STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 05/12/23 Census: Sample: 36 plus 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		7/7/23

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

Electronically Signed | 06/05/2023

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

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: NJ00154373 Based on interview and review of facility documentation, it was determined that the facility failed to follow upcoming policy changes within the timeframe provided to residents. This deficient practice was identified for 1 of 5 residents reviewed for [redacted] (Resident #104) and was evidenced by the following: On 05/08/23 at 10:26 AM, the surveyor interviewed Resident #104. The resident told the surveyor that when he/she came to the facility residents were allowed to [redacted] three times a day, and " a few months ago it was changed to	F 550	1) The social worker met with resident #104 to provide emotional support & discuss the fact that he/she had been denied his/her [redacted] privilege's on [redacted], which was prior to the 30 days of the initial notification. Resident #104 reported that he/she is fine and understands. 2) All residents who [redacted] have been identified as having the potential to be affected by this practice. A list of all [redacted] will be provided to the social services department by the activities department. Social Services will follow up	

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F 550	Continued From page 2 twice a day, about six I think". Resident #104 said, "There are days when we can't [redacted] at all, maybe every other month because the staff doesn't show up". The resident could not give specific dates when the [redacted] was suspended. At the same time, the surveyor reviewed the residents complaint which indicated the residents were not allowed to [redacted] on [redacted] Review of the Admission Record showed that Resident #104 was admitted to the facility on [redacted]. Medical diagnoses included, but not limited to NJ EX Order. 264b1 [redacted] Review of the quarterly Minimum Data Set, (an assessment tool) dated [redacted] indicated the resident had a Brief Interview of Mental Status of [redacted], meaning the resident was NJ EX Order. 264b1. On 05/08/23 at 10:37 AM, the surveyor reviewed Resident #104's paper chart. The surveyor reviewed the quarterly [redacted] assessments which indicated the resident was a safe [redacted] since admission to the facility [redacted]. The last quarterly [redacted] assessment that was reviewed was on [redacted]. On 05/09/23 at 10:29 AM, a surveyor interviewed the Director of Activities (AD)regarding smoking. The AD told the surveyor that at one point in time, the residents were NJ EX Order. 264b1 times a day. The surveyor asked the AD when the times changed, and the AD was unsure of specific dates but said it's been well over a year. The AD said when the [redacted] times changes, all the residents were educated, and a trial run was	F 550	on those residents to ensure that they are aware of the policy and to provide emotional support when necessary. 3) On June 19, 2023, the administrator in-serviced the Activities Director and on June 21, 2023, the Activities Director inserviced the activities department as to the importance of allowing all residents to exercise their rights. The [redacted] Policy and Procedure has been revised to include that [redacted] privileges' may be restricted at times that there is no trained staff member available to supervise the [redacted] 4) The Activities Director will Audit monthly for 3 months to ensure that residents are being allowed to exercise their rights to [redacted] as scheduled as per the revised policy. The activities Director will report the results of the Audit at the Quarterly QAPI Committee meeting.	

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F 550	Continued From page 3	F 550		

done prior so they could get used to it, and to see if they had any questions. The residents all signed agreements acknowledging the new rules, and it was also reflected in the resident's care plan.

On 05/09/23 at 10:54 AM, the surveyor reviewed Resident #104's care plan which showed the following focus regarding [redacted]: The [redacted] program will be reduced from [redacted] sessions a day to [redacted] sessions a day. We will be eliminating the afternoon session. If the current staff that were to call out from work for the day, we will do our utmost to cover the position for that day but if we are unsuccessful, we may have to suspend the program for that day. The care plan had a revised date [redacted]

On 05/10/23 at 10:36 AM, the facility provided progress notes from the social worker stating she met with Resident #104 on [redacted] to inform the resident of a change in [redacted] policy. The social worker explained to the resident that the changes would take effect in 30 days. The resident was told that there might be days when [redacted] would be eliminated if there were not staff available for supervision. It was documented that the resident understood although displeased with the change. The administrator also sent an email regarding the changes which were to take effect 30 days from [redacted] At the same time, the resident's care plan was revised to include the changes.

On 05/10/23 at 11:00 AM, the surveyor reviewed an email sent to resident representatives informing them of the upcoming [redacted] changes to take place 30 days from [redacted]. The email read that the notification on [redacted]

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F 550	Continued From page 4 NJ EX Orde, was a 30-day notice and the new NJ EX Order 2640 schedule would go into effect after 30 days. On 05/10/23 at 11:15 AM, the surveyor reviewed the NJ EX Order 264 Room" policy, dated January 22, 2021. The policy did not include a statement saying that if no staff were available NJ EX Order 2640 would be suspended for the residents. The surveyor then reviewed the revised policy, dated May 13, 2022, which then included that if a NJ EX Order 2 room attendant is unable to work their shift and coverage is unattainable, no NJ EX Order 2640 will be provided for the day. NJAC 8:39-31.6 (e, 3)	F 550		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 582		6/29/23

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F 582	Continued From page 5 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents (Residents #77 and #122) reviewed for Beneficiary Protection Notification. This deficient practice was evidenced by the following:	F 582	Leisure Chateau will continue to provide the NOMNC and ABN form as necessary for all applicable residents. To address survey concerns the facility has done the following. 1) Resident #122 has a guardian. The	

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F 582	Continued From page 6 On 5/09/23 at 10:00 AM, the surveyor reviewed three residents that were discharged from Medicare part A with days remaining. Resident #77 had a last covered day for Medicare of [redacted] The Notice of Medicare Non-Coverage (NMNC) and the Skilled Nursing Facility Advance Beneficiary Notice of Non- Coverage (SNFABN) was not signed by the representative nor was there documentation that the representative was notified. On 5/9/23 at 10:00 AM the surveyor reviewed the SNF Beneficiary Protection Notification Review form for Resident #122. Resident #122 had a LCD for Medicare of [redacted] The NMNC and the SNFABN was not signed by the representative nor was there documentation that the representative was notified. On 05/09/23 at 12:28 PM the surveyor interviewed the Social Worker (SW) regarding Residents' #77 and #122 SNF Beneficiary Protection Notification Review forms. She stated she cannot provide documentation that she spoke to the resident or the representative regarding the last covered day of [redacted] . She stated that she does her best to get them to sign but it is not always easy. On 05/09/23 at 12:43 PM the surveyor interviewed the Licensed Nursing Home Administrator. His expectation is that the ABN and NMONC forms are signed. On 05/11/23 at 12:01 PM, the surveyor reviewed the facility's NOMNC/ABN Policy reviewed on	F 582	Director of Social Services made another attempt to contact the guardian by phone. There was no answer, and a message was left on the guardians voice mail. The Director of Social Services sent another form and asked that the form be returned signed. The Director of Social Services wrote a note in the resident chart about the attempts to contact and acquire a signature. The representative for resident #77 was contacted again by the Director of Social Services and the representative came in on June 1, 2023 to sign the forms. 2) All residents who are admitted under the Medicare Part A program and are being discharged from the Part A Medicare stay can be affected by this deficient practice. 3) The policy & procedure for notification of the NOMNC and ABN will be revised to indicate the following: The Social Worker will prepare the forms for signature and bring to the resident to explain the contents of the forms and to get a signature at least 2 days prior to the discharge. If the resident is not alert and oriented, the Social Worker will call the resident representative by phone and let them know about the upcoming discharge and notify the representative of the Contents of the NOMNC and/or the ABN form that we are required to provide. The Social Worker will ask the Family Representative if they prefer to either come into the facility to sign the forms or to return the signed form by mail/email or	

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F 582	Continued From page 7 5/22 which reflects 2. The NOMNC/ABN will be brought to the resident or delivered for signature by at least two calendar days before Medicare covered services end. 3. Resident or family will be requested to come in to sign the forms or to return the forms as soon as possible. NJAC 8:39-4.1a(8)	F 582	fax. If the family will not be coming in, then the Social Worker will arrange for the forms to be sent to the resident representative. The Social Worker will make every attempt to have the forms signed. If the forms are not signed/returned, the Social Worker will document in the resident chart about his/her communications to the representative and the attempts that he/she made to get the form signed. 4) The Director of Admissions will audit weekly for 4 weeks and then monthly for 3 months to ensure that the Notifications are being completed. The Director of Admissions will report the results to the quarterly QAPI committee meeting. . Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued auditing, submission, and reporting.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		7/7/23

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F 584	Continued From page 8 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint # NJ00163390 Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to: a.) maintain a clean, comfortable, homelike environment on the [NJ EX Order 264] unit, b.) maintain privacy curtains free from stains in a resident's room c.) maintain cleanliness behind the blinds in a resident's room, and d.) paint over the spackle in a resident's room. This deficient practice was	F 584	1. Resident #33 has been identified as having been affected by this deficient practice. Resident #33 resides on the [NJ EX Order 264b] Unit. Resident #4 has been identified as having been affected by this deficient practice. Resident #4 resides on the [NJ EX Order 264b] Unit. The Social Worker will assess and offer emotional support to Residents #33 and #4 as necessary. Social Worker will re-assure Residents #33 and #4 that the identified	

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F 584	Continued From page 9 identified for two (2) of 36 resident's, (Resident #4 and Resident #33) and on one (1) of four (4) nursing units, ([redacted] unit) reviewed for clean, comfortable, homelike environment. The deficient practice was evidenced by the following: 1.) On 05/04/23 at 10:39 AM, the surveyor toured the [redacted] unit and observed that the gold-colored wallpaper to the right of room [redacted] was ripped from the wall leaving a white mark. On 05/05/23 at 11:49 AM, the surveyor toured the [redacted] unit in the presence of the Maintenance Director (MD). The MD observed the area and stated that it was hard to patch the wallpaper, but he would fix it as soon as he could. On 05/04/23 at 10:43 AM, the surveyor observed on the [redacted] unit in between rooms [redacted], scratches in the wall underneath the handrail. White indentations and holes were observed on the wall. On 05/05/23 at 11:50 AM, the surveyor toured the [redacted] unit with the MD who observed the scratches in the wall in between rooms [redacted] and [redacted]. The MD stated that the wall needed to be spackled and painted. On 05/04/23 at 10:45 AM, the surveyor observed on the [redacted] unit, white indentations and scratches at the bottom part of the wall, underneath the handrail between room [redacted] the day room. On 05/05/23 at 11:52 AM, the surveyor toured the [redacted] unit with the MD who observed the	F 584	environmental/maintenance issues will be corrected and that systems will be put into place to prevent re-occurrence. Resident #21 was identified as being affected by this deficient practice. Resident #21 is no longer a resident at Leisure Chateau. To address survey concerns the facility has done/will do the following: a) Rm [redacted] to the right gold peeled wallpaper repaired by the maintenance department on 6/12/2023. b) The scratches, white marks & holes between [redacted] underneath handrails were repaired by the maintenance department on 6/12/2023. c) The scratches and white marks Between [redacted] and [redacted] underneath the handrails were repaired by the maintenance department on 6/12/2023. d) The brown molding by the floor In between rooms [redacted] were removed and the area was repainted by the maintenance department on 6/28/2023. e) The brown and white indentations underneath the handrail between rooms [redacted] were repaired by the maintenance department on 6/28/2023. f) [redacted] day room white trim as well as wallpaper peeling under light switch has been repaired by the maintenance department on 6/12/2023. g) Scratches on the [redacted] shower room door were repaired on 6/28/2023. h) The discolored tiles on the floor In front of the [redacted] Nurses station were replaced on 7/5/2023 and the exit doors have been painted by the maintenance department on 6/12/2023. i) White stains in center of right door in	

