STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey 01/23/2025 Census: 162 Sample Size: 35 + 1 closed record C/O #'S NJ 170876, 175521, 175593, 175940, 178813, 179315, 179615, 179845, 181386, 182136 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		2/14/25

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

Electronically Signed | 02/13/2025

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure residents were treated with dignity whole being assisted with a [NJ Exec Ord] This deficient practice was identified for 1 of 3 units, West wing and was evidenced by the following: On 01/15/2025 at 12:38 PM, the surveyor observed the [US FOIA (b)(6)]) assisting a resident with their meal who was seated in his/her [NJ Exec O] chair. The [US FO] was standing over the resident while [NJ Exec Order 2] her/him. During an interview at that time, the [US FO] said "yes I attempting to [NJ Exec O] resident." When asked how should you be positioned when [NJ Exec Order 2] a resident and he replied "I would like to be head level with resident but I don't have a chair." On 01/16/2025 at 08:25 AM, Certified Nursing Assistant (CNA #1) was observed to be standing	F 550	F550 SS=D 1. Additional chairs were immediately brought in to the West Wing Dining room. [US FOIA (b)(6)] and CNA#1 were in serviced on the importance of being seated while feeding residents. 2. All Residents that need assistance with feeding have the potential to be affected by this deficient practice. 3. The Charge Nurse/Designee conducted an in service with the Nursing staff on 2/11/25 on the importance of being properly seated while assisting residents with feeding. The DON/Designee will round during meal time 3x a week for 3 months to ensure all staff that are assisting residents with	

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F 550	Continued From page 2 while assisting a resident to [NJ Exec] who was seated in a [NJ Exec O] chair in the [NJ Exec Order 26.4b] dining room. After CNA #1 completed assisting the 1st resident, CNA #1 proceeded to move to a 2nd resident and stood while [NJ Exec Order 2] him/her. There was a chair observed to be available for CNA #1 to sit in while assisting a resident to [NJ Exec] On 01/16/2025 at 12:16 PM, during a lunch meal observation on the [NJ Exec Order 26.4b], the surveyor observed CNA #1 to be assisting a resident to [NJ Exe] their entire meal from a standing position. The resident was seated in a [NJ Exec O] chair. During an interview with the surveyor on 01/22/2025 at 01:41 PM, the US FOIA (b)(6) [redacted] were asked is it appropriate for a staff to stand while assisting a resident with their [NJ Exec Ord] The [US FOIA (b)(6)] responded no, staff is supposed to be sitting while assisting residents with their [NJ Exec Order] A review of a facility policy on 01/22/2025 at 12:16 PM, titled [facility name] Feeding Assistance Guidance undated. The list of the guidance indicated that "sit facing the resident at eye level."	F 550	feeding are properly seated. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months for review. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
F 584 SS=D	NJAC8:39-4.1(a)(12) 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	F 584		2/14/25

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F 584	Continued From page 3 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure residents were treated with dignity while being assisted with a meal and creating a homelike environment during dining by removing the food from the tray. . This	F 584	F584 SS=D 1. US FOIA (b)(6) and CNA#1 were immediately in serviced on the importance of being properly seated while feeding residents.	

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F 584	Continued From page 4 deficient practice was identified for 2 of 3 units, [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] and was evidenced by the following: 1. On 01/15/2025 at 12:38 PM, Surveyor #1 observed the [US FOIA (b)(6)] assisting a resident with their [NJ Exec O] who was seated in his/her [NJ Exec O] chair. The [US FO] was standing over the resident while [NJ Exec Order 26] her/him. During an interview at that time, the [US FO] said "yes I attempting to [NJ Exec O] resident." When asked how should you be positioned when [NJ Exec Order 26] a resident and he replied "I would like to be head level with resident but I don't have a chair." 2. On 01/16/2025 at 08:25 AM, Certified Nursing Assistant (CNA #1) was observed to be standing while assisting a resident to [NJ Exec] who was seated in a [NJ Exec O] chair in the [NJ Exec Order 26.4b1] dining room. After CNA #1 completed assisting the 1st resident, CNA #1 proceeded to move to a 2nd resident and stood while [NJ Exec Order 26] him/her. There was a chair observed to be available for CNA #1 to sit in while assisting a resident to eat. On 01/16/2025 at 12:16 PM, during a lunch meal observation on the [NJ Exec Order 26.4b1], Surveyor #1 observed CNA #1 to be assisting a resident to [NJ Exe] their entire meal from a standing position. The resident was seated in a [NJ Exec O] chair. 3. On 01/15/2025 at 12:16 PM, Surveyor #2 observed the [NJ Exec Order 26.4b1] dining room at the lunch meal. Eight (8) residents were observed to be seated in the [NJ Exec Order 26.4b1] dining room across from nurse's station. The second meal cart arrived at 12:19 PM and staff were observed to hold the meal trays to ensure all trays were able to be passed at the same time. Trays were passed to	F 584	All residents who choose to eat in the Day Rooms are being served their meals without being placed on a tray. 2. All residents that need assistance with feeding and all residents that choose to eat in the day rooms have the potential to be affected by this deficient practice. 3. The Charge Nurse/Designee conducted an in service on 2/11/25 with the Nursing Staff on the importance of being properly seated while feeding residents. All Nursing Staff were in serviced on the importance of not serving residents who choose to eat in the Day rooms their meals on trays. The DON/Designee will round during meals 3x a week for 3 months to ensure the staff who are assisting with feeding residents are properly seated and those who choose to eat in the Day rooms are properly served their meals not using trays. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 584	Continued From page 5	F 584		

the eight residents at 12:23 PM, by 4 unit staff. 8 of 8 residents present in the dining room were served their lunch meal on the tray. The food was not removed from the tray when placed on the table.

4. On 01/16/2025 at 12:26 PM, Surveyor #2 arrived on the [NJ Exec Order 26.4b1] and observed the lunch meal on the [NJ Exec Order 26.4b1] dining room. The meal had already been served prior to the surveyor arriving on the unit and the 4 of 4 residents present in the dining room received their lunch meal on a tray.

5. On 01/21/2025 at 12:12 PM, Surveyor #2 observed the [NJ Exec Order 26.4b1] dining room at the lunch meal. 7 residents were observed in the [NJ Exec Order 26.4b1] dining room and were served the lunch meal on the tray.

During an interview with the survey team on 01/22/2025 at 01:38 PM, the [US FOIA (b)(6)] were notified of the above mentioned meals and the practice of facility staff standing while assisting residents with meals and serving meals on trays. Surveyor #1 asked if it was appropriate for staff to be standing while [NJ Exec Order 26] a resident. The [US FOIA (b)(6)] responded no, staff is supposed to be sitting while assisting resident during meals. Surveyor #2 asked the [US FOIA (b)(6)] if serving meals on trays in the dining room created a home-like environment for the residents. The [US FOIA (b)(6)] responded, "To be honest I think that is the way that they have always done it."

