].	F 698	698 Dialysis 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Upon notification of the deficient practice, those two residents that were identified as being affected by the deficient practice were immediately attended by assessing the residents and recording vital signs post dialysis. Dialysis communication log was reviewed and updated to reflect vital signs taken post dialysis. Education was immediately initiated by the DON and Nurse Supervisor on Resident Post Dialysis; they must have Vital signs checked and documented in the dialysis communication log. 2. Two residents were affected by the deficient practice; all residents have the potential to be affected by the deficient practice. An immediate audit was done on all residents on Dialysis by the DON to ensure that VS are taken and recorded	12/10/24

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F 698	Continued From page 36 The physician's NJ Ex Order 26.4(b)(1) Order Summary Report included the following NJ Ex O-related orders. NJ Ex O Monday, Wednesday, Friday chair time 5:30 AM. NJ Ex Order 26.4(b)(1) related to the presence of an NJ Exec Order 26.4b1 . Monitor NJ Exec Order 26.4b1 and symptoms of NJ Exec Order 26.4b1 . The surveyor interviewed the U.S. FOIA (b)(6) on 10/04/24 at 8:02 AM. The U.S. FOIA stated the nurses should be documenting promptly in the electronic progress notes vital signs and assessment of the NJ Ex Order 26.4(b)(1) when the resident returns from NJ Ex Or The U.S. FOIA was unable to locate the documentation in the electronic record when asked to do so by the surveyor. The U.S. FOIA (b)(6)) spoke with the surveyor on 10/07/24 at 10:41 AM. The U.S. FOIA (b) stated the NJ Exec Order 26.4b1 assessments were not done consistently on the resident. She stated the vital signs and the NJ Ex Order 26.4(b)(1) monitoring must be done NJ Exec Order 26.4b1 and documented in the progress notes. 2. On 10/2/24 at 9:25 AM, the surveyor observed Resident #134 asleep, covered with a blanket, and did not rouse to the voice of the surveyor. On 10/2/24 at 9:33 AM, the surveyor observed NJ Exec Order 26.4b1 verbally requested permission from Resident #134 to assess their NJ Exec Order 26.4b1). At that time the U.S. FOIA (b)(6) and the surveyor observed	F 698	upon return from the dialysis center. The facility policy on Hemodialysis was reviewed and revised adding checking of the VS and documenting on the Dialysis communication log upon return. 3. The following measures were put into place to ensure the deficient practice will not recur: In-service nurses on Monitoring Residents Post Dialysis. Audits on dialysis by the DON or designee to ensure that residents are checked and monitored post dialysis. 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The DON or designee will perform audits on residents in the facility for Dialysis weekly X 4 weeks then monthly X 3 months, then quarterly X 3 quarters to ensure monitoring residents post dialysis. The DON or designee will report all audits and findings in the Quarterly QAPI committee.	

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the NJ Exec Order 26.4b1

The surveyor reviewed the medical record for Resident #134.

According to the Admission Record, Resident #134 was admitted with diagnoses that included, NJ Exec Order 26.4b1

Review of the Admission Minimum Data Set (MDS), an assessment tool used to manage care dated NJ Exec Order 26, revealed Resident #134 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident was NJ Exec Order 26.4b1 and while a resident received NJ Exec Order 26.4b1

Review of Resident #134's medical record revealed that the resident was scheduled for hemodialysis (HD) on NJ Exec Order 26.4b1

During an interview with the surveyor on 10/2/24 at 9:36 AM, the U.S. FOIA (b)(6) stated that the process for communication with NJ Exec Order 26 was that the nurses would fill out a NJ Exec Order 26.4b1 communication log prior to the HD appointment which would be kept in the NJ Exec Order 26.4 communication book. The log contained information such medications sent with the resident, meals sent, labs drawn, NJ Ex Order 26 and vitals. The HD communication book would go with the resident to the HD center. After NJ Exec Order 26 the HD center would fill out the NJ Exec Order 26.4b1 communication log that contained information such as completion of treatment as ordered, pre NJ Exec Order 26 NJ Ex Order 26. and NJ Exec Order 26.4b1 NJ Ex Order 26.4 treatment complications, when a physician was notified, the

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NJ Ex Order 26.4(b)(1) report and the U.S. FOIA (b)(6) completing the report. The HD communication book traveled back with the resident to the facility.