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F 584	Continued From page 10 scratches and indentations at the bottom part of the wall, underneath the handrail between room [redacted] and the day room who stated that the wall was patched up, "less than a year ago, last May", but needed to be touched up again. On 05/04/23 at 10:47 AM, the surveyor toured the [redacted] unit and observed a hole in the brown molding attached to the wall by the floor in between rooms [redacted]. The surveyor further observed scratches and white indentations on the wall underneath the brown molding. On 05/05/23 at 11:53 AM, the surveyor toured the [redacted] unit in the presence of the MD who observed the hole in the brown molding attached to the wall by the floor in between rooms [redacted]. At that time, the MD stated that he didn't know how long it had been that way. The MD looked at the scratches and indentations in the wall and stated that, "it needed to be patched up". On 05/04/23 at 10:51 AM, the surveyor toured the [redacted] unit and observed scratches and holes in the wall, slightly above the brown molding attached to the floor in between rooms [redacted]. On 05/05/23 at 11:55 AM, the MD observed the scratches and holes in the wall, slightly above the brown molding attached to the floor in between rooms [redacted] in the presence of the surveyor. The surveyor observed the MD touch the wall and white debris was observed falling onto the floor. The MD stated that the wall needed to be patched up too. On 05/04/23 at 10:52 AM, the surveyor observed on the [redacted] unit underneath the handrail in between rooms [redacted] brown and white	F 584	front hall of [redacted] unit was repainted on 6/12/2023 j) The white scratches and marks on wallpaper in between rooms [redacted] was repaired by the maintenance department on 6/13/2023. k) The Indentation in the wall to the left of room [redacted] has been repaired by the maintenance department on 6/12/2023. l) The privacy curtain in the room of resident [redacted] has been replaced on 5/12/2023. m) The wall in Room [redacted] in the [redacted] unit was repainted on 6/12/2023, and the window blinds and wall borders were replaced on 7/5/2023. 2. All residents have the potential to be affected by an environment that is not well maintained. All resident rooms & common areas will be audited to determine if any of these areas have been affected by the same deficient practice. The audit will be done by the assistant administrator or his designee. All findings will be formally communicated to the maintenance and housekeeping departments as necessary, and repairs/corrections will be scheduled. 3. Systemic Changes a) The assistant administrator in charge of purchasing will purchase additional replacement privacy curtains to allow our housekeeping department to easily swap out and discard any stained privacy curtains that are discovered. b) AN Inservice to All nursing, housekeeping, maintenance & activities	

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	315190	A. BUILDING _____ B. WING _____	C 05/12/2023

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F 584	Continued From page 11 indentations throughout the wall. On 05/05/23 at 11:56 AM, the MD observed the brown and white indentations in the wall between rooms [redacted] with the surveyor and stated that the wall needed to be spackled and painted. On 05/04/23 at 10:54 AM, the surveyor observed in the day room on the [redacted] unit dents throughout the white trim in the room. The surveyor further observed wallpaper peeling underneath the light switch. On 05/05/23 at 11:57 AM, the surveyor entered the day room on the [redacted] unit with the MD who stated that if he painted the bottom of the trim in the day room, it would be dented in three (3) days and that the material of the trim should be plastic and not wood, due to the resiliency of the plastic. The MD told the surveyor that he could patch up the wallpaper with tape. On 05/04/23 at 10:55 AM, the surveyor observed scratches halfway up the door on the shower room door on the [redacted] unit. On 05/05/23 at 11:58 AM, the MD observed the scratches on the shower room door on the [redacted] unit and stated that he could use paint to fix it and put a water based 'NJ EX Order. 264b1, a material that coats an area making the area more durable) to seal the paint. On 05/04/23 at 10:56 AM, the surveyor observed on the Florida unit white, red, and brown discolorations throughout the tile in front of the nurse's station. The surveyor further observed scratches throughout the brown exit doors towards the right of the nurse's station.	F 584	staff was completed by 6/30/2023 on: " Observing the residents environment as they would their own home from both a cleanliness aspect and a maintenance aspect. " Stains on Privacy Curtains " Communicating any observations related to maintenance and housekeeping issues in the maintenance log that is located at each nurse's station. " Reporting to administration if the observations are not addressed in a timely fashion. c) The administrator or his designee will encourage the clinical morning meeting team which includes: " the Director of Nursing " the Assistant Administrator " Staff Educator " All 4 Unit Managers " Safety Coordinator " Infection Preventionist " Food Service Director " Dietician " Rehab Director " MDS Coordinator " Social Worker " Administrators in Training to share any observations related to maintenance/housekeeping, or any issues that are contraindicated to a homelike environment. The Assistant Administrator will communicate the observations with the housekeeping and maintenance department. d) The Activities Director will ask the participants of the Resident Council meeting about any maintenance or housekeeping issues they may have	

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F 584	Continued From page 12 On 05/05/23 at 12:00 PM, the MD observed the tile in the presence of the surveyor and stated that the housekeeping department was responsible for cleaning the tile. The MD further stated that he was unsure what the white marks on the door were, the door wasn't painted often, but could probably use a "touch up". On 05/04/23 at 12:06 PM, the surveyor observed white stains in the center of the right door in the front hall of the [redacted] unit On 05/05/23 at 12:01 PM, the MD observed the white stains on the doors in the presence of the surveyor and stated that the doors needed a touch up. On 05/05/23 at 08:41 AM, the surveyor observed on the [redacted] unit white marks and scratches on the wallpaper in between room 35 and room 37. On 05/05/23 at 12:05 PM, the MD observed the white marks and scratches on the wallpaper between rooms [redacted] in the presence of the surveyor. On 05/05/23 at 08:45 AM, the surveyor toured the Florida unit and observed an indentation in the wall to the left of room [redacted]. There was a rectangular white box observed over the indentation and the area surrounding the white box was observed to be caving into the wall. On 05/05/23 at 12:04 PM, the MD observed the indentation in the wall in the presence of the surveyor. The MD told the surveyor that the facility used to have lights there and the hole got too big, so they had to put a bigger plate there for	F 584	observed either in their rooms or in any of the common areas. All resident observations will be communicated to the appropriate department for correction. e) The Maintenance director or his/her designee will conduct monthly environmental rounds in resident rooms and common areas. The observations will include but not be limited to the condition of: " Walls-Wallpaper/Paint " Doors " Furniture " Light pull strings " Sink and toilet " Ceiling tiles " Floors " Beds f) The Housekeeping Director or his/her designee will conduct monthly environmental rounds in resident rooms and common areas. The observations will include but not be limited to the cleanliness of the floors, walls, bathrooms, windows and privacy curtains, high dusting & corners & edges. 4. Monitoring/QAPI " The Assistant Administrator or his/her designee will conduct a monthly audit for 6 months by inspecting a minimum of 2 randomly selected resident rooms and all common areas on each unit each month to ensure compliance. The Assistant Administrator will submit the audit results to the QAPI Committee Meeting which meets at a minimum on a quarterly basis. " The Housekeeping Director or his/her	

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F 584	Continued From page 13 now before the unit was redone. On 05/09/23 at 11:11 AM, the surveyor interviewed the [redacted] unit Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the maintenance department was responsible for fixing anything that was broken. The LPN/UM told the surveyor that if staff working on the unit identified that anything was broken, they would call maintenance to notify them and put it in the maintenance book on the unit. The LPN/UM explained that the Administration and Infection Preventionist rounded the unit monthly and made a list of things that needed to be fixed. Once the list was constructed, it would then be delegated to the different departments to delegate who was responsible for fixing what. The LPN/UM further stated that the maintenance department was responsible for fixing scratches, holes in walls, paint discoloration, and broken furniture. The LPN/UM stated that the expectation would be to hopefully fix things when they came up or monthly. The LPN/UM stated that, "it had been quite a few years since the [redacted] unit had been renovated and the unit takes quite a beating". On 05/09/23 at 12:25 PM, the surveyor interviewed the Housekeeping Director (HD) who stated that he made rounds on the unit daily. On 05/12/23 at 11:01 AM, the Administrator stated in the presence of the survey team that the maintenance department was short on staff, and he was in the process of hiring more staff. The Administrator stated that the Florida unit needed someone there to fix it very often and that sometimes they would fix something and then have to fix it again right away.	F 584	designee will Audit twice a week for 3 months and then monthly for an additional 3 months. The Audit will consist of an inspection of each scheduled carbolization room at the end of a random day and ALL resident common areas. The inspection will include attention to detail such as high dusting, corners and edges, furniture crevices stains on walls, stains on privacy curtains. The Housekeeping Director will submit the audit results to the QAPI Committee Meeting which meets at a minimum on a quarterly basis. The QAPI Committee will determine if compliance is met and POC solutions are sustained or if further additional intervention is necessary.	

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A review of the NJ EX Order. 264b1 unit Maintenance Log did not include any of the above observations documented in the log that needed repair.

A review of the Maintenance Director's Job Description and Performance Standards dated 07/12/22 indicated that the purpose of the position was to, "develop and implement facility maintenance policies and procedures in an efficient, cost-effective manner to meet safely meet resident's needs in compliance with federal, state, and local requirements." A further review of the Maintenance Director's Job Description revealed that the MD was responsible for developing and implanting repair and maintenance schedules for all the areas of the facility grounds and supervising the schedule for repair and maintenance by contractors.

2.) On 05/02/23 at 10:26 AM, the surveyor observed Resident #21 in their room. The surveyor observed that the privacy curtain between Resident #21 and his/her roommate was light peach in color and had light brown stains throughout.

On 05/03/23 at 12:08 PM, the surveyor observed the resident in their room seated in a NJ EX Order. 264b1 wheelchair. The surveyor observed that the privacy curtain between Resident #21 and his/her roommate was light peach in color and had light brown stains throughout.

05/04/23 11:42 AM, the surveyor observed the resident in his/her room seated in their NJ EX Order. 264b1 wheelchair. A staff member was in the room NJ EX Order. 26 the resident, seated next to the resident's wheelchair. At that time the surveyor observed

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that the privacy curtain between Resident #21 and his/her roommate was light peach in color and had light brown stains throughout. The surveyor further observed that the bottom part of the privacy curtain by the door in the resident's room had a red stain on it and browns stains throughout.

The surveyor reviewed the medical record for Resident #21.

A review of the resident's Admission Record (an Admission Summary) reflected that the resident had resided at the facility for [redacted] and had diagnoses which included but were not limited to [redacted]).

A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment toll used to facilitate the management of care dated [redacted] indicated that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of [redacted] which indicated the resident's cognition was [redacted]

On 05/05/23 at 09:55 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that they changed the privacy curtains in the resident's room the night before (05/04/23).

On 05/05/23 at 11:35 AM, the surveyor interviewed the housekeeper working on the [redacted] unit who stated that it was her job to change the privacy curtains in the resident's

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rooms.

On 05/09/23 at 10:52 AM, the surveyor conducted a follow up interview with the resident's LPN who stated that it was the responsibility of the housekeeping department to change the privacy curtains in the resident's rooms. The LPN told the surveyor that if the nursing staff noticed that the privacy curtains were dirty, the nursing staff would tell the housekeeper verbally when they saw them or document in the housekeeping communication book on the unit. The LPN further stated that if she directly spoke with the housekeeping staff, she would not document the request in the housekeeping book.

On 05/09/23 at 11:09 AM, the surveyor interviewed the [redacted] unit LPN/UM who stated that if staff noticed that the privacy curtains in the resident's room were dirty, the staff would call and notify the HD or document it in the housekeeping book for the unit. The LPN/UM further stated that the housekeeping department had a routine schedule where every room on the unit was deep cleaned once monthly and at that time the privacy curtains in the resident's rooms would be changed.

On 05/09/23 at 12:25 PM, the surveyor interviewed the HD who stated that he made rounds on the [redacted] unit every day and would look at everything including the cleanliness of medication carts, resident's wheelchairs, and the floors. The HD told the surveyor that the resident's rooms were deep cleaned every month and the privacy curtains in the resident's rooms would be changed at that time and when a resident was discharged from the facility. The HD explained that it was the housekeeping

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departments responsibility to change the privacy curtains and the Administration was aware that some of the privacy curtains were stained.

A review of NJ EX Order. 264b1 housekeeping book did not indicate that the nurses documented that the privacy curtain needed to be changed in Resident #21's room.

A review of the HD Job Description and Performance Standards dated [redacted] indicated, "the purpose of this position is to implement effective, efficient systems to operate the housekeeping department in a cost-effective, efficient manner to safely meet residents' needs in compliance with federal, state, and local requirements."

A review of the facility's House Keeping In-Service, Complete Room Cleaning dated [redacted], indicated, "cubicle curtains - check and report any soil or damage to supervisor."

3.) On 05/08/23 at 1:14 PM, the surveyor entered room [redacted] on the [redacted] Unit at the request of Resident #33. The surveyor observed a wall in the room with an area of spackle, approximately 4 feet long by six inches wide. The surveyor asked the resident if the facility recently started working on the wall and the resident told the surveyor, "Been like that since I came in the room in [redacted] The surveyor also noticed multiple sections of peeling wallpaper, which was a decorative border on three of the four walls. On the window blinds one small section of a blind slat was missing, approximately 5 inches on the right side, and when the blind was moved there was a buildup of a black substance on the back of the window blind.