A review of a facility policy on 01/22/2025 at 12:16 PM, titled [facility name]Feeding Assistance Guidance undated. The list of the guidance

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F 584	Continued From page 6 indicated that "sit facing the resident at eye level." N.J.A.C. 8:39-4.1(a)(12)	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to follow hold NJ Exec Order 26.4b1 for the administration of a NJ Exec Order 26.4b1 medication in accordance with professional standards of practice. This deficient practice was identified for 1 of 28 residents (Resident #46) reviewed for standards of practice and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title	F 658	F658 SS=D 1. The parameters for NJ Exec Order 26.4b1 for Resident #46 was updated (As per MD) to give 1 NJ Exec Order 26.4b1 by mouth 3x daily for NJ Exec Order 26.4b1 is greater than NJ Exec O 2. All residents on Midodrine have the potential to be affected by this deficient practice. 3. Nursing staff were in serviced by our Pharmacy Consultant on the new parameters of Midodrine. UM/Designee will audit 3 residents on Midodrine weekly x12 weeks to ensure the new parameters are properly followed. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued	2/14/25

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F 658	Continued From page 7 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 1/15/25 at 11:20 AM, the surveyor observed Resident #46 in their room seated in a NJ Exec Order 26.4b1 wheelchair. Resident #46 stated they were a NJ Exec Order 26 patient and went to the facility three times a week. The surveyor reviewed the medical record for Resident #46. A review of the Admission Record face sheet reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 A review of the most recent comprehensive Minimum Data Set (MDS), and assessment tool dated NJ Exec Order 26.4b reflected a brief interview for mental status (BIMS) score of NJ out 15, which indicated a NJ Exec Order 26.4b1 . A further review reflected the resident received NJ Exec Order 26 treatments. A review of the individualized person-centered care plan reflected a focus area initiated NJ Exec Order 26 for NJ Exec Order 26.4b1 three times a week related to NJ Exec Order 26.4b1 . Interventions included monitor vital signs. Notify US FOIA (b)(6)) of	F 658	submission and reporting.	

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NJ Exec Order 26.4b1.

A review of the Order Summary Report (OSR) included a physician's order (PO) dated NJ Exec Order 26, Vital signs every shift- if NJ Exec Order 26.4b1 See PRN (as needed) order for NJ Exec Order 26.4b1 every 8 hours.

The corresponding NJ Exec Order 26.4b1 order was as follows:

NJ Exec Order 26.4b1 give one tablet by mouth every 8 hours as needed for NJ Exec

A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed the resident's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and the resident did not receive NJ Exec Order 26.4b1 on the following days:

10:00 PM; NJ Exec Order 26.4b1

A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed the resident's NJ Exec Order 26.4b1) was NJ Exec Order 26.4b1 and the resident did not receive NJ Exec Order 26.4b1 on the following days:

2:00 PM; NJ Exec Order 26.4b1

10:00 PM; NJ Exec Order 26.4b1

A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR)

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F 658	Continued From page 9	F 658		

revealed the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 and the resident did not receive NJ Exec Order 26.4b1 on the following days:

2:00 PM; NJ Exec Order 26

10:00 PM; NJ Exec Order 26.4b1

Further review of the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 MAR revealed the resident had received NJ Exec Order 26.4b1 when the NJ Exec O was NJ Exec Order 26.4b1 and should not have been given on the following days:

NJ Exec Order 26.4 at 8:11 AM NJ Exec Order 26.4b at 12:49 PM

NJ Exec Order 26. at 10:17 AM NJ Exec Order 26. at 12:27 PM, and NJ Exec Order 26. at 11:17 AM

During an interview with the surveyor on 01/22/2025 at 11:14 AM, Licensed Practical Nurse # 4 (LPN #4) stated the resident received NJ Exec Order 26 three times a week and took NJ Exec Order 26.4b1 for their NJ Exec Order 26.4b1. At that time the surveyor and LPN #4 reviewed the resident's MARs. LPN #4 acknowledged the resident had not received NJ Exec Order 26.4b1 when their NJ Exec O was NJ Exec Order 26.4b1 on multiple occasions and had received NJ Exec Order 26.4b1 when the dose should have been held based on the physician's hold parameters.

During an interview with the surveyor on 01/22/2025 at 11:28 AM, Licensed Practical Nurse/ Unit Manager #2 (LPN/UM #2) and the surveyor reviewed the resident's MARs and confirmed the nurses were not following the physician's hold order NJ Exec Order 26.4b1 on multiple dates.

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F 658	Continued From page 10 During a meeting with the survey team on 01/22/2025 at 2:21 PM, with th US FOIA (b)(6) [redacted] The [redacted] stated the nurses should follow the parameters of the physician's orders like indicated in the [redacted] order for Resident #46. A review of the facility's "Medication Pass" policy dated reviewed 2023, included...Hold Parameters: check blood pressure and/or pulse rate immediately prior to pouring... The policy did not include following physician's order regarding medication hold parameters. NJAC 8:39-11.2(b); 27.1(a)	F 658		
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 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		2/14/25

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F 688	Continued From page 11 by: Based on observation, interview, review of the medical record, and other facility documentation, it was determined that the facility failed to ensure that a resident who was identified as having a NJ Exec Order 26.4b1 received services to prevent further NJ Exec Order 26.4b1 This deficient practice was identified for 1 of 1 resident reviewed for limited NJ Exec Order (Resident #78) and was evidenced by the following: On 01/15/2025 at 10:04 AM during the initial tour of the facility, Resident #78 was observed by the surveyor sleeping with NJ Exec Order 26.4b1 at the NJ Exec Order Their NJ Exec Order 26.4b1 was NJ Exec Order 26.4b . There was NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1. During an interview with the surveyor on 01/15/2025 at 12:36 PM, the resident family stated that NJ Exec Order 26.4b1 was being applied to resident's NJ Exec Order 26.4b1 The family said that Resident #78 used to NJ Exec Order 26.4b1 with their NJ Exec Order 26.4 to put in their NJ Exec Order 26.4b1, but someone removed it. The family went on to say they were told that they were going to be replaced with the appropriate device, but no device was provided. On 01/16/2025 at 08:10 AM, the surveyor observed Resident #78 in bed sleeping with NJ Exec O and their NJ Exec Order 26.4b1. There was no NJ Exec Order 26.4b1 noted on their NJ Exec Order 26.4b1. On 01/16/2025 at 08:11 AM, the surveyor observed resident #78 eating breakfast with their	F 688	F688 SS=D 1. Resident #78 was visited by NJ Exec Order 26.4 to determine the need of an NJ Exec Order 26.4b1. 2. All residents experiencing contractures have the ability to be affected by this deficient practice. 3. In service was provided to the nursing staff to ensure proper use of assistive devices and proper documentation. The Rehab Director/UM/Designee will do weekly audits x12 weeks of residents that utilize assistive devices to ensure they are properly in use. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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NJ Exec Order 26.4b1. Their NJ Exec Order 26.4b1 at the NJ Exec Order 26.4b1. Their NJ Exec Order 26.4b1 had NJ Exec Order 26.4b1.

A review of Resident #78's Admission Record, in the Electronic Medical Record (EMR) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 .

A review of the most recent Quarterly Minimum Data Set (QMDS), an assessment tool used to manage care, dated NJ Exec Order 26.4b1, reflected a Brief Interview of Mental Status (BIMS) score of /15 which indicated that the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. Further review of the QMDS under Section NJ Exec Order 26.4b1 Programs, did not include documentation of NJ Exec Order 26.4b1.