The U.S. FOIA (b)(6) stated that when the resident returned to the facility, the receiving nurse would assess the resident's NJ Ex Order 26.4(b)(1) ( ) and NJ Exec Order 26.4b1 , obtain vital signs and write the result of the assessment on the bottom of the HD communication log.

A review of the NJ Ex Order 26.4(b)(1) HD communication log reflected the following:

- NJ Ex Order 26.4 the U.S. FOIA (b)(6) communication to be filled out by the HD center was blank, and did not include pre- NJ Ex Order 26. post dialysis NJ Ex Order 26.4 treatment complication. The NJ Exec Order 26.4b1 assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility.
- NJ Ex Order 26.4(b NJ Exec Order 26.4b1 communication to be filled out by the HD center was blank, and did not include pre- NJ Ex Order 26. post dialysis NJ Ex Order 26.4 treatment complication. The U.S. FOIA (b)(6) assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility.
- NJ Ex Order 26.4(b the pre-dialysis communication log did not contain information such medications sent with the resident, meals sent, labs drawn, NJ Ex Order 26. and vitals.

the NJ Exec Order 26.4b1 communication to be filled out by the HD center was blank, and did not include pre- NJ Ex Order 26. post dialysis NJ Ex Order 26.4 treatment complication. The U.S. FOIA (b)(6) assessment completed by the facility staff was documented as

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positive however no vitals were documented after returning to the facility.
- [redacted] The [redacted] assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility.
- [redacted] The [redacted] assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility.

On 10/4/24 at 1:26 PM, in the presence of the survey team, the [redacted], the surveyor discussed the concerns regarding the failure to consistently and completely assess Resident #134's vitals upon return from the HD center as reflected on the HD communication log.

On 10/7/24 at 10:44 AM, in the presence of the survey team, the [redacted] acknowledged that the communication log was not always done and would be addressed,

A review of the facility provided policy End-Stage Renal Disease, Care of a Resident dated/revised 1/28/24 reflected that Agreements between this facility and the contracted ESRD facility included all aspects of how the resident's care will be managed, including how information will be exchanged between the facilities. The general medical nurse should document in the resident's medical record every shift as follows: location of catheter, condition of dressing (interventions if needed), if dialysis was done during shift, any part of report from dialysis nurse post-dialysis being given and observation post dialysis.

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F 725 SS=E	NJAC 8:39 - 27.1 (a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the	F 725	S 560 and F725 Corrective action for affected residents:	11/18/24

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F 725	Continued From page 41 required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties	F 725	Residents were not affected by this deficient practice. Other residents' potential to be affected: All residents have the potential to be affected by this deficient practice. Corrective measures and systemic changes: The administrator provided a review and reeducation to the Staffing Coordinator and Director of Nursing regarding the minimum mandated staffing requirements. The Administrator, Director of Nursing and Staffing Coordinator will meet weekly to review staffing levels as well as open positions and recruitment initiatives. Staffing agencies will be utilized when necessary to fill open slots, as well as offering extra shifts to facility staff. Ongoing aggressive recruitment efforts will include web-based advertising, agency contracting, sign-on and referral bonuses, job fairs, shift differentials, wage analysis and employee morale-boosting. The staffing coordinator will maintain the Excel daily report to track and trend actual numbers of staff working, in relation to the mandated expectations. Monitoring and Quality Assurance: The Staffing coordinator will report weekly to the Administrator and Director of	

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F 725	Continued From page 42 b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the period of 9/15/24 to 9/28/24 (2 weeks prior to the standard survey of 10/10/24) and the period of 5/5/24 to 5/11/24 (the time period covering complaint	F 725	Nursing weekly for 3 months, then monthly for the next 6 months. Findings will be shared at the Quality Assurance Committee meeting. Completion date: 11.18.24	

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investigations) revealed the following:

For the 2 weeks of staffing prior to survey from 09/15/2024 to 09/28/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows:

-09/15/24 had 18 CNAs for 170 residents on the day shift, required at least 21 CNAs.
-09/16/24 had 20 CNAs for 170 residents on the day shift, required at least 21 CNAs.
-09/17/24 had 16 CNAs for 170 residents on the day shift, required at least 21 CNAs.
-09/19/24 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs.
-09/20/24 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-09/21/24 had 18 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-09/22/24 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-09/23/24 had 21 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-09/24/24 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs.
-09/25/24 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs.
-09/26/24 had 20 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-09/27/24 had 21 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-09/28/24 had 19 CNAs for 177 residents on the day shift, required at least 22 CNAs.