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F 584	Continued From page 18 On 05/09/23 at 11:30 AM, the surveyor interviewed Maintenance Worker #1 (MW#1) and Maintenance Worker #2 (MW#2) and asked if there was a process of routine maintenance in the resident rooms or routine maintenance rounding. The MW #1 told the surveyor there was a "binder that staff would write down what needed to be fixed and the binder was checked in the morning and again later in the day". The surveyor asked what would happen if there was an urgent need for a repair and MW#1 said, "the staff would page us overhead". The surveyor entered room [redacted] on the [redacted] Unit with MW #1 and MW #2 with Resident #33 permission. The surveyor asked about the spackled areas on the wall. MW#1 said, "the guy who worked here before must have done that, maybe two months ago". MW#2 told surveyor that "maybe it was done 5 months ago". MW#1 told the surveyor "The maintenance director should know; he is on the roof right now". The surveyor asked MW#1 to provide more information if available. No further information was provided to the surveyor. NJAC 8:39-31.2(e), 31.4 (a)(f)	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		6/30/23

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(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

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including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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F 623	Continued From page 21 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide written notification of the emergency transfer to the resident, resident representative, and the Office of the Long-Term Care Ombudsman (LTCO) for one (1) of two (2) residents (Resident # 124), reviewed for hospitalizations. This deficient practice was evidenced by the following: The surveyor reviewed the medical records of Resident # 124. Review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to NJ EX Order. 264b1 NJ EX Order. 264b1 Review of the New Jersey Universal Transfer Form (NJUTF) dated NJ EX Order. 264b1 indicated the resident was transferred to the hospital for NJ EX Order. 264b1 Review of the Minimum Data Set (MDS) dated NJ EX Order. 264b1 indicated the resident had a discharge assessment with return anticipated. Review of the NJUTF dated NJ EX Order. 264b1, indicated the resident was transferred to the hospital for	F 623	1) On June 28, 2023, a notice of discharge/transfer was completed and sent to the representative of Resident #124 for the Hospital Transfers of NJ EX Order. 264b1 and NJ EX Order. 264b1 and to the office of the Ombudsman. 2) All residents who are discharged to an acute setting can be affected by this deficient practice. 3) Between 6.24, 2023 and 6.29.2023, the Staff Educator In-Serviced the Nursing Staff, and on 6.28.2023 the Administrator inserviced the Admissions staff, the receptionist and the Social Services Department about the requirement to send the Notice of Discharge to the Resident or the resident representative, prior to or upon discharge, or within 24 hours post discharge. A copy must also be sent out to the Ombudsman. The policy will be updated to reflect that The Admissions Director will oversee that the receptionist sends the notice out. 4) the Admissions Director will audit weekly for 1 month and the monthly for 2 additional months to ensure that the "Notice of Discharge" was sent out to both the Resident or Resident Reprsentative and the Ombudsman. Admissions	

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F 623	Continued From page 22 NJ EX Order. 26 Review of the MDS dated NJ EX Order. 264b1, indicated the resident had a discharge assessment with return anticipated. Review of the NJUTF dated NJ EX Order. 264b1 indicated the resident was transferred to the hospital for an NJ EX Order. 264b1 Review of the MDS dated NJ EX Order. 264b1, indicated the resident had a discharge assessment with return anticipated. On 05/11/23 at 12:29 PM, the surveyor interviewed the front desk receptionist (FDR) who stated she was responsible for notifying the residents and resident representatives of the facility's bed-hold policy and notice of transfers. She stated she began her position as the FDR approximately 2 years ago and started sending the notifications out about 4 weeks ago, in April. The FDR stated before her the Social Worker (SW) was the staff who sent out the last notifications. On 05/11/23 at 12:33 PM, the surveyor interviewed the SW who stated she began her position as the SW, NJ EX years ago. The SW confirmed that she was one of two staff responsible for notifying the Long-Term Care Ombudsman (LTCO) office of emergency transfer(s) and discharges on a monthly basis but confirmed the facility had not completed them for a long time before NJ EX Order. 264b1 due to staffing. On that same date at 12:48 PM, the FDR provided the surveyor with one Notice of Transfer	F 623	Director will report audit results to the Quarterly QAPI committee meeting.	

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F 623	Continued From page 23 for Resident #124 dated [redacted]. The FDR could not provide any documented evidence of the Notice of Transfer notices sent to the resident representative or the LTCO for [redacted] and [redacted]. On 05/11/23 at 12:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and discussed the above findings. There was no additional information provided. Review of the facility's policy for "Notice Requirements for Transfer/Discharge of a Long-Term Care Resident" include that the notice of transfer or discharge form will be completed by the nursing/social services department. The resident/responsible party will be notified. Resident discharge list will be emailed to the Ombudsman office on a monthly basis. NJAC 8:39-5.3; 5.4	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for three (3) of 38 residents, (Resident #65, Resident #104, Resident #144) reviewed for accuracy of MDS coding.	F 641	F 641 ¿483.20 (g) Accuracy of Assessments The MDS assessment will accurately reflect the resident□s status at the time of assessment. Leisure Chateau Care and Rehabilitation Center licensed professional nursing staff	6/29/23

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F 641	Continued From page 24 This deficient practice was evidence by the following: 1. On 05/02/23 at 10:24 AM, the surveyor observed Resident #65 self-propelling in his/her wheelchair from the smoking section on the [redacted] unit to their room. At that time, the surveyor interviewed the resident whose [redacted] was [redacted]. The resident stated that he/she [redacted] and [redacted] for them. The surveyor reviewed the medical record for Resident #65. A review of the resident's Admission Record (an Admission Summary) reflected that the resident had resided at the facility for over [redacted] years and had diagnoses which included but were not limited to [redacted]. A review of the resident's most recent annual MDS, dated [redacted], indicated that the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's cognition was [redacted]. A further review of the resident's MDS, [redacted] - Current [redacted] Use indicated that the resident did [redacted]. A review of the resident's Safe [redacted] Assessment, dated [redacted], indicated that the resident had [redacted],	F 641	who complete the MDS assessments will conduct their assessments which will represent an accurate picture of the resident□s status during the observation period of the MDS. 1. Residents # 65, 104 and 144 were affected by the deficient practice. Resident # 65 was re-assessed and re-evaluated and was noted to have no negative outcomes as a result of the observed deficient practice. Resident # 104 was re-assessed and re-evaluated and was noted to have no negative outcomes as a result of the observed deficient practice. Resident # 144 was re-assessed and re-evaluated and was noted to have no negative outcomes as a result of the observed deficient practice. The following medical records for Residents #65, 104 and 144 were audited and reviewed for accuracy of coding documentation in the area of [redacted] a) Residents # 65, 104 and 144 Safe Smoking Assessments b) Residents # 65, 104, and 144 Care Plans c) Resident # 65 Annual MDS Assessment □ 3/04/23 with Modification [redacted] Resident # 104 Annual MDS Assessment □ [redacted] with Modification [redacted] Resident # 144 Annual MDS Assessment □ [redacted] with Modification [redacted]	

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F 641	Continued From page 25 NJ EX Order. 264b1 and NJ EX Order. 264b1 NJ EX Order. 264b1. The resident's Safe Smoking Assessment further revealed that the resident did not have any physical limitations which could impact NJ EX Order. 264b1 or a history of other NJ EX Order. 264b1 related issues. A review of the resident's Care Plan (CP), initiated on NJ EX Order. 264b1 and revised on NJ EX Order. 264b1, reflected a focus area that the resident was at an increased risk of NJ EX Order. related to NJ EX Order. 264b1. The goal of the resident's CP was that the resident would remain free from injuries from smoking. The interventions in the resident's CP included to monitor clothing for any NJ EX Order. from NJ EX Order. 264b1 during NJ EX Order. 264b1, to use NJ EX Order. 264b1 during NJ EX Order. 264b1 and to monitor NJ EX Order. 264b1 prior to leaving the NJ EX Order. 264b1 On 05/05/23 at 10:44 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was alert, oriented, and could make needs known. The CNA told the surveyor that the resident was a NJ EX Order. 26. On 05/05/23 at 11:05 AM, the surveyor made the Registered Nurse/Minimum Data Set Coordinator (RN/MDSC) aware that section NJ EX Order. M was not filled out correctly. The RN/MDSC stated that she would review the resident's medical record and modify the annual MDS dated NJ EX Order. 264b1 On 05/05/23 at 12:09 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident NJ EX Order. 264b1 NJ EX Order. 264b1 On 05/09/23 at 11:17 AM, the surveyor	F 641	2. All medical records for past year for residents who NJ EX Order. 2 were audited and reviewed to ensure there were no noted coding errors and/or missing documentation in area of NJ EX Order. 264b1 assessments. A listing of all residents who smoke was obtained from the Activity Director and verified by Unit Managers. Auditing included: a) Safe NJ EX Order. 264b1 Assessments b) Care Plans with Focal Area of NJ EX Order. 264b1 with Potential Risk for Injury Related to NJ EX Order. 264b1 c) Admission/Annual/Significant Change MDS□ d) Current listing of residents who smoke and their protective devices e) NJ EX Order. 264b1 Attendant□s NJ EX Order. 26 Logs 3. All professional nursing staff will be re-educated on Safe NJ EX Order. 264b1 Assessments and care planning associated with the focal area of NJ EX Order. 264b1. After completion of the Interdisciplinary Team□s Safe Smoking Assessment, list of smokers and their protective devices will be revised as needed. a) Staff Development Coordinator will re-educate all staff, RNs, LPNs, CNAs, and Activity Staff in reference to Safe NJ EX Order. 264b1 Practices.	

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F 641	Continued From page 26 interviewed the resident's Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that the resident NJ EX Order. 264b1. 2. On 05/08/23 at 10:26 AM, the surveyor interviewed Resident #104. The resident told the surveyor that when he/she came to the facility they were allowed to NJ EX Order. 264b1 times a day, and "few months ago it was changed to twice a day, about six months I think". The surveyor asked if the resident was a NJ EX Order. 264 since being admitted to the facility and the resident replied, "yes". A review of the resident's Admission Record indicated that Resident #104 was admitted to the facility in NJ EX Order. 264b1 Medical diagnoses included, but not limited to, NJ EX Order. 264b1 [redacted] The resident had a Brief Interview of Mental Status of NJ EX Order. 264b1, meaning the resident was NJ EX Order. 264b1. On 05/10/23 at 10:30 AM, the surveyor reviewed the resident CP which showed a focus of NJ EX Order. 264b1, with potential risk NJ EX Order. 264b1 related to NJ EX Order. 264b1 The CP was initiated on NJ EX Order. 26[illegible]. On 05/10/23 at 10:50 AM, the surveyor reviewed Resident #104's annual MDS, dated NJ EX Order. 264b1 Section NJ EX Order., titled "health conditions" was marked zero for NJ EX Order. 264b1, meaning the resident was not a NJ EX Order. 26[illegible]. The surveyor then reviewed the annual MDS dated NJ EX Order. 264b1, section NJ EX Order. 2[illegible] was marked zero for NJ EX Order. 264b1, meaning the resident was not a NJ EX Order. 264b1.	F 641	b) MDS Staff will be re-in-serviced to review the resident's medical record in its entirety including, but not limited to: i. Safe NJ EX Order. 264b1 Assessments ii. Resident's Care Plan iii. Activity's listing of NJ EX Order. 264b1 and their safe NJ EX Order. 264b1 devices. prior to completing on the Annual MDS Assessments Section NJ EX Order. 2[illegible] 4. Director of Nursing or his/her designee will conduct a monthly review for 6 months of five (5) residents' Admission/Annual/Significant Change MDS for those who NJ EX Order. 2[illegible] for accuracy of coding in addition to Safe NJ EX Order. 264b1 Assessments and Care Planning with focal area of NJ EX Order. 264b1 including their safety devices. A. Director of Nursing will report results of the Accuracy of Assessments related to NJ EX Order. 264b1 Coding on Annual/Significant Change MDS QAPI to the Quality Assurance Committee that meets at a minimum on a quarterly basis.	