A review of the active Physician Orders on NJ Exec Order 26.4b1 at 12:21 PM did not reveal order for any care or treatment for the NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1

A review of Resident #78's Care Plan initiated on NJ Exec Order 26.4b1, with focus for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 included the following goal: To remain free of complications related to NJ Exec Order 26.4b1 including NJ Exec Order 26.4b1 .... Interventions included: Monitor/document/report as needed any signs and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Provide NJ Exec Order 26.4b1 as tolerated with daily care; Provide supportive care, assistance

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F 688	Continued From page 13	F 688		

with NJ Exec Order 26.4b1 as needed; Document assistance as needed; and NJ Exec Order 26.4b1 referrals as ordered as needed. The ongoing care plan did not reveal a specific intervention for the resident's NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1

A review of the Physician's History and Physical progress notes by Advanced Practice Nurses (APN) dated NJ Exec Order 26.4b1 revealed assessments of the NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1. There was no treatment plan addressing the NJ Exec Order 26.4b1 in the notes.

During an interview with the surveyor on 01/21/2025 at 10:18 AM, the US FOIA (b)(6) stated that the most recent date that the resident was on NJ Exec Order 26.4b1 was on NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 notes revealed the reason for therapy was because the resident was at risk for NJ Exec Order 26.4b1. Discharge recommendations included: Patient agreed to don and maintain wearing of NJ Exec Order 26.4b1 with daily caregiver NJ Exec Order 26.4b1

During an interview with the surveyor on 01/21/2025 at 10:15 AM, Certified Nursing Assistant (CNA #3) stated that they washed the resident, set up their tray and let them stay in bed per resident's preference.

During an interview with the surveyor on 01/21/2025 at 10:23 AM, CNA #4 stated that they

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took care of the resident in coordination with the US FOIA (b)(6). They also stated that there were no devices being applied to the resident.

During an interview with the surveyor on 01/21/2025 at 11:47 AM, Licensed Practical Nurse/ Unit Manager (LPN/UM #1) stated that they had a NJ Exec Order 26 and a NJ Exec Or for the resident before, but the resident NJ Exec Order 26.4b1. When asked what the staff were doing at present for the NJ Exec Order 26.4b1 LPN/UM #1 stated that they would ask the US FOIA (b) to examine the resident for any recommendations. LPN/UM #1 further stated that they did not know what happened with the recommendations as she was not working during that time period.

During an interview with the surveyor on 01/22/2025 at 10:20 AM, NJ Exec Order 26 aide (NJ Exec #1) was asked what care she provided to the resident. NJ Exec #1 stated that they had to put washcloth in the NJ Exec Order 26.4b1 to clean it because the resident was stiff in the hand. NJ Exec #1 further stated that it was difficult to clean under because it was NJ Exec Order 26.4b1.

During a telephone interview with the surveyor on 01/22/2025 at 11:03 AM, the APN #1 stated that NJ Exec Order 26 followed up the resident and that the NJ Exec Order 26 aide placed NJ Exec Order 26.4b1 in the resident's NJ Exec Orde.

During an interview with the survey team on 01/22/2025 at 11:32 AM, the US FOIA (b)(6) was asked how the facility addressed residents with NJ Exec Order 26.4b1. The US FOIA (b) stated that the following interventions were being practiced: Residents were encouraged to NJ Exec Order 26.4b1 staff anticipated their needs all shifts, the residents

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F 688	Continued From page 15 were encouraged to get out of bed, follow up with psychiatry if the residents were not compliant, [redacted] will be addressed by the Nurse Practitioners, therapy referral if related to [redacted] The [redacted] further stated that these interventions are in the care plans and orders of the EMR. A review of an undated facility policy on 01/21/2025 at 12:42 PM titled [facility name] Assistive Device Policy under Covered Indications revealed on the third paragraph: The clinician, (therapy department or clinician designee) will usually initiate the discussion and consideration of MAE (mobility assistive equipment) use. Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs (mobility-related activities of daily living) such as toileting, feeding, dressing, grooming, and bathing. N.J.A.C. 8:39-27.1(a), 27.2(m)	F 688		
F 689 SS=E	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 observation, interview, record review and review of other facility documentation, it was	F 689	F689 SS=E	2/14/25

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F 689	Continued From page 16 determined that the facility failed to consistently perform quarterly NJ Exec Order 26.4 assessments according to facility policy for residents designated as NJ Exec Order 26.4b1. This deficient practice occurred for 3 of 3 residents (Resident #30, #58, and #127) reviewed for NJ Exec Order 26.4b. This deficient practice was evidenced by the following: 1. On 01/15/2025 at 10:21 AM, Surveyor #1 observed Resident #30 in his/her room getting a NJ Exec Order 26 Resident #30 stated that he/she was a NJ Exec Order 26 and that the facility staff held their NJ Exec Order 26.4b1. Resident told Surveyor #1 that he/she had designated NJ Exec Order times, and they could not NJ Exec Order whenever they wanted to. On 01/16/25 at 12:44 PM, Surveyor #1 reviewed the electronic medical record (EMR) as follows; A review of the Admission Record revealed Resident #30 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 A review of the Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, revealed that Resident #30 had a Brief Interview for Mental Status score of NJ Exec indicating NJ Exec Order 26.4b1. According to Section J Resident #30 was an NJ Exec Order 26.4b1. A review of Resident #30's comprehensive care plan revealed the following care plan Focus: I [resident name]am a NJ Exec Order 26 of long duration. The following were listed as Interventions: NJ Exec Order 26.4b supplies are stored in the activity office, instruct resident about NJ Exec Order 26.4 risks and hazards and about NJ Exec Order 26.4 cessation aids that are	F 689	1. NJ Exec Order 26.4b1 for Residents #30,#58 and #127 were immediately updated. 2. All Smoking residents have the ability to be affected by this deficient practice. 3. The US FOIA (b)(6) was in serviced by the Administrator on the importance of keeping up to date with smoking assessments. The Activity Director or Designee will do weekly audits x3 months to ensure that all Smoking assessments are completed timely. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 689	Continued From page 17 available, instruct resident about the facility policy on [NJ Exec Order 26.4b] locations, times, safety concerns, monitor oral hygiene, notify charge nurse immediately if it is suspected resident has violated facility [NJ Exec Order 26.4b1], and observe clothing and skin for signs of [NJ Exec Order 26.4b1] date initiated: [NJ Exec Order 26.4b1] The care plan did not address quarterly [NJ Exec Order 26.4] assessments. The EMR revealed that Resident #30's original [NJ Exec Order 26.4] contract was completed and signed on [NJ Exec Order 26.4b] Resident #30 had quarterly smoking assessments completed on [NJ Exec Order 26.4b] Review of the "Assmt" (assessment)tab in the EMR revealed no quarterly [NJ Exec Order 26.4] assessment had been completed since [NJ Exec Order 26.4b1] (approximately [NJ] for Resident #30. 2. On 01/16/2025 at 01:22 PM, Resident #127 was observed by Surveyor #1 outside in the designated [NJ Exec Order 26.4] area without staff supervision. On 01/17/2025 at 08:39 AM, Resident #127 was observed lying in bed and watching television. Resident #127 told Surveyor #1 that he/she does not possess their [NJ Exec Order 26.4] materials in their room or on their person. Resident #127 explained that they must pay for their own [NJ Exec Order 26.4b1] and that staff holds them until the [NJ Exec Order 26.4b1] time which was like [NJ Exec Order 26.4] per day. Staff would provide [NJ Exec Order 26.4] and [NJ Exec Order] to resident at designated [NJ Exec Order] times. According to the Admission Record Resident #127 was admitted to the facility with the following but not limited to diagnoses; [NJ Exec Order 26.4b1]	F 689		

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NJ Exec Order 26.4b1

A review of the comprehensive MDS dated NJ Exec Order 26.4b1, Resident #127 had a Brief Interview for Mental Status score of NJ Exec which indicated intact NJ Exec Order 26.4b1 Section J of the MDS revealed that Resident #127 was a NJ Exec Order 26.4b1

According to Resident #127's comprehensive care plan date initiated: NJ Exec Order 26.4b1 revealed the following care plan Focus: "I [resident name] am a NJ Exec Order 26 Review of the care planned interventions did not address quarterly NJ Exec Order 26.4 assessments.