For the week of Complaint staffing from 05/05/2024 to 5/11/24, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:

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F 725	Continued From page 44 -05/05/24 had 21 CNAs for 181 residents on the day shift, required at least 23 CNAs. -05/06/24 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs. -05/07/24 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs. -05/08/24 had 20 CNAs for 179 residents on the day shift, required at least 22 CNAs. -05/11/24 had 20 CNAs for 176 residents on the day shift, required at least 22 CNAs. On 10/8/24 at 12:15 p.m., the surveyor informed the U.S. FOIA (b) (6) of the staffing ratio and resident care concerns. On 10/1/24 at 11:34 AM, the surveyor observed Resident #59 in bed on a specialty mattress, with his/her eyes open. Resident #59 did not respond to the surveyor's greeting. The surveyor observed a NJ Exec Order 26.4b1 in the resident's room. On 10/1/24 at 11:40 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who had been assigned to Resident #59's care for the 7AM-3:00 PM shift. During the interview, the U.S. FOIA (b) stated that she had 10 residents on her assignment and that this was the first opportunity she had to provide care to Resident #59. The surveyor asked the U.S. FOIA (b) how often she provided NJ Ex Order 26.4(b)(1) to the residents on her assignment. The U.S. FOIA (b) replied she would usually provide NJ Exec Order 26.4b1 3 times a shift, but today it would be only twice since it was already so late. On 10/1/24 at 11:45 AM, the U.S. FOIA (b) exposed Resident #59's NJ Exec Order 26.4b1. The surveyor	F 725		

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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
F 725	Continued From page 45 and CNA observed that the Resident's [redacted] had a NJ Exec Order 26.4b1 inserted within the [redacted]. The [redacted], pad and pad under the resident were all [redacted] On 10/7/24 at 10:35 AM, in the presence of the survey team, the [redacted] stated that despite the number of residents the CNAs have on their assignments, NJ Ex Order 26.4(b)(1) should be provided to the residents three times on the night shift and every 2 hours on the day shift. Refer to F677D NJAC 8:39-5.1(a); 27.1(a); 27.2(d); 27.2(h)	F 725		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061408	A. BUILDING: _____ B. WING _____	C 10/10/2024

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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S 000	Initial Comments THE FACILITY WAS 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the	S 560	S 560 and F725 Corrective action for affected residents: Residents were not affected by this deficient practice. Other residents' potential to be affected: All residents have the potential to be affected by this deficient practice.	11/18/24

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

Electronically Signed | 11/04/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061408	A. BUILDING: _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth	S 560	Corrective measures and systemic changes: The administrator provided a review and reeducation to the Staffing Coordinator and Director of Nursing regarding the minimum mandated staffing requirements. The Administrator, Director of Nursing and Staffing Coordinator will meet weekly to review staffing levels as well as open positions and recruitment initiatives. Staffing agencies will be utilized when necessary to fill open slots, as well as offering extra shifts to facility staff. Ongoing aggressive recruitment efforts will include web-based advertising, agency contracting, sign-on and referral bonuses, job fairs, shift differentials, wage analysis and employee morale-boosting. The staffing coordinator will maintain the Excel daily report to track and trend actual numbers of staff working, in relation to the mandated expectations. Monitoring and Quality Assurance: The Staffing coordinator will report weekly to the Administrator and Director of Nursing weekly for 3 months, then monthly for the next 6 months. Findings will be shared at the Quality Assurance Committee meeting. Completion date: 11.18.24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061408	A. BUILDING: _____ B. WING _____	C 10/10/2024

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S 560	Continued From page 2 place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the period of 9/15/24 to 9/28/24 (2 weeks prior to the standard survey of 10/10/24) and the period of 5/5/24 to 5/11/24 (the time period covering complaint investigations) revealed the following: For the 2 weeks of staffing prior to survey from 09/15/2024 to 09/28/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -09/15/24 had 18 CNAs for 170 residents on the day shift, required at least 21 CNAs. -09/16/24 had 20 CNAs for 170 residents on the	S 560		

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S 560	Continued From page 3	S 560		

day shift, required at least 21 CNAs.
-09/17/24 had 16 CNAs for 170 residents on the day shift, required at least 21 CNAs.
-09/19/24 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs.
-09/20/24 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-09/21/24 had 18 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-09/22/24 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-09/23/24 had 21 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-09/24/24 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs.
-09/25/24 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs.
-09/26/24 had 20 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-09/27/24 had 21 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-09/28/24 had 19 CNAs for 177 residents on the day shift, required at least 22 CNAs.