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F 641	Continued From page 27	F 641		

On 05/10/23 at 11:15 AM, the surveyor interviewed the MDS coordinator regarding Resident #104. The surveyor asked the MDS coordinator how she would find out if a resident was a [redacted]. The MDS coordinator told the surveyor, "We look at documentation, but now we are verbally asking because of the lack of documentation". The surveyor then asked the MDS coordinator to look at Resident #104's annual MDS dated [redacted], section [redacted] the [redacted] section. The MDS coordinator said, "After it was reviewed, a modification was completed for both the annuals from [redacted]. The surveyor asked when the modifications were completed, and the MDS coordinator said, "yesterday [redacted], originally they were done incorrectly but then a modification was done on [redacted]", after surveyor inquiry.

3. On 05/02/23 at 01:07 PM, the surveyor observed Resident #144 returning from the [redacted] area and was sitting in his/her room with a blanket over their head seated in a wheelchair. Resident #144 confirmed with the surveyor that he/she was a [redacted] but did not want to talk any further.

The surveyor reviewed the medical record for Resident #144.

On 05/02/23 at 01:37 PM, a review of the resident's Admission Record (an Admission Summary) reflected that the resident was admitted [redacted] and had diagnoses which included but were not limited to [redacted],

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NJ EX Order. 264b1 .

On 05/12/23 at 12:53 PM, a review of the resident's most recent annual MDS, dated [NJ EX Order. 264b1], indicated that the resident had a Brief Interview for Mental Status score of [NJ EX Order. 264b1] which indicated the resident's [NJ EX Order. 264b1] A further review of the resident's MDS, Section [NJ EX Order.] under Current [NJ EX Order. 264b] Use was coded [NJ E] and indicated that Resident #144 was not identified as a [NJ EX Order. 26] on the MDS, which was coded incorrectly.

At that same date and time, the surveyor reviewed the resident CP which showed a focus of [NJ EX Order. 264b], with potential risk for [NJ EX Order.] related to [NJ EX Order. 264b]. The CP was initiated on [NJ EX Order. 264b].

On 05/12/23 at 11:05 AM, the surveyor interviewed the Social Worker (SW) in the MDS Coordinator's absence and made the SW aware that Section [NJ EX Order.] of the MDS did not identify Resident #144 as a [NJ EX Order. 26] and was not coded correctly. The SW confirmed the MDS was initially not coded correctly but provided the surveyor with a copy of the modified annual MDS dated [NJ EX Order. 264b].

A review of CMS RAI Version 3.0 Manual, Section [N] - Health Conditions indicated in [NJ EX Order. 2] Current [NJ EX Order. 264b] Use, that the negative effects of [NJ EX Order. 264b] can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life. In planning for care, this item opens the door to negotiation of a plan of care with the resident that includes support for NJ EX Order. 264b1. If [NJ EX Order. 264b] is declined, a care plan that allows safe and

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F 641	Continued From page 29 environmental accommodation of resident preferences is needed. Facility staff is to conduct an assessment and ask the resident if he or she used tobacco in any form during the seven (7) day look-back period. If the resident states that he or she used [redacted] in some form during the 7-day look-back period, code 1, yes. If the resident is unable to answer or indicates that he or she did not use [redacted] of any kind during the look-back period, review the medical record and interview staff for any indication of [redacted] use by the resident during the look-back period. Coding Instructions indicated to code "0" for no, indicating the resident did not [redacted] and "1" for yes, indicating that the resident did smoke. NJAC 8:39-11.2(e)1	F 641		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §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	F 688		6/29/23

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F 688	Continued From page 30 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to apply a physician ordered [redacted] device to a resident with contractures. This deficient practice was identified for 1 of 2 residents' (Resident #41) reviewed for position and mobility and was evidenced by the following: On 05/02/23 at 11:00 AM, during the initial tour of the facility Resident #41 was observed out of bed in the room in a reclining chair. The residents [redacted] appeared contracted, and the surveyor did not observe a [redacted] or [redacted]. Review of the Admission Record indicated that Resident #41 was admitted to the facility on 06/28/18. Medical diagnoses included, but were not limited to traumatic [redacted] The surveyor reviewed the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] which showed the residents Brief Interview of Mental Status was "incomplete" due to [redacted]. On 05/02/23 at 11:46 AM, the surveyor reviewed the physician orders which revealed the following active order dated [redacted] patient will tolerate wearing a [redacted] on [redacted] for improved [redacted] and decrease risk [redacted] for [redacted] hours in the morning and [redacted] hours in the afternoon. [redacted] checks in between [redacted]	F 688	Leisure Chateau Care and Rehabilitation Center failed to apply a physician ordered splinting device to a resident with contractures. 1. Resident # 41 was affected by the deficient practice. Upon being made aware that the [redacted] was not applied to resident #41, The Nurse re-applied the hand splint for Resident #41. Between [redacted] and [redacted] the Staff educator in-serviced the nursing staff, RN's LPN's and CNA's regarding the application and removal of [redacted] of Resident #41 as well as all other residents. RN's and LPN's were re-educated as well on following physician orders. The nurse who signed for the [redacted] was disciplined. Resident #41 was re-assessed and re-evaluated and was noted to have no negative outcomes as a result of the observed deficient practice. The following medical records for Resident #41 were audited and reviewed for any signs of worsening contractures: a) Physician order for a right resting hand splint b) Treatment Administration Record (TAR) for splint donning and doffing c) Certified Nursing Assistant (CNA) Assignment Sheet for splinting d) Physical/Occupational Therapy Evaluations e) MDS f) Restorative Nursing Program (RNP) Progress Notes	

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F 688	Continued From page 31 On 05/02/23 at 11:54 AM, the surveyor reviewed the Treatment Administration Record (TAR), the splint was signed as applied for NJ EX Order. 264b1 for the morning shift. On 05/03/23 at 09:40 AM, the surveyor reviewed the care plan which showed the following focus: I will maintain current level of physical and functioning abilities. The care plan included the following intervention "regarding NJ EX Order. 264b1 : o NJ EX Order. 264b1 . The care plan was initiated NJ EX Order. 264b1 On 05/03/23 at 09:53 AM, the surveyor reviewed the residents TAR. The order for the NJ EX Order. 264b1 being applied was signed by the nurse as being completed, meaning the NJ EX Order. 264b1 was applied on the resident. On 05/03/23 at 11:24 AM, the surveyor observed Resident #41 in the room in a NJ EX Order. 264b2 chair. The surveyor did not observe a NJ EX Order. to the residents NJ EX Order. 264b1 . On 05/03/23 at 12:13 PM, the surveyor reviewed the most recent MDS a quarterly assessment tool dated NJ EX Order. 264c Under NJ EX Order. 264b2 titled functional status, it indicated that the resident had NJ EX Order. 264b1 . On 05/04/23 at 09:49 AM, the surveyor reviewed the TAR. The TAR was signed for NJ EX Order. 264b1 NJ EX Order. 264b1 as if it was applied on the resident. On 05/04/23 at 09:55 AM, the surveyor observed the resident in the room in a NJ EX Order. 264b chair. The resident did not have a NJ EX Order. 264 the NJ EX Order. 264b1	F 688	g) Care Plan 2. All residents who are admitted to Leisure Chateau without limited NJ EX Order. 264b have a potential to be affected by this deficient practice, thereby experiencing a reduction in NJ EX Order. 264b . All residents that are admitted with limited NJ EX Order. 264b1 can be affected by this deficient practice thereby developing a further decline in NJ EX Order. 264b All residents with physician ordered NJ EX Order. 264b devices with contractures requiring NJ EX Order. 264b devices was audited. a) A Point Click Care recapitulation of NJ EX Order. 264b orders was reviewed and audited for orders including: i. Application time of NJ EX Order. and duration of use ii. Removal time of NJ EX Or iii. NJ EX Orde checks before NJ EX Order. 264 and after NJ EX Order. 2 b) All physician ordered NJ EX Order. 264b devices to a resident with NJ EX Order. 264b1 requiring NJ EX Order. 264 with comprehensive physician orders were accurately plotted on the TAR c) Restorative Nursing Progress (RNP) Notes were audited and reviewed to ensure there were no noted decline and/or worsening in NJ EX Order. 264b1 . 3. On 6/29/2023, The staff Educator re-educated All professional nursing staff on NJ EX Order. 264b1 Management and	

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	315190	A. BUILDING _____ B. WING _____	C 05/12/2023

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F 688	Continued From page 32 NJ EX Order. 264b1 On 05/04/23 at 10:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) caring for Resident #41 regarding the signed TAR as the NJ EX Order was applied. In the presence of the surveyor the nurse viewed the residents TAR. The section for the right NJ EX Order. 264b1 was reviewed by the surveyor and the LPN. The surveyor asked if it was signed did it mean the NJ EX Order was applied and the LPN stated " yes, it's on, we can go look now". The surveyor entered the room in the presence of the LPN and the NJ EX Order was not on the resident. The surveyor then observed the LPN look in the resident's nightstand drawer and reach to the back of the drawer to retrieve the NJ EX Order. The LPN said, "there it is, it should be on", and proceeded to get the help of a Certified Nursing Assistant (CNA) to apply the NJ EX Order On 05/08/23 at 12:24 PM, the surveyor reviewed the policy titled, NJ EX Order(NJ EX Order. 264b1 Devices" dated January 2022. The policy sated that NJ EX Order. 2 adaptive devices are to be applied as ordered by the physiatrist, attending physician, or nurse practitioner. Under number 12 of the procedure section of the policy, it indicated nursing will document NJ EX Order application and or removal of the NJ EX Order. 2 on the residents Treatment administration record. Number 13 indicated that nursing will discuss with therapy and/or Medical Doctor if the resident refuses the NJ EX Order. 2NJ EX Order. 3devices. On 05/12/23 at 10:31 AM, the surveyor met with the Director of Nursing (DON). The DON told the surveyor that the nurse who was caring for Resident #41 told me, "She did not put the NJ EX Order	F 688	reporting to therapy if a contracture or decline in NJ EX Order. 264b1 develop and the importance of following physician orders. a) Staff Development Coordinator re-educated all RNs, LPNs and CNAs in reference to: i. NJ EX Order. 26 Adaptive Devices Policy and Procedure ii. NJ EX Order. 264b1 Management/declines in NJ EX Order. iii. Application and Removal of NJ EX Order. 264b1 Devices 4. Director of Nursing or his/her designee will: a) Conduct a monthly review for 6 months of RNP Monthly Progress Notes after the monthly RNP Meeting which reviews the: i) Recommendations for continuation of program, ii) Decline or no decline noted, iii) Changes to plan iv) Verification of physician order(s), v) Review of RNP Care Plan. b) Director of Nursing or his/her designee will conduct two (2) weekly observations for 2 months and then two (2) monthly observations for an additional 4 months of applications of a NJ EX Order on a resident to include: i. NJ EX Order. 264b1 with time of observation	

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F 688	Continued From page 33 on, she was very anxious". The DON told the surveyor that the resident will be reassessed by physical therapy to ensure that there was "no negative affect by not wearing the [redacted] ". NJAC 8:39-27.1 (a)	F 688	ii. TAR documentation iii. Point Click Care (PCC) health status notes if applicable iv. Review of monthly RNP Notes post conference to note if decline noted c) Director of Nursing will report results of the Increase/Prevent Decrease in ROM AUDIT/QAPI to the Quality Assurance Committee that meets at a minimum on a quarterly basis. Effective Date: June 29, 2023	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation it was determined, that the facility failed to provide a resident who was a [redacted] r with a [redacted] [redacted] This deficient practice was identified for one (1) of five (5) residents, (Resident #65), reviewed for safe [redacted] practices and was	F 689	1. Resident # 65 was affected by the deficient practice. Upon being made aware that resident #65 did not have a [redacted] on while [redacted] the Activities Director re-educated the smoke room staff to	6/29/23