A review of the EMR revealed Resident #127 had their initial NJ Exec Order 26.4 safety evaluation completed on NJ Exec Order 26.4b1. According to the EMR on NJ Exec Order 26.4b1 at 01:30 PM under the heading "Next Assessment Due" Resident #127's NJ Exec Order 26.4b Safety Evaluation V 2.0: was 63 days overdue - with a due date of NJ Exec Order 26.4b1

During an interview with Surveyor #1 on 01/17/2025 at 08:44 AM, the US FOIA (b)(6) was asked what the facility process was for residents who were active NJ Exec Order 26.4b The US FOIA told the surveyor that we purchase the NJ Exec Order 26.4b1 for the residents, and we also possess NJ Exec Order 26.4 materials which are locked away during NJ Exec Order 26.4b1 times. The US FOIA further stated that we distribute NJ Exec Order 26.4 materials to NJ Exec Order 26.4 at designated NJ Exec Order times and the NJ Exec Order monitor will supervise during the designated times. We have a designated smoke monitor. When asked who was responsible for completing NJ Exec Order 26.4 assessments the US FOIA

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stated nursing completes the smoking evaluations.

During an interview with Surveyor #1 on 01/17/2025 at 08:50 AM, Licensed Practical Nurse/Unit manager (LPN/UM#1) was asked asked who was responsible for the completion of [redacted] assessments. LPN/UM #1 told the Surveyor #1 that initial and quarterly [redacted] assessments are completed by activities staff. She further stated that nursing does not complete the [redacted] evaluations but if I see something wrong, I will give them my input.

During an interview with the survey team on 01/17/2025 at 10:41 AM, Surveyor #1 asked the [redacted]) who was responsible for the completion of [redacted] assessments. The [redacted] replied, our activities department completes the [redacted] evaluations, and the MDS coordinator assists as needed."

During an interview with Surveyor #1 on 01/17/25 at 10:45 AM, the [redacted] was made the [redacted] aware that resident [redacted] assessments that were reviewed were noted to not been completed timely. The [redacted] told the surveyor that the facility activities director [redacted] and [redacted]. The [redacted] told the surveyor "We are actively seeking a new director."

3. On 01/15/2025 at 10:50 AM, during the initial tour, Surveyor #2 observed Resident # 58 in his/her room. Resident #58 stated that he/she [redacted] during scheduled times and that the activities staff holds his/her [redacted]. He/she added that staff is always present during [redacted].

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F 689	Continued From page 20 On 01/15/2025 at 01:51 PM, Surveyor #2 reviewed the Electronic Medical Record (EMR) for Resident #58 as follows; A review of the admission record reflected that Resident #58 was admitted to the facility with a diagnosis that included but not limited to, [redacted]. A review of the most recent MDS dated [redacted], indicated that Resident # 58 had a BIMS score of [redacted]/15 indicating Resident #58 was [redacted] and under section J indicated that Resident #58 was a [redacted]. A review of Resident #58's Comprehensive Care Plan had a focus area indicating, [residents name] am a [redacted] ... A review of Resident #58's admission [redacted] Safety Evaluation, with an effective date of [redacted] indicated that Resident # 58 was an [redacted]. A further review of the EMR for Resident #58 did not include any further [redacted] evaluations. A review of the facility policy titled Smoking Policy - Residents, Staff and Visitors, undated. The following was revealed under the Policy Interpretation and Implementation: 5. The resident will be evaluated on admission to determine if he or she is a smoker or	F 689		

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F 689	Continued From page 21 non-smoker. If a smoker, the evaluation will include: a. Current level of tobacco consumption. b. Method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.). c. Desire to quit smoking if a current smoker; and d. Ability to smoke safely with or without supervision (per a completed Smoking Evaluation). e. All residents that smoke are required to sign a smoking agreement contract. f. All residents that smoke are required to purchase their own smoking materials. 7. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. N.J.A.C. 8:39-31.6 (e)	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. §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	F 690		2/14/25

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F 690	Continued From page 22 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 observations, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain an NJ Exec Order 26.4b1 off the floor to prevent the spread of NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 2 residents (Resident #261) reviewed for NJ Exec Order 26.4b1 care and was evidenced by the following: On 1/15/25 at 11:14 AM, during initial tour the surveyor observed Resident #261 seated in a wheelchair NJ Exec Order 26.4b1 using his/her feet down the hallway. The resident was NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 out of their NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 was dragging on the ground below the chair.	F 690	F690 SS=D 1. Resident #261 was discharged from the facility that day NJ Exec Order 26.4b1. 2. All residents who utilize a catheter have the ability of being affected by this deficient practice. 3. ADON/Designee conducted an in service on 2/11/25 for the Nursing staff on the importance of ensuring that any resident who utilizes a catheter, the tubing should be properly placed so it does not touch the floor and in the event that it does come into contact with the floor it	

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WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 23 The surveyor reviewed the medical record for Resident #261 as follows: A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1 [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 reflected that the resident had a brief interview for mental status (BIMS) score of [redacted]/15, which indicated a NJ Exec Order 26.4b1. It further included that the resident had an NJ Exec Order 26.4b1. A review of the resident's individualized person-centered Care Plan (CP) included a focus area initiated on NJ Exec Order 26.4b for utilizing an NJ Exec Order 26.4b1 related to a diagnosis of NJ Exec Order 26.4b1 [redacted] Interventions included to: monitor, document, notify medical doctor of signs and symptoms of complication; assess for NJ Exec Order 26.4b1 [redacted] per facility protocol. During an interview with the surveyor on 01/22/2025 at 2:23 PM, the US FOIA (b)(6) [redacted] stated nothing should touch the floor, the NJ Exec Orde and NJ Exec should fit in the NJ Exec Order 2 [redacted] its important because you don't want cross contamination and germs spread and don't want the resident to get an NJ Exec Order 26.4b	F 690	should immediately be changed. The Unit Manager/Designee will audit 3 patients who utilize Catheters, weekly x12 weeks to ensure proper placement of catheter tubing. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 690	Continued From page 24 During an interview with the surveyor on 01/22/2025 at 10:29 AM, Licensed Practical Nurse (LPN #5) stated the NJ Exec Order 26.4b1 should never touch the ground. If the did touch the floor the nurse should replace it. During an interview with the surveyor on 01/22/2025 at 10:57 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated the NJ Exec Order 26.4b1 should be placed beneath the resident's and in a . The should never touch the ground, its an NJ Exec Order 26.4b1, the should then be changed. During an interview with the survey team on 01/22/2025 at 2:23 PM, the US FOIA (b)(6) were questioned on if it was appropriate for NJ Exec Order 26.4b1 to touch the floor. The stated NJ Exec Order 26.4b1 should never be on the floor, its an NJ Exec Order 26.4b1 and concern. The nurse should then change the for the resident. A review of the facility's undated "Foley Catheter Care" policy included... The drainage bag must not touch the floor at any time... The policy did not include that the tubing must also be maintained off the floor. NJAC 8:39- 19.4 (a)5; 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.	F 695		2/14/25