For the week of Complaint staffing from 05/05/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:

-05/05/24 had 21 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-05/06/24 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs.
-05/07/24 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs.
-05/08/24 had 20 CNAs for 179 residents on the day shift, required at least 22 CNAs.
-05/11/24 had 20 CNAs for 176 residents on the day shift, required at least 22 CNAs.

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 4 On 10/8/24 at 12:15 p.m., the surveyor informed the Director of Nursing, Licensed Nursing Home Administrator (LNHA), and Assistant LNHA of the staffing ratio concerns.	S 560		
S1350	8:39-19.4(d) Mandatory Infection Control and Sanitation The infection control coordinator shall provide continuous collection and analysis of data, including determination of nosocomial infections, epidemics, clusters of infections, infections due to unusual pathogens or multiple antibiotic resistant bacteria, and any occurrence of nosocomial infection that exceeds the usual baseline levels. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to adhere to the Executive Directive No. 20-0261 issued by the New Jersey Commissioner in response to the [redacted] by failing to hire a full-time Infection Control Preventionist for the facility. This deficient practice was evidenced by the following: On 10/1/24 at 10:59 AM, during the initial tour of the B1unit, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she was the Unit Manager (UM) for the B1 unit, the Infection Control Preventionist (ICP) for the facility and the Assistant Director of Nursing (ADON). On 10/4/24 at 10:35 AM, the surveyor interviewed	S1350	S 1350 Infection preventionist 1 Residents were not affected by this deficient practice. 2 All residents had the potential to be affected by this deficient practice. 3 The current Infection Preventionist has become full time IP, so that all the various infection control tasks and duties are her primary focus. She is no longer responsible for oversight as a Unit Manager. The prior Unit Manager duties have been assigned to a different nurse. 4. The DON/designee will meet with the Infection Preventionist weekly for 3 months to ensure that job duties are in compliance with sole focus on infection	12/10/24

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S1350	Continued From page 5 the Regional Director of Nursing (RDON) and the Director of Nursing (DON) who confirmed that the ICP was also the full-time NJ Ex Order 26.4(b)(1) for the B1 unit. On 10/7/24 at 10:35 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), RDON and DON. The RDON stated that the facility planned to hire a full- time Unit Manager for the B1 unit, so that the ICP could function in her role as the ICP full-time. The surveyor reviewed the Job Description/ Competency Evaluation for the Infection Control Preventionist which revealed the following: Position Summary: The employee health and Infection Control Preventionist is responsible for the overall coordination of employee hiring practices related to health compliance. This position also monitors and coordinates all infection control issues on the campus and prepares reports as needed. Qualifications: Graduate of an accredited hospital or school of professional nursing ...currently licensed in the state of NJ as an RN or LPN ...certification in Infection Control ... No further information was provided by the facility.	S1350	control responsibilities. IP will continue to attend and actively participate in the quarterly QAPI meetings. The results of the weekly audit / meetings will be reported to the QAPI Committee for 3 months. Completion date 12.10.24	
S1690	8:39-25.2(d) Mandatory Nurse Staffing In facilities with 150 licensed beds or more, there shall be an assistant director of nursing who is a registered professional nurse.	S1690		12/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1690	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Assistant Director of Nursing (ADON) was a registered professional nurse (RN). This deficient practice was identified and evidenced by the following: During entrance conference on 10/1/24 AT at 10:24 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing Acting (DON) how many licensed beds the facility had. The LNHA stated the facility had 189 beds with a resident census of 176. On 10/4/24 at 12:35 PM, the surveyor interviewed the DON, who stated that the facility has three Unit Managers (UM) who are Licensed Practical Nurses, and the UMs also have the title of ADON. The DON further explained that the facility does not have a RN fulfilling the role of ADON. On 10/7/24 at 10:35 AM, the DON and the LNHA stated that the facility is aware that they need a RN ADON and are looking to hire someone for this position.	S1690	S 1690 ADON/RN 1 Residents were not affected by this deficient practice. 2 All residents had the potential to be affected by this deficient practice. 3 The administrator, in conjunction with the HR/ recruitment division, immediately began aggressive recruitment and interviewing for an experienced RN to assume the ADON position and responsibilities, including looking within the organization for a qualified candidate and reaching out to colleagues in the industry. The newly hired RN will immediately upon hire assume the Assistant Director of Nursing position to assist the DON with the various administrative regulations, as well as adherence to policies and procedures and assuring optimum resident care. 4 The Director of Nursing will meet with the new ADON weekly after hire for 3 months, and will assign specific tasks and a clear job description, to assure that he/she is complementing and enhancing appropriate service delivery of the Nursing department. Results of the weekly meetings will be shared with the quarterly Qapi Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061408	A. BUILDING: _____ B. WING _____	C 10/10/2024