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F 689	Continued From page 34 evidenced by the following: On 05/02/23 at 10:24 AM, the surveyor observed Resident #65 self-propelling in his/her wheelchair from the [redacted] section on the [redacted] unit to their room. At that time, the surveyor interviewed the resident whose [redacted] was [redacted]. The resident stated that he/she [redacted] and the staff held his/her [redacted] and for them. On 05/05/23 at 10:17 AM, the surveyor observed Resident #65 seated in his/her wheelchair in the outside [redacted] section on the [redacted] unit with the [redacted] attendant present. The surveyor observed the resident appropriately holding his/her [redacted]. The cigarette had a [redacted]) attached to it. The surveyor observed the resident was [redacted], resting his/her [redacted] on their [redacted]. The [redacted] was observed positioned in front of the resident's body. The surveyor did not observe a [redacted] worn by the resident. At that time, the surveyor conducted an interview with the resident who told the surveyor that he/she always used the [redacted] and never wore the [redacted]. On 05/05/23 at 10:20 AM, the surveyor interviewed the [redacted] attendant who stated that Resident #65 never wore a [redacted], just the [redacted]. The [redacted] attendant then showed the surveyor a piece of paper which included a list of the resident's names who [redacted] on the unit. The surveyor reviewed the piece of paper in the presence of the [redacted] attendant. Next to the list of the resident's names who [redacted], was a second list of identifiers for	F 689	ensure that resident #65 has a [redacted] on while [redacted] Resident #65 has been provided with the [redacted] and has been wearing it while [redacted] Resident # 65 was re-assessed and re-evaluated and was noted to have no negative outcomes as a result of the observed deficient practice. [redacted] Room List for Resident #65 was audited and reviewed for accuracy of protective devices in the area of [redacted]: a) Residents # 65 Safe [redacted] Assessments b) Residents # 65 Care Plans 2. All residents who are approved to [redacted] in Leisure Chateau can be affected by this deficient practice. The [redacted] Room List of residents who [redacted] was audited and reviewed to ensure there were no noted errors and/or missing documentation in the area of [redacted] assessments. A list of all residents who smoke was obtained from the Activity Director and verified by Unit Managers. Auditing included: a) Safe Smoking Assessments b) Care Plans with Focal Area of [redacted] with Potential Risk for Injury Related to [redacted] c) Current listing of residents who	

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F 689	Continued From page 35 residents who NJ EX Order. 264b1 and residents who were required to utilize an NJ EX Order. 264b1. Resident #65's name was included under the list of names for residents who were required to wear an NJ EX Order. 264b1. The surveyor asked the NJ EX Order. 264b attendant, "How do you know which residents wear the NJ EX Order or the NJ EX Order. 264b?" The NJ EX Order. 264b attendant stated that the resident had always just used the NJ EX Order. 264b The surveyor reviewed the medical record for Resident #65. A review of the resident's Admission Record (an Admission Summary) reflected that the resident had resided at the facility for over NJ EX Order. 264b1 and had diagnoses which included but were not limited to NJ EX Order. 264b1 A review of the resident's most recent annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ EX Order. 264b1 indicated that the resident had a Brief Interview for Mental Status score of NJ EX Order. 264b1 which indicated that the resident's cognition was NJ EX Order. 264b1 A review of the resident's Safe NJ EX Order. 264b1 Assessment, dated NJ EX Order. 264b1 indicated that the resident had NJ EX Order. 264b1. The resident's Safe NJ EX Order. 264b1	F 689	NJ EX Order. 2 and their protective devices d) NJ EX Order. 264b1 Attendant□s Smoke Logs 3. The Activities staff were re-educated on safe NJ EX Order. 26 assessments and protective devices. After completion of the Interdisciplinary Team□s Safe NJ EX Order. 264b1 Assessment, a list of smokers and their protective devices will be revised as needed. Activities Director re-educated all Activity Staff regarding adequate supervision, assistance devices to prevent accidents, and continued safe NJ EX Order. 264b1 practices. Activities Director will conduct a monthly audit/review for 6 months of five (5) residents who NJ EX Order. 26 for Safe NJ EX Order. 264b1 Assessments and Care Planning with focal area of smoking including protective devices. The Activities Director will report audit results related to the completed Safe NJ EX Order. 264b1 QAPI to the Quality Assurance Committee that meets at a minimum on a quarterly basis.	

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F 689	Continued From page 36	F 689		

Assessment further revealed that the resident did not have any physical limitations which could impact [redacted] or a history of other [redacted] related issues. The Safe [redacted] Assessment indicated that the resident required a [redacted] and [redacted] while [redacted].

A review of the resident's Care Plan (CP), revised on [redacted] reflected a focus area that the resident was at an increased risk of injury related to [redacted]. The goal of the resident's CP was that the resident would remain free from injuries from [redacted]. The interventions in the resident's CP included to monitor clothing for any [redacted] to wear a NJ EX Order. 264b1 during [redacted] to use NJ EX Order. 264b1 during [redacted], and to monitor NJ EX Order. 264b1 prior to leaving the [redacted] area. The resident's CP did not indicate that facility staff observed [redacted] in the resident's [redacted], that the resident had a history of being NJ EX Order. 264b1 or had dropped the [redacted] on himself/herself while [redacted]

On 05/05/23 at 10:30 AM, the surveyor interviewed the resident's Nursing Assistant (NA) who stated that she worked at the facility since [redacted] and always shared an assignment and performed care with a Certified Nursing Aide (CNA) present. The NA stated that the resident was [redacted] and had never showed signs of [redacted] when she cared for him/her. The NA further stated that she got the resident up and dressed in the morning so the resident could go outside and NJ EX Order. 264b1. The NA stated that she would bring the resident to the [redacted] and the [redacted] attendant was responsible for supervising the area. The NA told the surveyor that the resident could feed

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F 689	Continued From page 37	F 689		

himself/herself and to her knowledge the resident had never dropped a [redacted].

On 05/05/23 at 10:44 AM, the surveyor interviewed the resident's CNA who stated the resident was [redacted], and could [redacted]. The CNA explained that the resident was a [redacted], and she was unsure if the resident was required to wear a [redacted] because the [redacted] attendant who worked for the recreation department was always outside supervising. The CNA further stated that to her knowledge, the resident never [redacted] himself/herself while [redacted].

On 05/05/23 at 12:09 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident was [redacted], and a very nice person. The LPN further stated that the resident [redacted] and had never burned himself/herself while [redacted].

On 05/09/23 at 10:24 AM, the surveyor interviewed the Director of Activities (DOA) who stated that the facility had [redacted]) separate [redacted] locations and the residents were monitored twice daily during the scheduled [redacted] times by the [redacted] attendant. The DOA told the surveyor that the times were scheduled so the [redacted] attendant could observe and help all the residents who [redacted] at the facility.

On 05/09/23 at 11:17 AM, the surveyor interviewed the resident's Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that the [redacted] attendant was responsible for making sure the residents were provided with [redacted]

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F 689	Continued From page 38 NJ EX Order. 264b1 and NJ EX Order. 264b1 as a safety precaution. The LPN/UM stated that Resident #65 had never NJ EX Order. 264b1 himself/herself while NJ EX Order. 264b1 and the NJ EX Order. 264b1 was an additional intervention to protect the resident. A review of the facility's NJ EX Order. 264b1 room document, revised 05/01/23, indicated that Resident #65 was to wear an NJ EX Order. 264b1 and an NJ EX Order. 264b1 while NJ EX Order. 264b1. A review of the facility's NJ EX Order. 264b1 Room Policy," revised 05/23, indicated, "7. Safety is the number one priority; NJ EX Order. 264b1 and/or NJ EX Order. 264b1 NJ EX Order. 264b1 will be offered to all patients/residents who NJ EX Order. 264b1 and provided to those patients/residents who have the potential to NJ EX Order. 264b1 and/or NJ EX Order. 264b1 secondary to their disease process (i.e. NJ EX Order. 264b1 and/or NJ EX Order. 264b1 NJ EX Order. 264b1. These NJ EX Order. 264b1 will also be provided to any resident who request to use it. 8. NJ EX Order. 264b1 NJ EX Order. 264b1 will be monitored by the NJ EX Order. 264b1 attendant to be in good condition." NJAC 8:39-27.1(a)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		6/29/23

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F 690	Continued From page 39 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation it was determined that the facility failed to appropriately store an NJ EX Order. 264b1 NJ EX Order. 264b1 in a manner to prevent against infection. This deficient practice was identified for one (1) of 1 resident, (Resident #4) reviewed for NJ EX Order. 264b1 care. This deficient practice was evidenced by the following:	F 690	Leisure Chateau Care and Rehabilitation Center failed to appropriately store an NJ EX Order. 264b1 in a manner to prevent against infection. 1. Resident # 4 was affected by the deficient practice. Resident # 4 was re-assessed and re-evaluated and was noted to have no negative outcomes because of the observed deficient practice. The NJ EX Order. 264b1 for resident #4 was discarded and a new	

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F 690	Continued From page 40 On 05/02/23 at 11:10 AM, the surveyor entered Resident #4's vacant room and observed a NJ EX Order. 264b1 attached the resident's bed frame. The NJ EX Order. 264b1 was empty. The surveyor knocked on the door to the resident's unoccupied bathroom and observed a plastic bag tied to the handrail in the bathroom. Inside of the plastic bag, the surveyor observed an NJ EX Order. 264b1 with a NJ EX Order. 264b1 attached to the end of the NJ EX Order. 264b1 The NJ EX Order. 264b1 was dated NJ EX Order. 264b1 On 05/03/23 at 12:25 PM, the surveyor entered Resident #4's vacant room and observed an empty NJ EX Order. 264b1 attached to the resident's bed frame. The surveyor then entered the resident's unoccupied bathroom and observed a plastic bag tied to the handrail in the bathroom. Inside of the plastic bag, the surveyor observed an NJ EX Order. 264b1. The NJ EX Order. 264b1 to the NJ EX Order. 264b1 r was NJ EX Order. 264b1 and in direct contact with the plastic bag. The NJ EX Order. 264b1 bag was dated NJ EX Order. 264b1. On 05/04/23 at 12:13 PM, the surveyor entered Resident #4's unoccupied bathroom and observed the resident's NJ EX Order. 264b1 stored inside of the plastic bag attached to the handrail in the resident's bathroom. The NJ EX Order. 264b1 to the NJ EX Order. 264b1 NJ EX Order. 264b1 was observed to be NJ EX Order. 264b1 and in direct contact with the plastic bag. The surveyor further observed NJ EX Order. 264b1 inside of the NJ EX Order. 264b1. The NJ EX Order. 264b1 was dated NJ EX Order. 264b1.	F 690	NJ EX Order. 264b1 was placed. Staff were instructed between 5/8/2023 and 5/11/2023 not to re-use any NJ EX Order. 264b1 for resident #4 and to follow a "One and Done" procedure only. The following medical records for Resident # 4 were audited and reviewed for any signs and symptoms of a NJ EX Order. 264b1 since NJ EX Order. 264b1: a) Hospital Admission Records of NJ EX Order. 264b1 admitted with NJ EX Order. 264b1 r secondary to obstructive NJ EX Order. 264b1 for which he refused NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 b) NJ EX Order. 264b1 Consults- NJ EX Order. 264b1 inserted 1 NJ EX Order. 264b1 8 secondary to recurrence of NJ EX Order. 264b1 NJ EX Order. 264b1 c) Lab Results- NJ EX Order. 264b1 2. All residents with NJ EX Order. 264b1 and NJ EX Order. 264b1 were audited and reviewed to ensure: a) Type of NJ EX Order. 264b1 and diagnosis for NJ EX Order. 264b1 usage b) There were no NJ EX Order. 264b1 NJ EX Order. 264b1 secondary to transfer of NJ EX Order. 264b1 NJ EX Order. 264b1 c) NJ EX Order. 264b1 NJ EX Order. 264b1 were changed and stored in a manner to prevent against infection. 3. a) The NJ EX Order. 264b1 Care Policy & Procedure has been revised to reflect	