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F 695	Continued From page 25 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, review of the medical record and review of other facility documentation, it was determined that the facility failed implement infection control measures for the handling and storage of [redacted] equipment for 1 of 3 residents reviewed for [redacted] care reviewed (Resident #53). This deficient practice was evidenced by the following: During the initial tour on 01/05/2025 at 09:26 AM, the surveyor interviewed Resident #53 who stated that they had [redacted] During the interview, the surveyor observed a [redacted] was face down inside the bedside on top of the resident's belongings including a book, mirror, napkins, and bracelet. The [redacted] was exposed and was undated. On 01/16/2025 at 08:09 AM, the surveyor observed Resident #53 eating breakfast in bed. A [redacted] connected to the machine was observed inside the side table drawer exposed and undated on top of the side table.	F 695	F695 SS=D 1. The [redacted] and [redacted] for resident #53 was immediately removed. 2. All residents that have a need for nebulizer treatments have the ability to be affected by this deficient practice. 3. All nursing staff were in serviced on the importance of properly bagging nebulizer masks. The UM/Designee will audit 3 residents who utilize nebulizer treatments weekly x12 weeks to ensure the nebulizer machines and masks are properly bagged. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 695	Continued From page 26	F 695		

On 01/17/2025 at 09:40 AM, the surveyor observed that the resident was out of the room and the NJ Exec Order 26.4b1 mask laying inside the half-open bedside drawer exposed.

A review of the Admission Record revealed Resident #53 was admitted to the facility with diagnoses including but not limited to; NJ Exec Order [redacted]

A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, reflected a Brief Interview for Mental Status (BIMS) score of NJ E[redacted]/15, which indicated that the resident was NJ Exec Order 26.4b1. A further review of Section NJ[redacted] reflected the resident had not received any NJ Exec Order 26.4b1 during a seven day look back period.

A review of the Order Summary Report (OSR) dated as of NJ Exec Order 26.4b1 included the following:

A Physician Order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 [redacted] every 6 hours as needed for NJ Exec Order 26.4b1
A further review of the OSR showed the order for the NJ Exec Order 26.4b1 was discontinued on NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) indicated the last time the resident had received the NJ Exec Order 26.4b1 [redacted] was NJ Exec Order 26.4b1

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F 695	Continued From page 27 A review of the individualized person-centered care plan included a focus for NJ Exec Order which included an intervention for administration of NJ Exec Order 26.4b1 as ordered. On 01/21/2025 at 10:28 AM, the surveyor and the resident's Licensed Practical Nurse (LPN #1) together observed the NJ Exec Order 26.4b1 in the resident's side table. LPN #1 stated that the NJ Exec Ord should have been bagged and labeled. On 01/22/2025 at 01:55 PM, in the presence of the survey team, the NJ Exec Order 26.4b1 stated that the NJ Exec Order 26.4b1 should be put in a bag when not in use. A review of the undated facility's "Oxygen Administration" policy did not address the care or storage of nebulizers. NJAC 8:39-27.1 (a)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the electronic medical record (EMR) and review of other facility documentation, it was determined that the facility failed to consistently ensure communication with a contracted NJ Exec Order 2 facility according to facility policy and procedure. This	F 698	F698 SS=D 1. The communication binder for Resident #88 was pulled right away for review as well as the NJ Exec Order 26.4b1 for other	2/14/25

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F 698	Continued From page 28 deficient practice was evidenced for 1 of 2 residents (Resident #88) reviewed for NJ Exec Order 26 This deficient practice was evidenced by the following: 1. On 01/15/2025 at 10:31 AM, during the initial tour of the facility, the surveyor interviewed Resident #88 room and asked if he/she had any concerns with their NJ Exec Order 26 treatment. Resident #88 stated that he/she attends NJ Exec Order 26 4 days per week. Resident #88 stated that they had been receiving NJ Exec Order 26 treatment for approximately 5 years. A review of Resident #88's Admission Record revealed that he/she had been admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted]. According to the quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1 Resident #88 had a Brief Interview for Mental Status score of NJ Ex /15 indicating NJ Ex Order 26.4(b)(1). Section O of the MDS revealed that Resident #88 received NJ Exec Order 26 According to the Order Summary Report with active orders as of NJ Exec Order 26.4b1, Resident #88 had the following physician order: NJ Exec Order 26 on Mon, Tues, Thurs, Sat at [facility name] 5 AM pickup. Order date: NJ Exec Order 26.4b1 A review of Resident #88's comprehensive care plan revealed a care planned Focus of: I [resident name] receive NJ Exec Order 26.4b1 3x/week related to NJ Exec Order 26.4b1 with an initiated ate	F 698	NJ Exec Order 26.4b1 to make sure going all necessary documentation and communication is properly noted. 2. All Dialysis patients have the potential of being affected by this deficient practice. 3. Nurses were in serviced by ADON/Designee on proper documentation in the Dialysis communication binders. The Unit managers/Designee will audit weekly for 12 weeks all Dialysis communication binders to ensure proper documentation. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 698	Continued From page 29	F 698		

of [NJ Exec Order 26.4b1] The following was listed as a care planned Intervention: Monitor VITAL SIGNS (Notify MD (medical doctor) of significant [NJ Exec Order 26.4b1] Date initiated: [NJ Exec Order 26.4b1] The care planned interventions did not reference the use of a communication record.

On 01/21/2025 at 10:32 AM the surveyor reviewed the Nursing Facility/[NJ Exec Order 26] Center Communication Records for Resident #88 via the EMR, as the forms had been scanned into the EMR by the facility. The surveyor reviewed the past 60 days of communication records up to the present date ([NJ Exec Order 26.4b1]

A review of the [NJ Exec Order 26] communication forms revealed that the facility did not document the following information to the [NJ Exec Order 26] center on the following dates for Resident #88: Information From Sending Facility; Temperature,[NJ Exec Order 26.4b1] Pulse, Access Site Status, and Any Problems/Patient complaints or Other Concerns Since Last [NJ Ex Order 26.4] Treatment on the following dates: [NJ Exec Order 26.4b1] and an undated communication record that was scanned into the EMR on [NJ Exec Order 26.4b1]

During an interview with surveyor on 01/21/2025 at 10:44 AM, Licensed Practical Nurse (LPN#3) who was assigned to Resident #88 was asked what the facility process was for residents who received [NJ Exec Order 26] and the use of the Nursing Facility/[NJ Exec Order 26] Center Communication Records. LPN#3 told the surveyor we send a [NJ Exec Order 26] book with the resident. It's a full sheet that we document vitals before leaving and we can also report [NJ Exec O] or details concerning the [NJ Exec Order 26.4b1]

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F 698	Continued From page 30	F 698		

if needed. LPN#3 further explained the NJ Exec Order 26 center is to provide information such as NJ Exec Order 26 medications provided, vital signs and any other pertinent recommendations. The surveyor then asked LPN#3 if the top portion of the communication form in the information from sending facility section was to be completed by the assigned nurse prior to the resident attending NJ Exec Order 26 treatment. LPN#3 stated "Yes, the top portion of the form should be filled out by nurses at the facility." LPN#3 also explained that if the NJ Exec Order 26 center forgets to document the information from NJ Exec Order 26 center section I will call the NJ Exec Order 26 center and obtain the necessary information.