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LINCOLN PARK RENAISSANCE	**521 PINE BROOK ROAD LINCOLN PARK, NJ 07035**

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S1690	Continued From page 7	S1690	Completion date December 10,2024	

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)	12/11/2024 (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 F0684 Reg. # 483.25 LSC	Correction Completed 12/10/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/10/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315042 Y1	A. Building B. Wing Y2	12/11/2024 Y3

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 F0558	Correction	ID Prefix F0640	Correction	ID Prefix F0641	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	12/10/2024	LSC	12/10/2024	LSC	12/10/2024
ID Prefix F0658	Correction	ID Prefix F0677	Correction	ID Prefix F0684	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25	Completed
LSC	12/10/2024	LSC	12/10/2024	LSC	12/10/2024
ID Prefix F0688	Correction	ID Prefix F0695	Correction	ID Prefix F0698	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed
LSC	12/10/2024	LSC	12/10/2024	LSC	12/10/2024
ID Prefix F0725	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/18/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/10/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061408	A. Building B. Wing	12/11/2024

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/18/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061408 (Y1)	A. Building B. Wing (Y2)	12/11/2024 (Y3)

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/18/2024	ID Prefix S1350 Reg. # 8:39-19.4(d) LSC	Correction Completed 12/10/2024	ID Prefix S1690 Reg. # 8:39-25.2(d) LSC	Correction Completed 12/10/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**10/10/2024**

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 (NJDOH), Health Facility Survey and Field Operations on 10/10/24. 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 (NJDOH), Health Facility Survey and Field Operations on 10/10/24 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Lincoln Park Renaissance is a two-story building constructed in the 1970's. It is composed of Type II (000) construction and is divided into ten smoke compartments. The facility has a complete automatic sprinkler system (wet). The diesel generator powers 25% of the building. The number of occupied beds was 123 out of 133.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/10/24 and the facility and was	K 000		

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

Electronically Signed | 10/30/2024

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

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K 000	Continued From page 1 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 is a two-story building constructed in the 1970's. It is composed of Type II (000) construction and is divided into ten smoke compartments. The facility has a complete automatic sprinkler system (wet). The diesel generator powers 25% of the building. The number of occupied beds was 123 out of 133 on 10/10/24 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. JDT Villa at Lincoln Park is a five-story building constructed in 2013. It is composed of Type II (111) construction and is divided into ten smoke compartments. The facility has a complete automatic sprinkler system (wet). The facility has piped in medical gas. The wood attic is separated from the rest of the building via ULPS33. The diesel generator powers 50% of the building. The number of beds occupied was 53 out of 56.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous	K 223		11/10/24