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F 690	Continued From page 41 On 05/04/23 at 12:18 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was [redacted] and [redacted] with NJ EX Order. 264b1. The CNA stated that he changed the resident's NJ EX Order. 264b1 NJ EX Order. 264b1 to a [redacted] every morning and that he would empty the NJ EX Order. 264b1 [redacted] after use and store the bag that the resident wore at night in a plastic bag in the resident's bathroom. The surveyor asked the CNA if he NJ EX Order. 264b1 on the [redacted] The CNA stated that he would put the [redacted] on the [redacted] "sometimes" and the purpose for putting the [redacted] on the [redacted] was so the [redacted] would not leak and that it would have been protected against contamination. The CNA further stated that he had cared for the resident during the 7:00 AM - 3:00 PM day shift the day before [redacted] On 05/04/23 at 12:22 PM, the surveyor entered the resident's bathroom with the CNA. The CNA put on a pair of gloves in the presence of the surveyor, touched, and observed the resident's NJ EX Order. 264b1 and confirmed that the [redacted] to the [redacted] ag was [redacted] At that time the CNA stated, "the [redacted] should have been [redacted]." On 05/04/23 at 12:24 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that she was not very familiar with the resident. The LPN further stated that the resident was NJ EX Order. 264b1 with [redacted], could make needs known, and ask for help. The LPN told the surveyor that the staff performed [redacted] r care for the resident and that the resident had a NJ EX Order. 264b1 ([redacted]	F 690	that NJ EX Order. 264b1 are not to be re-used. All NJ EX Order. 264b1 Bags are to be discarded after use. b) On 6/29/2023 Staff Development Coordinator with the assistance of the Infection Preventionist completed an inservice, re-educating All professional nursing staff, RNs, and LPNs/Certified Nursing Assistants (CNAs) on Care of NJ EX Order. 264b1. The In-service included: i. NJ EX Order. 264b1; revised NJ EX Order. 264b1 Policy and Procedure, which specifies that NJ EX Order. 264b1 are not to be re-used. ii. [redacted] Care iii. NJ EX Order. 264b1 - Signs and Symptoms 4. Infection Preventionist or his/her designee will conduct a monthly audit for 3 months of ALL residents with [redacted] who change to [redacted]. Infection Preventionist or his/her designee will conduct a monthly audit for an additional 3 months of 4 randomly selected residents with NJ EX Order. 264b1 who change to [redacted]. A. The audit sheet will monitor: a) Date b) Resident c) Date on NJ EX Order. 264b1 d) NJ EX Order. 264b1 e) Appearance of NJ EX Order. 264b1 f) Date on NJ EX Order. 264b1 Securing Device	

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	315190	A. BUILDING _____ B. WING _____	C 05/12/2023

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F 690	Continued From page 42 NJ EX Order. 264b1 NJ EX Order. 264b1 that is used to NJ EX Order. 264b1 from the NJ EX Order. 264b1 for NJ EX Order. 264b1 (a condition where NJ EX Order. 264b1 NJ EX Order. 264b1 or at all when you NJ EX Order. 264b1. The LPN stated that she thought "maybe" the NJ EX Order. 264b1 to the NJ EX Order. 264b1 NJ EX Order. 264b1 should have a NJ EX Order. 264b1 on it. 05/04/23 12:28 PM, the surveyor entered the resident's bathroom and observed the indwelling NJ EX Order. 264b1 in the presence of the LPN. The LPN stated that she did not see a NJ EX Order. 264b1 on the NJ EX Order. 264b1 and was unsure if the NJ EX Order. 264b1 needed one because she had never seen one on them before. On 05/04/23 at 12:30 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the NJ EX Order. 264b1 NJ EX Order. 264b1 came with a NJ EX Order. 264b1. The LPN/UM further stated that if the NJ EX Order. 264b1 was not on the NJ EX Order. 264b1 NJ EX Order. 264b1 while it was being stored and not in use, then the NJ EX Order. 264b1 should be thrown away and the staff would be required to utilize a new NJ EX Order. 264b1 for the resident. On 05/04/23 at 12:33 PM, the surveyor entered the resident's bathroom with the LPN/UM. The LPN/UM observed, in the presence of the surveyor, that the NJ EX Order. 264b1 was dated NJ EX Order. 264b1 and was uncapped. At that time the LPN/UM stated that the NJ EX Order. 264b1 should have been placed on the NJ EX Order. 264b1 for infection control purposes. On 05/04/23 at 2:04 PM, the surveyor interviewed the Licensed Practical Nurse/Infection	F 690	g) Comments B. Director of Nursing will report results of the NJ EX Order. 264b1 NJ EX Order. 264b1 Audits/QAPI to the Quality Assurance Committee that meets at a minimum on a quarterly basis.	

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F 690	Continued From page 43	F 690		

Preventionist (LPN/IP) who stated that sometimes the NJ EX O would go at the end of the indwelling NJ EX Order. 264b1 when the NJ EX O was not in use. The LPN/IP stated that the facility's practice was to change out the NJ EX Order. 264b1 weekly and store the NJ EX O in a plastic bag when not in use. The LPN/IP told the surveyor that the purpose of the NJ EX O was to prevent "anything" from getting inside the NJ EX Order. that could have potentially caused an infection.

On 05/04/23 at 02:16 PM, the surveyor interviewed the LPN/IP who stated that Resident #4 had not had a history of a NJ EX Order. 264b1 NJ EX Order. 264 in the last four (4) months.

On 05/05/23 at 11:15 AM, the surveyor observed Resident #4 walk with a cane into the NJ EX Order. 264b section on the unit. The resident was observed wearing loose, long pants. The surveyor interviewed the resident who stated that the CNAs helped him/her with the care of his/her NJ EX Order. 264b. The resident further stated that he/she could not remember the last time they had a NJ EX Order. 264b1.

On 05/09/23 at 09:01 AM, the surveyor conducted a follow up interview with the LPN/IP who stated that moving forward, the facility was going to dispose of the NJ EX Order. 264b1 bags and NJ EX Order. 264b1 bags after each use. The LPN/IP further stated that the instructions for NJ EX Order. 264b1 and the NJ EX Order. 26 indicated to dispose of the bags after one use to prevent against microbial growth within the NJ EX Order. 264b1.

The surveyor reviewed the medical record for Resident #4.

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A review of the resident's Admission Record (an Admission Summary) reflected that the resident had resided at the facility for over NJ EX Order. 264b1 and had diagnoses which included but were not limited NJ EX Order. 264b1).

A review of the resident's most recent annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ EX Order. 264b1, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of NJ EX out of NJ EX which indicated that the resident was NJ EX Order. 264b1 t. A further review of the resident's MDS, NJ EX Order. 264b1 reflected that the resident had an NJ EX Order. 264b1 NJ EX Order. 264

A review of the resident's NJ EX Order. 264b1 Order Summary Report (OSR) reflected a Physician's Order (PO) dated NJ EX Order. 264b1 to change NJ EX Ord weekly. Date and initial device. Rotate application site every night shift on NJ EX Order. 264b1 for protection. A further review of the NJ EX Order. 264b1 OSR did not reveal a PO for changing the NJ EX Order. 264b1 to a NJ EX Order. 264b1 daily or for the storage of the NJ EX Order. 264b1 .

A review of the NJ EX Order. 264b1 Medication Administration Record (MAR) did not reflect that nurses were signing that the resident's NJ EX Order. 264b1 was changed to a NJ EX Order. 264 daily or for the storage of the NJ EX Order. 264b1

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NJ EX Order. 264b1

A review of the NJ EX Order. 264b1 Treatment Administration Record (TAR) indicated that on NJ EX Order. 264b1 the nurses signed on the night shift that the resident's NJ EX Order. 264b1 device was changed for prevention. A further review of the NJ EX Order. 264b1 did not reveal that the nurses were signing that the resident's NJ EX Order. 264b1 was changed to a NJ EX Order. 26 daily or for the storage of the NJ EX Order. 264b1 NJ EX Order. 264b1.

A review of the resident's Care Plan (CP), revised on NJ EX Order. 264b1 indicated a focus area that the resident had potential for NJ EX Order. 264b1 and NJ EX Order. 264b1 The goal of the resident's CP was that the resident's NJ EX Order. 264b1 would remain intact and the resident would be free from signs and symptoms of a NJ EX Order. 264b1. The interventions in the resident's CP included to provide proper NJ EX Order. 264b1, monitor NJ EX Order. 264b1 for signs and symptoms of infection during routine care, ensure NJ EX Order. 264b1, change NJ EX Order. 264b1 weekly, and NJ EX Order. every shift.

A review of the facility's, NJ EX Order. 264b1 NJ EX Order. 264b1 Policy and Procedure," dated 05/04/23, indicated that every attempt should be used to maintain a NJ EX Order. 264b1. The Policy and Procedure further indicated to change NJ EX Order. 264b1 when NJ EX Order. 264b1 was changed and when changing from a NJ EX Order. 26 to a NJ EX Order. 26 as ordered by physician. The Policy and Procedure instructed staff to use a new NJ EX Order. 264b1 every time the NJ EX Order. 264b1 was NJ EX Order. 26 NJ EX Order. 264b1 the NJ EX O

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F 690	Continued From page 46 with the date and the resident's room number, discard the used NJ EX Orde do not wash, or disinfect NJ EX Order. 264b1 to reuse them. NJAC 8:38-27.1(a)	F 690		
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 and review of medical records and other pertinent facility documentation it was determined that the facility failed to assure that a resident received oxygen as ordered by the physician. This deficient practice was identified for 1 of 3 residents (Resident #25) reviewed for respiratory care and was evidenced by the following: According to the Admission Record, Resident #25 was admitted to the facility with the diagnoses which included but was not limited to NJ EX Order. 264b1 [redacted] The quarterly Minimum Data Set (MDS-an assessment tool utilized to facilitate the care of a resident), dated NJ EX Order. 264b1, indicated that the resident was NJ EX Order. 264b1 and required NJ EX Order. 264b1 with activities of daily living.	F 695	1. Resident # 25 was affected by the deficient practice; Resident #25 was provided with a NJ EX Order. 264b1 and nurse made sure that resident was comfortable. Resident #25 uses an O2 concentrator at night and switches to a NJ EX Order. 264b1 in the morning when leaving resident room. Staff on the unit were educated to make sure that when resident #25 is ready to leave resident room in the morning that the NJ EX Orde be filled immediately prior to that. Resident # 25 was re-assessed and re-evaluated and was noted to have no negative outcomes as a result of the observed deficient practice of failure to assure that a resident received NJ EX Order. 26 as ordered by the	6/30/23

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F 695	Continued From page 47 The MDS also indicated that the resident was on [redacted]. On 05/02/23 at 10:20 AM, the surveyor was conducting a tour on the [redacted] Unit and observed Resident #25 in their room and was being administered [redacted]. The surveyor observed that the [redacted] was hooked up to a [redacted] that was located on the back of the resident's chair. The [redacted] reading indicated that the [redacted] was empty. Resident #25 was not in any [redacted]s and there was no evidence that he/she was [redacted]. The resident was observed moving about the room in the wheelchair. Resident #25 was interviewed at this time, and he/she indicated that he/she could not feel the [redacted] coming through the [redacted] and did not know when the [redacted] was last filled with [redacted]. On 05/02/23 at 10:57 AM, the surveyor reviewed the Resident's Physician Order Summary (POS) which reflected orders for: - [redacted] and may titrate to maintain [redacted] or greater every shift. -Check [redacted] placement/integrity every shift for [redacted]. The surveyor reviewed the Treatment Administration Record (TAR) dated [redacted] which reflected a physician's order for [redacted] and may [redacted] or greater every shift and [redacted]	F 695	physician. The order for [redacted] to maintain [redacted] or greater every shift on both the physician order sheet (POS) and Treatment Administration Record (TAR) of Resident # 25 along with [redacted] surveillance and respiratory assessments every shift was audited and reviewed. No complaints of shortness of breath and/or respiratory difficulty reported, BIMS [redacted] Resident # 25 did not exhibit any [redacted] nor was there any evidence of resp [redacted] infection. 2. All residents using [redacted] outside of their rooms which is changed to a [redacted] may be affected. A listing of all residents receiving [redacted] was obtained from Specialty Rx and compared to both facility acuity listing and CMS 672. All identified resident's physician order sheets (POS) for [redacted] orders and TARs were audited and reviewed to ensure there were no discrepancies amongst the [redacted] treatment orders including [redacted] 3. All professional nursing staff were re-educated between June 25th and June	