During an interview with the survey team on 01/22/2025 at 01:51 PM, the US FOIA (b)(6) the surveyor asked the US FOIA (b) what facility process was for documenting on NJ Exec Order 26 communication forms prior to the resident leaving the facility for NJ Exec Order 26 treatment. The US FOIA (b) told the surveyor we utilize a communication book, but urgent communications would be conducted by phone call to the NJ Exec Order 26 facility or to the facility by NJ Exec Order 26 The facility is responsible for looking at the book, the weight before, and vitals before NJ Exec Order 26 The surveyor asked the US FOIA (b) if the sending nurse was responsible to fill out the Information from Sending Facility prior to NJ Exec Order 26 treatment. The US FOIA (b) responded, "They (nursing staff) are to ensure that the form is completed. There shouldn't be blank forms before the resident goes to dialysis. It would be good; it should be filled out."

A review of a facility provided policy titled [facility name] Dialysis Policy, undated, revealed under

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F 698	Continued From page 31 General Statement of Policy: [Facility Name] has established standards of care for the dialysis resident. Designated Licensed Nurse will maintain the established standard of care. Section F of the policy titled Communication revealed the following: Communication with the dialysis center will be maintained through the use of a communication book. The book is located at the nurse's station and is clearly labeled with the resident's name. The communication book is sent with the resident each time they are transported to dialysis. The nursing staff and the dialysis center will communicate any pertinent information through the communication book. The communication book will be reviewed by the licensed nurse upon return from dialysis. N.J.A.C. 8:39-27.1 (a)	F 698		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician,	F 712		2/14/25

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F 712	Continued From page 32 required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Electronic Medical Record (EMR), and review of other facility documentation, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face to face visits and wrote progress notes at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. This deficient practice continued over several months for 8 of 35 sampled residents (Resident #1, Resident #31, Resident #53, Resident #59, Resident #78, Resident # 79, Resident #120, and Resident#139) and was evidenced by the following: 1.) On 01/21/2025 at 09:01 AM, a review of the EMR for Resident # 139 revealed the following: According to the Admission Record, Resident #139 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] A review of the EMR revealed that there was no documentation to indicate Resident #139 was seen by attending physician at any time from NJ Exec Order 26.4b1. Resident #139 was seen by the US FOIA (b)(6) [redacted] on NJ Exec Order 26.4b1 [redacted]	F 712	F712 SS=E 1. Residents #1,#31,#53,#59,#78,#79,#120,#139 were visited by the Doctor. 2. All residents have the Potential to be affected by this deficient practice. 3. The Administrator on 2/7/25 Reviewed with the MD the regulations pertaining to the required frequency and timeliness of patients being seen by his/hers doctor. The DON/Designee will audit 5 patients weekly for 12 weeks to ensure that they are seen by the doctor according to regulation. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 712	Continued From page 33	F 712		

2.) On 01/16/2025 at 10:22 AM, a review of the EMR for Resident #79 revealed the following:

According to the Admission Record, Resident #79 was admitted to facility with diagnoses including but not limited to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

A review of the EMR for Resident #79 did not include documentation that Resident 379 was seen by the attending physician since NJ Exec Order 26.4b1.

Resident #79 was seen by the US FOIA on NJ Exec Order 26.4b1

3.) On 01/17/2025 at 09:41 AM, a review of the EMR for Resident #59 revealed the following:

According to the Admission Record, Resident #59 was admitted to facility with diagnoses including but not limited to NJ Exec Order 26.4b1

A review of the EMR for Resident #59 did not include documentation that Resident #59 was seen by the attending physician in greater than the past 60 days

Resident #59 was seen by the US FOIA on NJ Exec Order 26.4b1

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4.) On 01/15/2025 at 01:44 PM, a review of the EMR for Resident #120 revealed the following:

According to the Admission Record, Resident #120 was admitted to facility with diagnoses including but not limited to NJ Exec Order 26.4b1 [redacted]

A review of the EMR for Resident #120 did not include documentation that Resident #120 was seen by the attending physician since NJ Exec Order 26.4b1 [redacted]

Resident #120 was seen by the US FOIA (b) on NJ Exec Order 26.4b1 [redacted]

5.) On 01/20/2025 at 09:23 AM, a review of the EMR for Resident #31 revealed the following:

According to the Admission Record, Resident #31 was admitted to facility with diagnoses including but not limited to NJ Exec Order 26.4b1 [redacted]

A review of the EMR for Resident #31 did not include documentation that Resident #31 was seen by the attending physician from NJ Exec Order 26.4b1 [redacted]

Resident #31 was seen by the US FOIA (b) on NJ Exec Order 26.4b1 [redacted]

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F 712	Continued From page 35	F 712		

6.) On 01/20/2025 at 02:09 PM, a review of the EMR for Resident #1 revealed the following:

According to the Admission Record, Resident #1 was admitted to facility with diagnoses including but not limited to NJ Exec Order 26.4b1.

A review of the EMR for Resident #1 did not include documentation that Resident #1 was seen by the attending physician in greater than 60 days.

Resident #31 was seen by the US FOIA on NJ Exec Order 26.4b1

7.) On 01/16/2025 at 12:39 PM, a review of the EMR for Resident #78 revealed the following:

According to the Admission Record, Resident #78 was admitted to facility with diagnoses including but not limited to NJ Exec Order 26.4b1

A review of the EMR for Resident #78 did not include documentation that Resident #78 was seen by the attending physician in greater than 60 days.

Resident #78 was seen by the US FOIA on NJ Exec Order 26.4b1

8.) On 01/16/2025 at 11:58 AM, a review of the

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	315293	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 36 EMR for Resident #53 revealed the following: According to the Admission Record, Resident #53 was admitted to facility with diagnoses including but not limited t NJ Exec Order 26.4b1 [redacted] A review of the EMR for Resident #53 did not include documentation that Resident #53 was seen by the attending physician in greater than 60 days. Resident #53 was seen by the US FOIA on NJ Exec Order 26.4b1 [redacted]. On 01/21/2025 at 09:59 AM, the surveyor interviewed Licensed Practical Nurse (LPN#2) who stated that all physicians document their notes in the EMR since they have access to it. On 01/21/2025 at 10:03 AM, the surveyor interviewed LPN #3 who stated that all doctors' notes are in the EMR. LPN #3 further stated that if some people could not access it, the handwritten notes are scanned to the EMR, and that the facility did not have paper charts. On 01/21/2025 at 11:47 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/ UM #1) who stated that the doctors' notes were in the EMR under progress notes section.	F 712		