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K 223	Continued From page 2 area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors with self-closing devices were automatic closing and only held open with approved hold-open devices in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.8.2. This deficient practice had the potential to affect staff and seven residents. Findings include: An observation on 10/10/24 at 10:23 AM of the smoke barrier at Rehab revealed a hold-open device installed on the smoke door that was not tied to the fire alarm system. The device prevented the self-closing device from functioning in a fire emergency. During an interview at the time of the observation, the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) confirmed the finding and stated the facility was unaware that doors with self-closing devices could not be held open with devices that were not tied to the fire alarm system. NJAC 8:39-31.1(c), 31.2(e)	K 223	Plan of Correction: Lincoln Park Renaissance-Survey Date 10/10/2024 K-0223 (E) NFPA 101- Doors with Self Closing Devices REVISED It is the practice of the facility to ensure all doors in exit passageway close 1. The facility has removed the hold open device in rehab room and the door will remain in the closed position as of 10/29/2024. 2. All remaining egress path doors have been inspected and found to comply. All resident areas are free from hazard and all systems are operating as designed. 3. Education is completed with Maintenance staff to confirm proper function and maintenance of all egress path doors 4. All exit path doors will be audited weekly by the Maintenance Director or designee for 3 months, then quarterly for 3 quarters, to check for proper functioning. This information will then be entered on an audit tool , and will be	

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K 223	Continued From page 3	K 223	presented to the Quarterly QAPI meeting. Date of Compliance: 11/10/2024	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to separate hazardous areas from other	K 321	K-0321 (E) Hazardous Areas REVISED	11/10/24

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K 321	Continued From page 4 parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. This deficient practice had the potential to affect staff and seven residents. Findings include: Observations on 10/10/24 at 10:50 AM of the combustible storage area, located in the Dining Area by Dietary revealed the area was not separated from the Corridor and other parts of the building with smoke resisting partitions. The combustible storage included bulk paper products and food items that exceeded 50 square feet in size. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the findings and stated the facility had recently ordered the items in bulk in preparation for potential shortages caused by the recent port strike. According to the U.S. FOIA (b)(6), the facility had not found a good place to store the combustible items yet. NJAC 8:39-31.2(e)	K 321	It is the practice of the facility to not maintain storage in bulk in corridor areas 1. The kitchen has relocated bulk storage to a storage closet with self-closing device as of 10/29/2024. 2. All corridors were inspected for storage and found to comply. All resident areas are free from hazard and all systems are operating as designed. 3. Education is completed with Maintenance staff to confirm proper storage. 4. All corridor areas will be checked for improper storage by the Maintenance Director or designee , weekly for 3 months, and then quarterly for 3 quarters. This information will then be entered on a log and will be presented to the quarterly QAPI meeting. Date of Compliance: 11/10/2024	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		11/10/24

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K 324	Continued From page 5 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hood system in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition). The deficient practice had the potential to affect staff only and all residents. Findings include: An observation on 10/10/24 at 10:55 AM of the hood system, located in the Kitchen above the cooking equipment, revealed an unsealed gap three inches in diameter by the filters which allowed grease laden vapors to infiltrate the area behind the hood and filters. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the gaps in the hood system. He stated the facility was	K 324	K-0324 (F) Cooking Facilities REVISED It is the practice of the facility to ensure cooking facilities suppression devices have proper fireproofing around gaps 1. We have sealed the small gaps with proper UL rated fire caulk to prevent infiltration of vapors from the hood as of 10/29/2024. 2. All other areas in the kitchen have been inspected and comply. All resident areas are free from hazard and all systems are operating as designed. 3. Education is completed with Maintenance staff to confirm proper gap penetration seals. 4. All kitchen suppression devices and food areas will be checked weekly for 3 months for proper fireproofing around any	

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K 324	Continued From page 6 unaware of the gaps in the hood system. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	gaps for excess penetrations, by the Maintenance Director or designee ,as well as quarterly for 3 quarters. This information will then be entered on a log and will be presented to the quarterly QAPI meeting. Date of Compliance: 11/10/2024	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	K 363		11/10/24

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K 363	Continued From page 7 sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 30 residents. Findings include: An observation on 10/10/24 at 10:30 AM revealed the corridor door of room 103 failed to close and positive latch in the door frame. The positive latching hardware was not functioning. An observation on 10/10/24 at 11:22 AM revealed the corridor door of room 248 failed to close and positive latch in the door frame. The bed was blocking the door from closing in the door frame. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was unaware the doors were not closing and latching prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K 363	K-0363 (F) Corridor- Doors REVISED It is the practice of the facility to ensure smoke, Fire and corridor doors will operate as per design. 1. The corridor doors of rooms 103 and 248 have been repaired and now positively close and latch as per design as of 10/29/2024 2. Doors throughout the facility were checked to allow for closure ; all resident areas are free from hazard and all systems are operating as designed. 3. Education completed with Maintenance staff regarding monitoring doors and rating labels to ensure they close properly. 4. All fire and corridor doors will be checked weekly for 3 months by Maintenance Director or designee , to ensure proper operation per design and to ensure that the doors fully close, and then checked quarterly for 3 quarters This information will then be entered on a log and will be presented to the quarterly QAPI meeting. Date of Compliance: 11/10/2024	