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F 695	Continued From page 48 NJ EX Order. 264b1) and NJ EX Order. 264b1 placement/integrity every shift for NJ EX Order On 05/02/23 at 11:36 AM, the surveyor interviewed the Registered Nurse (RN) who stated that she had been employed in the facility for the last NJ EX years. The RN stated Resident # 25 had been on routine NJ EX Order. 264b1 for quite some time. She explained that she had not yet checked the resident's portable NJ EX Order. 264b1 that was hanging on the back of the resident's wheelchair. The surveyor asked the RN who was responsible to assure that the NJ EX Order. 264b1 t NJ EX O was NJ EX Order. 264b1, and she explained that the Certified Nursing Assistant (CNA) was responsible to assure that the NJ EX Order. 264b1 was NJ EX Order. The RN accompanied the surveyor to the resident room, and she confirmed that the NJ EX Order. 264b1 was empty, and that the resident was not receiving the NJ EX Order 30 that was ordered by the physician. On 05/02/23 at 11:43 AM, the surveyor interviewed the CNA who was caring for Resident #25. The CNA stated that she thought that the resident was on the NJ EX Order. 264b1 that was in the resident's room and did not realize that the resident was on the NJ EX Order. 264b1 that was on the resident's wheelchair. She stated that she did not know that the resident's NJ EX Order. 264b1 was empty, and that the resident was not receiving the NJ EX that was ordered by the physician. The CNA stated that the nurses and the CNAs were responsible to assure that the NJNJ EX Order. 2 NJ EX Order. 264b1 was filled with NJ EX. She stated that the resident would usually tell her that the tank was empty, but the resident did tell her anything that morning.	F 695	30th on adherence to policy and procedure for NJ EX Order. 264 Administration and NJ EX Order. 264b1 specifically how to read the measurements for full and empty. ALL CNA's were re-educated at that time as well via a NJ EX Order. 264b1 Fill Competency exam to ensure that they are competent in filling the NJ EX Order. 264b1. a) Staff Development Coordinator educated all professional nursing staff-RNs, LPNs and CNAs on: i. NJ EX Order. 264b1 and NJ EX Order. 264b1 including the transference from the NJ EX Order. 26 NJ EX Order. 264b1 usage in room to a NJ EX Order. 264b1 for outside of room usage. ii. All CNAs were re-educated on reporting any changes to the nurses regarding any changes or actions of their residents which may affect their plans of care. iii. All CNAs have been determined to be and will continue to be clinically competent in usage of and procedure for NJ EX Order. 264b1 of a NJ EX Order. 264b1 unit. 4) A. Director of Nursing or his/her designee will randomly select three (3) residents who transfer to a NJ EX Order. 264 weekly for 1 month and then monthly for an additional 5 months to determine whether the: a) Prescribed NJ EX Order. 264b1 NJ EX O is consistent to what the resident is receiving; b) NJ EX Order. 264b1 has sufficient	

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F 695	Continued From page 49 On 05/03/23 at 11:43 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that Resident # 25 usually used the NJ EX Order: 264b1 while in the room and utilized the NJ EX Order. 264b1 when out of the room. She stated that the CNA's were responsible to check the NJ EX Order. 264b1 every couple hours to make sure they were filled. She explained that the nurses and the CNAs did not have to sign any paperwork that indicated that they were checking the portable NJ EX Order 264 to assure that it was filled with NJ EX. On 05/03/23 at 11:47 AM, the surveyor observed the resident sitting in the room and was wearing NJ EX at NJ EX Order. 264b1 the NJ EX Order. 264b1 that was hanging on the back of the resident's chair. The portable NJ EX Order. 264 was filled, and the resident stated that NJ EX O felt the NJ 264 coming out of the NJ EX Order. 264b1. On 05/10/23 at 12:40 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurses and the CNAs were responsible to assure that the NJ EX Order. 264b1 NJ EX Order were filled and explained that they all knew how to fill it and they all knew that they should have checked that it was filled. On 05/12/23 at 10:23 AM, the surveyor in the presence of the survey team, interviewed the DON who stated that the nurses and the CNAs were trained on NJ EX Order. 264b1 knew how to care for residents on NJ EX Order. 264b1. She explained that the nursing staff knew how to fill the NJ EX Order. 264 . The DON stated that she spoke with the CNA that was caring for Resident #25 on NJ EX Order. 264b1 7:00 AM- 3:00 PM shift and that the CNA stated that the NJ EX Order. 264 was approaching the	F 695	NJ EX Order to deliver prescribed NJ EX Order. 264b. B. Director of Nursing or his/her designee will review all resident□s new orders/and any change in existing orders, on a daily basis for 1 month and then weekly for an additional 5 months, identifying any/all residents who may have a new/change order for NJ EX Order n administration and update monitoring tool. Director of Nursing will report results of the Oxygen Administration Audits/QAPI to the Quality Assurance Committee that meets at a minimum on a quarterly basis.	

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F 695	Continued From page 50 NJ E" mark which would have indicated that the NJ EX Order was empty but did not feel that it would have emptied that quickly. The DON stated that there was no paperwork that the CNAs filled out when they checked the NJ EX Order. 264b1. The surveyor reviewed the facility policy, "NJ EX Order NJ EX Order. 264b" dated October 29, 2022, which indicated that the facility utilized NJ EX Order. 264b1 technology to supply its residents with their NJ EX Order. 26 needs. It's the facility policy to ensure safe transportation, use and storage of both NJ EX Order based units and NJ EX Order. 264b1 units; ensure that the filling of NJ EX Order. 26, herein referred to as NJ EX Order. 264b1, from the NJ EX Order. 264b1 base unit to the NJ EXEX Order. 3 unit id done properly and complied with the State Department of Health and Federal Regulation and maintains the safety precautions in the transportation, use, storage, NJ EX Order. 264b1 of units and handling of NJ EX Order. 26. The policy also indicated that the residents using NJ EX Order. 264 will utilize NJ EX Order. 264b1 in their rooms and while outside of their rooms, residents will be transferred to a NJ EX Order. 264b1. Prior to this transfer, the caregiver-nurse and or CNAs will check the NJ EX Order. 264b1 to determine how much NJ EX is left; if not a NJ EX Order. 264, the nurse and or CNA should fill the tank utilizing the procedure for NJ EX Order. 264b1 of a NJ EX Order. 264b1. NJAC 8:39-19.4(a)	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		7/6/23

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F 812	Continued From page 51 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of facility documentation it was determined that the facility failed to: a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination and c.) maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 05/02/23 at 09:51 AM, in the presence of the Food Services Director (FSD), the surveyor toured the kitchen and observed the following: 1. In the dairy freezer, there was one (1) knotted clear plastic bag which contained several frozen brown coated squares of meat, which the FSD identified as breaded fish squares, with no label	F 812	Leisure Chateau Care & Rehabilitation will: a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination and c.) maintain adequate infection control practices during food service in the kitchen. To address survey concerns the facility has done and will do the following: 1) The former Food Service Director immediately removed and disposed of the following exposed and/or undated and unlabeled and dented items that were identified during the survey: a) one (1) knotted clear plastic bag which containing several frozen brown coated squares of breaded fish squares found in the dairy freezer.	

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	315190	A. BUILDING _____ B. WING _____	C 05/12/2023

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F 812	Continued From page 52 and no dates. The FSD acknowledged there was no label and stated that he did not know how old the food was and stated that the bag should have been marked when it was opened and what the contents were. There was a large metal tray which contained white pieces of meat that were partially covered with clear plastic wrap. The meat was visible and exposed to air on both sides of the tray. The FSD identified the meat as flounder filets and stated that the plastic wrap should have completely covered the fish to prevent contamination. There was one (1) large knotted blue plastic bag which contained brown coated square pieces of meat, that the FSD identified as vegan chicken patties, with no label and no dates. There was a large round hole observed in the bag with the meat visible and exposed to air. The FSD acknowledged that there should have been a label and a use by date and stated that the hole should not have been in the bag. There was one (1) knotted clear plastic bag with several round flat yellowish pieces of dough, that the FSD identified as crepes, with no label and no dates. There were two (2) knotted large blue bags with several round white and tan pieces of dough, that the FSD identified as pizza shells, with no label and no dates. The FSD was unable to state how old the food items were and acknowledged that the crepes and the pizza shells had no labels and no dates. The FSD further stated that it was important that the food was labeled and dated so that everyone would have known what the food was and how old the product was. The FSD removed the bags from the freezer. 2. In the walk-in refrigerator, there was one (1) opened bag of shredded yellow cheddar cheese wrapped in clear plastic wrap with no opened or use by date. The FSD acknowledged that he did	F 812	b) a large metal tray which contained flounder filets found in the dairy freezer c) one (1) large knotted blue plastic bag which contained vegan chicken patties found in the dairy freezer d) one (1) knotted clear plastic bag with crepes e) two (2) knotted large blue bags with several pieces pizza shells f) one (1) opened bag of shredded yellow cheddar cheese found in the walk in refrigerator g) 15 small plastic plates of fruit covered with clear plastic wrap, with no labels and no dates, found in a metal half pan in the walk in refrigerator h) one (1) knotted clear plastic bag that contained beef patties found in the meat freezer i) one opened bag of chocolate pudding wrapped in clear plastic wrap found in the dry storage room j) one opened bag of quick rolled oats wrapped in clear plastic wrap found in the dry storage room k) one (1) 115 ounce can tomato ketchup with a large dent found in the can area in the dry storage room l) one (1) 100 ounce can cut sweet potatoes with a large dent found in the can area in the dry storage room m) six (6) 108 ounce cans diced potatoes with large dents found in the can area in the dry storage room n) one (1) 66.5 ounce can chunk light tuna with a large dent found on the top shelf on a large metal rack in the dry storage room. o) two (2) opened bags of confectioner	

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F 812	Continued From page 53 not know when the cheese was opened and stated that it should have been marked with the date when it was opened. In a metal half pan, there were 15 small plastic plates of fruit covered with clear plastic wrap, with no labels and no dates. The FSD acknowledged that he did not know how old the undated plates of fruit were and that they should have had a label and a use by date. The FSD removed the cheese and the fruit from the refrigerator. 3. In the meat freezer, there was one (1) knotted clear plastic bag that contained several brown circular patties, that the FSD identified as beef patties, with no label and no dates. When the surveyor inquired as to how old the beef patties were, the FSD stated, "You wouldn't know by looking at it." The FSD acknowledged that the beef patties should have had a label and use by date and that it was important to label and date the food products because contamination could have caused sickness. The FSD discarded the meat into the garbage. 4. In the dry storage room, there was one opened bag of chocolate pudding wrapped in clear plastic wrap with no open or use by date. There was one opened bag of quick rolled oats wrapped in clear plastic wrap with no open or use by date. The FSD stated he was unsure how long the pudding and the oats were good for and that they should have been dated when they were opened. In the can section on a metal rack, there was one (1) 115 ounce can tomato ketchup with a large dent, one (1) 100 ounce can cut sweet potatoes with a large dent and six (6) 108 ounce cans diced potatoes with large dents. On the top shelf on a large metal rack there was one (1) 66.5 ounce can chunk light tuna with a large dent. The FSD	F 812	sugar each wrapped in clear plastic wrap with no open or use by dates found in the dry storage room p) one (1) large opened brown bag in an opened clear plastic bag, that contained potato flakes found in the dry storage room q) several coffee filters that were exposed, found in the dietary cart room The 2 large cutting boards with black smudges were cleaned Sanitizers that were not the correct PPM were adjusted to the correct PPM 2) All residents that are not strictly receiving their nourishment from a feeding tube can be affected by this deficient practice. 3) a) The former Food Service Director that was present during survey is no longer employed at Leisure Chateau as of 6/2/2023. b) A new Food Service Director has been hired and started on Friday 6/2/2023. The new Director is experienced for many years and is highly regarded in the industry with a focus on sanitation, infection control and developing & implementing policies and procedures. c) The new Food Service Director reviewed and developed as necessary policies on food storage labeling and dating both refrigerated and dry storage, Sanitizer Solution & cleaning of surfaces, Dented Cans, kitchen audits. All policy revisions were complete by 6/21/2023	