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F 712	Continued From page 37 On 01/22/2025 at 12:45 PM, Surveyors #1 and #2 interviewed the US FOIA (b)(6) who stated that he see's their patients every other month or every third month. US FOIA stated that they usually see their patients in the hospital. The US FOIA confirmed that they do not write physician notes and instead the APNs write the physician notes in the EMR. During an interview with the survey team on 01/22/2025 at 01:55 PM, the US FOIA (b)(6) stated that the APNs visit the residents twice a week and that the medical director could be contacted anytime. The US FOIA (b) further stated that the physician notes were in the EMR which included the History and Physical Examination, diagnosis list, medication review, current complaints, and laboratory findings. A review of a facility provided policy titled Physician Services revised in April 2013 under Policy Interpretation and Implementation included 5. Physician visits, frequency of visit, emergency care of residents, etc. are provided in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. Consultative services shall be made available from community-based consultants or from a local or medical center. NJAC 8:39-23.2 (b), 23.2 (d)	F 712		
F 812 SS=E	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		2/14/25

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F 812	Continued From page 38 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner. This deficient practice was evidenced by the following: On 01/15/2025 at 09:16 AM, the surveyor, accompanied by the US FOIA (b)(6) observed the following in the kitchen: 1. A meat slicer was observed on a metal table in the cook's area. The meat slicer was not covered and was exposed to the air. The surveyor asked the facility cook if she had used the meat slicer at any point this AM for food production. The cook stated that she had not utilized the meat slicer for food production this AM. The surveyor asked the US FOIA (b)(6) if the meat slicer was cleaned and sanitized and he said yes that it was cleaned and sanitized. The table behind the blade guard/slicer wheel had unidentified food debris and a white slimy substance present when observed. The meat	F 812	F812 SS=E 1. The Meat Slicer was immediately recleaned and covered. The 4 top pans were rewashed, sanitized and air dried. The Freezer in the North Pantry was defrosted. 2. All residents have the ability to be affected by this deficient practice. 3. The Dietary department were in serviced on the proper cleaning, storing and drying protocols for Dietary equipment, utensils and pantry freezers the FSD or Designee will do weekly rounds x12 weeks to ensure The Meat Slicer is properly cleaned and covered, Pans are properly air dried and Pantry freezers are properly defrosted.	

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F 812	Continued From page 39 slicer was not covered while not in use and was exposed to contamination. The cook then further clarified to the surveyor that she had not used the meat slicer today. When interviewed the [US FOIA] confirmed that the meat slicer was cleaned and sanitized and stated it was not going to be used any time soon. The [US FOIA] then told a kitchen staff to re-clean and sanitize the meat slicer and cover it when not in use. 2. On a lower shelf of what the [US FOIA] identified as Drying Rack number 2 a stack of approximately 8 deep 1/4 pans were in the inverted position. The surveyor lifted the top quarter pan and observed a wet water-like substance on the pan directly below in the stack, commonly known in the food service industry as wet nesting (the practice of stacking wet dishes or pots and pans together, which prevents them from drying and creates an environment where bacteria and other microorganisms can grow). The [US FOIA] told the surveyor "there wet" when he observed the stack of deep 1/4 pans. The surveyor and [US FOIA] touched with their finger the 1/4 pans and agreed that the pans were not completely air dried prior to stacking. The top 4 pans in the stack were all observed to be wet with a clear, water-like liquid. The deep 1/4 pans were removed from the rack and returned to the dish room to be rewashed and sanitized and completely air dried prior to stacking. On 01/21/2025 from 09:21 to 09:34 AM, the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM #2), observed the following on the North Pantry/Nourishment room: 1. The surveyor observed a thick buildup (about a 1/4 inch) of ice on the bottom of the freezer.	F 812	4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 812	Continued From page 40	F 812		

Embedded in the ice was a white plastic spoon and what appeared to be several pieces of white napkin, aluminum foil, and what appeared to be Styrofoam pieces. There were also bagged ice packs stored in the freezer with resident food. When interviewed the LPN/UM #2 did not know who was responsible for the maintenance of the pantry/nourishment room freezer. A review of the facility policy titled Foods Brought by Family/Visitors, reviewed 5/2023, failed to identify who was responsible for the maintenance and sanitation of the facility resident nourishment refrigerators.

A review of a facility provided policy titled [facility name] Sanitization/Cleanliness, revised November 2024, revealed under Policy Interpretation and Implementation:

7. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination.

8. When cleaning fixed equipment (e.g., mixers, slicers, and other equipment that cannot readily be immersed in water), the removable parts are:
a. washed and sanitized and non-removable parts cleaned with detergent and hot water, rinsed, air-dried, and sprayed with a sanitizing solution (at the effective concentration); and
b. the equipment is reassembled and any food contact surfaces that may have been contaminated during the process are re-sanitized (according to the manufacturer's instructions).

N.J.A.C. 8:39-17.2(g)

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F 849	Continued From page 41	F 849		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the	F 849		2/14/25

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F 849	Continued From page 42	F 849		

communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration

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F 849	Continued From page 43	F 849		

of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives

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F 849	Continued From page 44	F 849		

and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest

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F 849	Continued From page 45 practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to maintain a NJ Exec Order 26 Communication Record for 1 of 1 resident (Resident #85) reviewed for NJ Exec Order 26 Services. This deficient practice was evidenced by the following: During the initial tour of the NJ Exec Order 26.4b1 on 01/15/2025 at 10:19 AM, the surveyor observed Resident #85 in his/her room with no concerns. At that time, Resident #85 was identified as having NJ Exec Order 26.4b1. A review of the admission record, revealed Resident # 85 was admitted with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ Exec Order 26.4b indicated that Resident #85 was on NJ Exec Order 26 Care. A review of Resident #85's individual comprehensive care plan (ICCP) on NJ Exec Order 26.4b1 at 11:39 AM, included a focus area, dated NJ Exec Order 26.4b that indicated resident #85 was on NJ Exec Order 26.4b Interventions included to coordinate Care Plan with NJ Exec Order 26.4b evaluate effectiveness of medications/interventions to address comfort, and to notify NJ Exec Order 26 of any change in condition or medication changes. During an interview with the surveyor on	F 849	F849 SS=D 1. Resident #85's NJ Exec Order 26 Communication was immediately downloaded and updated in the Communication binder. 2. All Hospice residents have the ability to be affected by this deficient practice. 3. The Nursing Staff were in serviced on the importance of keeping all hospice documentation updated in the communication binders. The UM/Designee will do weekly audits x12 weeks to ensure all Hospice patients communication's are properly located in the Communication Binders. 4. The results of the weekly audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 849	Continued From page 46 01/17/2025 at 9:22 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #2) was asked to provide Resident #85's NJ Exec Order 26.4b1 Book. At that time, LPN/UM#2 stated that she would have to get permission from her US FOIA (b)(6) [redacted] LPN/UM #2 then provided the NJ Exec Order 26 Communication Book and upon review of the book, there were only 2 documents found that included a "facility billing notification and a "symptom management recommendation." When further questioned, LPN/UM #2 was unable to provide any additional documentation or communication from the NJ Exec Order 26 providers. A review of the facility's "Hospice Program" policy, with a review date of 5/2023, included, "Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day ..." NJAC 8:39-27.1(a)	F 849		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: Findings include: 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	S 560	S560 1. Staffing Coordinator was educated by administrator on New Jersey state staffing ratio requirements. Efforts are ongoing to hire facility staff and will continue until there is adequate staff to meet the minimum staff to resident ratios. Until that time, the facility will use staffing agencies and offer additional shifts to current staff with bonuses as required. Facility Administrator continues to work with Human resources to secure additional staffing agency usage. Interdisciplinary team met to discuss	2/14/25