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K 372	Continued From page 8	K 372		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6.2. This deficient practice had the potential to affect 70 residents. Findings include: An observation on 10/10/24 at 10:28 AM of the smoke barrier located in room 140 revealed a two-inch overcut around the pipe penetration under the sink. An observation on 10/10/24 at 11:21 AM of the smoke barrier located in the Spa by room 241 revealed a four-inch unsealed gap at the top wall above the ceiling tile in the corner by the corridor.	K 372	K-0372 (F) NFPA 101 Subdivision of Building Spaces-Smoke Barrier REVISED 2 12.1 It is the practice of the facility to ensure smoke barrier walls to be free of penetration. 1. Penetrations by room 140, spa room near 241, Dining room by 231, inside room 222, Villa 407,301, and 101 will be sealed using 3M UL rated fire caulk as per design. 2. All other smoke barriers throughout the facility were checked for penetrations on 10/29/24 and repaired using fire barrier sealant that is intumescent. 3. Education completed with Maintenance staff regarding monitoring smoke barrier wall penetrations. 4. Every month for one year, the	11/10/24

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K 372	Continued From page 9 An observation on 10/10/24 at 11:31 AM of the smoke barrier located inside the Dining Room by room 231 revealed a five-inch gap in the wall at the corner above the ceiling tile near the exterior wall. An observation on 10/10/24 at 11:34 AM of the smoke barrier located inside room 222 revealed a four-inch unsealed overcut around a conduit penetration above the ceiling near the corridor wall. A ten-inch by eight-inch gap was observed in the wall above the ceiling tile and nurse call light. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the unsealed gaps and penetrations. The U.S. FOIA (b)(6) stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372	Maintenance Director or designee will check 10 barrier walls throughout the facility to ensure they are free from penetrations. This information will then be entered on a log and will be presented to the quarterly QAPI meeting committee. Date of Compliance: 11/10/2024	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system	K 372		11/10/24

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K 372	Continued From page 10 in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6.2. This deficient practice had the potential to affect 40 residents. Findings include: An observation on 10/10/24 at 12:48 PM of the smoke barrier located in the corridor by Room 407 revealed a four-inch overcut around a group of wire penetrations above the smoke doors and ceiling tile. An observation on 10/10/24 at 1:05 PM of the smoke barrier located in the corridor by Room 301 revealed a four-inch overcut around a group of wire penetrations above the smoke doors and ceiling tile. An observation on 10/10/24 at 1:22 PM of the smoke barrier located in the corridor by Room 101 revealed a five-inch overcut around a group of wire penetrations above the smoke doors and ceiling tile. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the unsealed gaps and penetrations. The U.S. FOIA (b)(6) stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers.	K 372	K-0372 (F) NFPA 101 Subdivision of Building Spaces-Smoke Barrier REVISED 2 12.1 It is the practice of the facility to ensure smoke barrier walls to be free of penetration. 1. Penetrations by room 140, spa room near 241, Dining room by 231, inside room 222, Villa 407,301, and 101 will be sealed using 3M UL rated fire caulk as per design. 2. All other smoke barriers throughout the facility were checked for penetrations on 10/29/24 and repaired using fire barrier sealant that is intumescent. 3. Education completed with Maintenance staff regarding monitoring smoke barrier wall penetrations. 4. Every month for one year, the Maintenance Director or designee will check 10 barrier walls throughout the facility to ensure they are free from penetrations. This information will then be entered on a log and will be presented to the quarterly QAPI meeting committee. Date of Compliance: 11/10/2024	

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	315042	A. BUILDING **01, 02** B. WING _____	**10/10/2024**

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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 372	Continued From page 11 NJAC 8:39-31.1(c), 31.2(e)	K 372		

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 02 - JDT PAVILLION B. Wing Y2	12/11/2024 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 Reg. # NFPA 101 LSC K0372	Correction Completed 11/10/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			