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F 812	Continued From page 54 acknowledged the dents and stated that the dented cans should have been put on the dented can shelf. There were two (2) opened bags of confectioner sugar each wrapped in clear plastic wrap with no open or use by dates. There was one (1) large opened brown bag in an opened clear plastic bag, that contained visible white flakes that were exposed to air, with no label and marked 4/18/23. The FSD identified the white flakes as potato flakes and stated that he was unsure if the marked date indicated if the bag was opened at that time. The FSD further stated that the bag should have been wrapped and closed and have had a label and a use by date. 5. On the meat side of the kitchen, under a metal food prep area, there was a red bucket that contained a white rag and clear liquid. The FSD identified the bucket contents as sanitizer and stated that the bucket was made at the start of the shift and it was used to wipe down the prep area. The FSD used a chlorine paper test strip to test the sanitizer which revealed a light grey color. The FSD stated it read "nothing" and that it should have read 200 parts per million (ppm.) The FSD then used a QT10 paper test strip to test the sanitizer which revealed a light orange color which the FSD stated read "more like 100 ppm" and that it should have read 200 ppm. The FSD acknowledged that the sanitizer bucket did not contain enough sanitizer and instructed the cook to add sanitizer to the bucket. 6. On the drying rack there were two (2) large red cutting boards with black smudges and gouges. The FSD acknowledged that the smudges and gouges should not have been there and used his finger to scrape at the smudges. The FSD stated that it was important to use clean equipment to	F 812	d) The new Food Service Director reviewed and developed as necessary Supervisor Monitoring checklists related to all functions of the food service department and has trained/re-educated the relevant staff on the proper use/timing and accuracy of these forms. b) Prior to the new Food Service Director starting, during survey, Leisure Chateau brought in a Food Service Consultant who had begun the process of in-servicing the staff, which included the former Food Service Director, the Assistant Food Service Director, Cooks and Line staff - In-Services to all the staff were given again by the new food service director and have been completed by 6/30/2023. the Inservices covered the following: i)proper labeling and dating ii)food storage (cold and dry) iii)Storage of Disposable items iv) labeling and dating v) Sanitation, cleanliness and Proper Sanitizing procedures vi)Dented Cans 4) The Food Service Director or his/her designee will audit twice a week for 1 month to ensure that the following is done: i)proper labeling and dating ii) proper food storage (cold and dry) iii)Proper Storage of Disposable items iv) Proper Sanitizing procedures vi) Proper procedure of Dented Cans vii) supervisors accurate use of all monitoring checklists	

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F 812	Continued From page 55 prevent cross contamination. 7. In the three-compartment sink, the sanitizer sink was filled with clear liquid. The FSD tested the liquid with a QT10 paper test strip which matched 300 ppm. The FSD acknowledged the 300 ppm and stated that the liquid should have been 200 ppm and added more water to the sink. 8. On the dairy side of the kitchen, in the three-compartment sink in the dish washing area, the sanitizer sink was filled with clear liquid. The FSD tested the liquid with a QT10 paper test strip which revealed a dark green color that matched 400 ppm. The FSD acknowledged the 400 ppm and stated that the liquid should have been 200 ppm and instructed the dish washer to empty some liquid from the sink and add more water then retest. On 05/05/23 at 10:52 AM, in the presence of the FSD, the surveyor observed the door to the dietary cart room opened and held ajar with a five-gallon bucket. 9. In the dietary cart room on the top shelf of a metal five-tiered cart, which contained paper and plastic products, there were several large coffee filters resting on the shelf which were exposed to air. The FSD acknowledged that the coffee filters should not have been stored that way and that they should have been in a bag to prevent contamination. The FSD discarded the coffee filters into the garbage. On 05/05/23 at 11:00 AM, in the presence of the FSD, the surveyor toured the kitchen and observed the following:	F 812	The Food Service Director will continue to Audit weekly for another 3 months. Food Service Director will report the findings of the Audits to the QAPI Committe meeting which meets quarterly at a minimum.	

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F 812	Continued From page 56	F 812		

10. On the meat side of the kitchen, there was a red bucket labeled sanitizer which contained a rag and clear liquid. The FSD tested the liquid with a QT10 paper test strip which revealed a dark green color which matched 400 ppm. The FSD acknowledged the strip read 400 ppm and stated that it should have read 200 ppm. The FSD emptied some of the liquid into the sink and added more water then retested the liquid with a QT10 paper test strip which matched 200 ppm.

11. On the dairy side of the kitchen, there was a red bucket marked sanitizer which contained a rag and clear liquid. The FSD tested the liquid with a QT10 paper test strip which matched 400 ppm. The FSD acknowledged the strip read 400 ppm and stated that it should have read 200 ppm. The FSD emptied some of the liquid into the sink and added more water then retested the liquid with a QT10 paper test strip which matched 200 ppm. The FSD stated that after any meal prep that the counters were washed with soap and water and then the sanitizer was used. The FSD further stated that it was important to have the correct amount of sanitizer so that there was an optimum level of chemical to clean any bacteria.

A review of the undated facility policy, "Cleaning and Disinfection of Kitchen Equipment," revealed, Policy Interpretation and Implementation 2. All Kitchens, kitchen areas and dining areas shall be kept free clean ...3. Sanitizing of Environmental surfaces must be performed with one of the following solutions... b. 150-200 ppm of approved sanitizing solution which is the one used here in Leisure Chateau.

A review of the facility document, "Sanitizer Buckets," with a revision date 5/23, revealed, 3.

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F 812	Continued From page 57	F 812		

Buckets should be filled and checked and fixed until the test strip reads 200 ppm of solution, which is the optimal cleaning reading.

A review of the undated facility policy, "Cleaning Instructions: Cutting Boards," revealed, Policy: Cutting boards will be cleaned and sanitized after each use. Procedure: 2. After each use, wash cutting in hot soapy water. 3. Rinse and sanitize

A review of the facility policy, "Dented Can Policy,", with a revision date of 8/2022, revealed, Procedure: 1. Identify an acceptable/unacceptable dented can. Unacceptable: Any dent, crease, bulge, swelling, or rust. 2. Upon discovery, place dented can in the designated "Dented Can" area.

A review of the facility policy, "Receiving and Storage," dated 2/2020, revealed Procedure: 2. d. All foods are dated as they are placed in storage and dated using a "first in-first out" system. 3. a. i. Dented cans-Not acceptable and should be stored in designated area for pick up from the vendor at a later time.

A review of the facility policy, "Receivable and Storage Policy," with a revision date of 7/2022, revealed, Procedure: 8. Ensure that all foods are securely covered, dated, and labeled.

NJAC 8:39-17.2(g)

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: NJ 00154373 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey for a.) the week of 04/24/22 to 04/30/22, b.) the weeks of 04/16/23 to 04/29/23, and c.) 04/09/22 through 04/15/22. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1) A root cause analyses were conducted by the Administrator, Director of Nurses, and the Staffing Coordinator to identify the underlying cause of the deficient practice. We identified that the failure to staff the facility according to the requirements of the New Jersey guidelines is a global acute shortage of individuals who are certified as Certified Nursing Assistants. We have reached out to the agencies and offered/agreed to higher hourly rates for the staff in order to immediately get more staff in. A referal bonus to our staff has been offered for recruitment of CNA's. 2) All Residents can be affected by this deficient practice. 3) a) On June 4th, 2023, The Director of	7/7/23

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. a.) As per the "Nurse Staffing Report" completed by the facility for the week of 04/24/2022 to 04/30/2022, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift for residents on 2 of 7 day shifts as follows: -04/24/22 had 18 CNAs for 180 residents on the day shift, requires 22 CNAs. -04/30/22 had 20 CNAs for 181 residents on the day shift, required 23 CNAs. b.) As per the "Nurse Staffing Report" completed by the facility for the weeks of 04/16/2023 to 04/29/2023 for the 05/12/2023 standard survey, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows:	S 560	Nurses In-Serviced the Staffing Coordinator on the NJ Staffing requirements for Certified Nursing Assistants. b) The Staffing Coordinator or his/her designee will continue to attempt to recruit new Certified Nursing Assistants that will work directly for Leisure Chateau and be accountable to Leisure Chateau to follow policies and procedures safely and professionally in the care of our residents. c) The Director of Nursing Services will conduct additional approved classes for Certified Nursing Assistants to recruit and hold on to Newly Certified Nursing Assistants. d) Since the facility must in the interim continue to rely on Staffing Agencies for supplemental staff, The administrator has signed an additional contract with a staffing agency and will continue to recruit new agencies that can assist with supplemental staffing as necessary. 4) The Staffing Coordinator or his/her designee will complete an audit weekly for 1 month and then monthly for an additional 2 months to ensure that the staffing ratio is compliant with the New Jersey Staffing requirements for Certified Nursing Assistants. The Staffing Coordinator will submit results to the Director of Nursing monthly. The Director of Nursing will report Audit results to the quarterly QAPI committee meeting.	

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S 560	Continued From page 2	S 560		

-04/16/23 had 20 CNAs for 175 residents on the day shift, required 22 CNAs.

-04/17/23 had 15 CNAs for 174 residents on the day shift, required 22 CNAs.

-04/23/23 had 16 CNAs for 174 residents on the day shift, required 22 CNAs.

-04/24/23 had 21 CNAs for 174 residents on the day shift, required 22 CNAs.

-04/27/23 had 21 CNAs for 176 residents on the day shift, required 22 CNAs.

-04/29/23 had 19 CNAs for 175 residents on the day shift, required 22 CNAs.

McCrayReid, Andrea

c.) As per the "Nurse Staffing Report" completed by the facility for the week of 04/09/2022 to 04/15/2022, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift for residents on 2 of 7 day shifts as follows:

The facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:

-04/09/23 had 16 CNAs for 173 residents on the day shift, required 22 CNAs.
-04/11/23 had 20 CNAs for 173 residents on the day shift, required 22 CNAs.
-04/13/23 had 19 CNAs for 176 residents on the day shift, required 22 CNAs.
-04/14/23 had 20 CNAs for 174 residents on the day shift, required 22 CNAs.
-04/15/23 had 19 CNAs for 174 residents

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LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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S 560	Continued From page 3 on the day shift, required 22 CNAs. On 05/09/23 at 10:04 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she reviewed staffing and census daily and then based staffing off those numbers. The SC stated that she knows what number of staff was needed to assure that staffing was adequate and met the needs of the residents. She stated that she knew what acuities were on the units and how many staff would be needed so that adequate care was provided for those residents. She stated that the facility would have staff call outs which could contribute to a low staffing on some shift. She stated that the facility knew how to notify the staffing coordinator when there was a call out and that she would try to replace the staff member. The SC explained that she would contact any staff member that was not working to see if they could fill the spot and if not, then she would reach out to agency staff to see if she could find a replacement. She stated that she did not leave the facility on a Fridays until staff needs were met for the weekends. She continued to explain that when there was a call out on the weekend bonuses were offered to the staff to come in or to the staff to cover the shift. She stated that staff were encouraged to bring workload concerns to the SC and Administration and that she would bring the concerns to the DON or Administrator. She added that if a staff member resigned from the facility that they conducted exit interviews and if the concern was regarding increase in salary the Administrator would try to help and meet the staff member's needs. She stated that the facility tried to recruit staff by going nursing schools and step-up recruitment tables. She explained that to the new nurses that the facility was a great place to start a career in nursing and that LTC is a rewarding job.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061515	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(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 4 She stated that the facility also recruited potential employees on job websites, and we offer competitive salaries. On 05/09/23 at 10:25 AM, the surveyor interviewed the Director of Nursing (DON) who stated that staffing has changed since the pandemic and the facility was attempting to recruit staff through job websites and career fairs, referral bonuses and word of mouth. She explained that the facility tries to retain staff and the Administrator was putting in a tuition reimbursement plan to try and retain staff and encourage CNAs, Licensed Practical Nurses (LPNs) to come and work at the facility. She stated that the Administration conduct exit interviews with the employees that what to resign and make all attempts at retaining the staff. She stated that the facility was also taking nurses that were on the Recovery and Monitoring Program (RAMP) because we know their restrictions and report monthly to RAMP. She explained that there was a difference between the CNAs and the nurses. The CNAs were unionized and must follow union guidelines and discipline for excessive call outs or poor attendance. The Administration replace call outs with agency nurses or CNAs. She stated that the facility also had an overtime sign in sheet to see if anyone wanted to work extra. She also added that if the facility had an on-call list so that if an employee called the SC knew who to call to get a replacement. She stated that the facility offered bonus pay for any employee that wanted to work overtime. NJAC 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061515 Y1	A. Building B. Wing Y2	7/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/07/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315190 Y1	A. Building B. Wing Y2	7/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0582	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	07/07/2023	LSC	06/29/2023	LSC	07/07/2023
ID Prefix F0623	Correction	ID Prefix F0641	Correction	ID Prefix F0688	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	06/30/2023	LSC	06/29/2023	LSC	06/29/2023
ID Prefix F0689	Correction	ID Prefix F0690	Correction	ID Prefix F0695	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	06/29/2023	LSC	06/29/2023	LSC	06/30/2023
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/06/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/12/2023	☐ YES ☐ NO