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

Electronically Signed | 02/13/25

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WHITING GARDENS REHABILITATION AND NU	3000 HILLTOP ROAD WHITING, NJ 08759

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of AAS-11 staffing from 12/29/2024 to 1/11/2025, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -12/29/24 had 18 CNAs for 169 residents on the day shift, required at least 21 CNAs. -12/30/24 had 20 CNAs for 169 residents on the day shift, required at least 21 CNAs. -12/31/24 had 19 CNAs for 167 residents on the day shift, required at least 21 CNAs. -01/01/25 had 19 CNAs for 167 residents on the day shift, required at least 21 CNAs. -01/02/25 had 20 CNAs for 167 residents on the day shift, required at least 21 CNAs. -01/03/25 had 19 CNAs for 167 residents on the day shift, required at least 21 CNAs. -01/04/25 20 CNAs for 166 residents on the day shift, required at least 21 CNAs. -01/05/25 had 18 CNAs for 166 residents on the	S 560	recruitment and retention interventions. 2. All residents have the the ability to be affected by this deficient practice. 3. Weekly recruitment , retention and employee appreciation meetings are ongoing and continues to be led by the Director of Human Resources or designee. Hiring and recruitment efforts including pay for experience, online job listings, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities, employee morale incentives and potential job fair. The HR Director or designee will continue to track and document all recruitment and retention efforts weekly. The DON or designee will review staffing schedules weekly to ensure adequate staffing for all shifts. 4. The results of the weekly recruitment and retention audits will be submitted to the QAPI Committee meeting monthly for 3 months. Based on the results of these audits a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061534	A. BUILDING: _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NU	3000 HILLTOP ROAD WHITING, NJ 08759

(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 2 day shift, required at least 21 CNAs. -01/06/25 had 14 CNAs for 166 residents on the day shift, required at least 21 CNAs. -01/07/25 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -01/10/25 had 19 CNAs for 157 residents on the day shift, required at least 20 CNAs. -01/11/25 had 18 CNAs for 157 residents on the day shift, required at least 20 CNAs. During an interview with the surveyor on 01/22/2025 at 01:45 PM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), was asked the if he was familiar with the state mandated minimum staffing ratios. The LNHA responded that he was and told the surveyor the following ratios: 1 to 8 on the 7-3 shift, 1 to 10 on the 3-11 shift, and possibly 1 to 15 on the 11-7 shift. The surveyor then asked the LNHA if the facility was consistently meeting the required ratios and the LNHA told the surveyor, "We try very hard. It's a challenge and we try the best we can."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315293 Y1	A. Building B. Wing Y2	3/5/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

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 F0584	Correction	ID Prefix F0658	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	02/14/2025	LSC	02/14/2025	LSC	02/14/2025
ID Prefix F0688	Correction	ID Prefix F0689	Correction	ID Prefix F0690	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	02/14/2025	LSC	02/14/2025	LSC	02/14/2025
ID Prefix F0695	Correction	ID Prefix F0698	Correction	ID Prefix F0712	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.30(c)(1)-(4)	Completed
LSC	02/14/2025	LSC	02/14/2025	LSC	02/14/2025
ID Prefix F0812	Correction	ID Prefix F0849	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(n)(1)-(4)	Completed	Reg. #	Completed
LSC	02/14/2025	LSC	02/14/2025	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?
1/23/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061534 (Y1)	A. Building B. Wing (Y2)	3/5/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/14/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/23/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING **02** B. WING _____	**01/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NURSING CENTER	**3000 HILLTOP ROAD** **WHITING, NJ 08759**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 01/15/2025 to 01/17/2025. The facility was found to be in non-compliance with 42 CFR 483.73.	E 000		
E 020 SS=F	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or	E 020		2/14/25

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

Electronically Signed | 02/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING 02 B. WING _____	01/23/2025

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E 020	Continued From page 1 REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 01/17/25 in the presence of the[US FOIA (b)(6)] [redacted], it was determined the facility failed to ensure the transportation agreements were updated annually. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review at approximately 10:40 AM revealed that the facility had an outdated agreement with the following transportation service:	E 020	E20 SS=F 1. The Transportation Agreement date was updated to be within the year. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] was in serviced by the Admin to ensure the Transfer Agreement is updated yearly. The Maintenance Director or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING **02** B. WING _____	**01/23/2025**

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E 020	Continued From page 2 GEM Ambulance dated 10/29/20. The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code exit conference on 1/17/25 at 12:45 PM. N.J.A.C. 8:39-31.6 (f) (3)	E 020	will audit quarterly for 4 quarters the EP Binder to ensure the Transfer agreements are properly updated. 4. The results of these audits will be presented to the monthly QAPI committee quarterly x4 quarters for review and to determine the need of future audits.	
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at	E 025		2/14/25

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E 025	Continued From page 3 §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and interview on 01/17/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to to ensure transfer agreements were updated annually. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review at approximately 10:40 AM revealed that three (3) facilities did not have updated transfer agreements. These 3 facilities were: Complete Care at Holiday City dated 3/25/22 Complete Care at Sharrock dated 3/25/22 Complete Care at Arbor dated 3/25/22 The facility's US FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 1/17/25 at 12:45 PM..	E 025	E025 SS=F 1. The Maintenance Director updated the EP Manual and removed the 3 outdated Facility Transfer Agreements and kept the ones that were updated within the last year. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was in serviced on the importance to ensure the facility Transfer Agreements are updated yearly. The Maintenance Director or Designee will audit quarterly x4 quarters the EP Binder to ensure the facility transfer agreements are properly updated.	

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E 025	Continued From page 4 N.J.A.C. 8:39-31.6 (f) (2)	E 025	4. The results of these audits will be presented to the monthly QAPI Committee quarterly for 4 quarters for review and to determine the need for future audits.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)	E 041		2/14/25

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E 041	Continued From page 5 Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1	E 041		

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E 041	Continued From page 6 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 01/17/25 in the presence of the US FOIA (b)(6) [redacted] the facility failed to to ensure the generator fuel agreements were updated annually. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review at approximately 10:40 AM revealed that two (2) generator fuel suppliers did not have updated fuel agreements. These 2 suppliers were:	E 041	E041 SS=F 1. Power House is our Generator Vendor and backup generator supplier. Dover Oil is our Fuel Supplier. Both Agreements were updated to reflect current dates. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] was in serviced by the Administrator to ensure	

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WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

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E 041	Continued From page 7 Power House Generator dated 3/1/23 Dover Oil Company dated 10/26/22 In an interview with [U.S. F] at approximately 11:00 am, the [U.S. F] stated, "We no longer use Power House, we are only using Dover Oil Company." The facility's US FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 1/17/25 at 12:45 PM. N.J.A.C. 8:39-31.2 (e)	E 041	that all Facility agreements are updated yearly with current dates. The Maintenance Director or Designee will audit quarterly x4 quarters the EP Binder to ensure all agreements are properly updated. 4. The results of these audits will be presented to the monthly QAPI Committee quarterly for 4 quarters for review and to determine the need for future audits.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 1/15/25, 1/16/25 and 1/17/25 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Whiting Gardens is a one story building that was built in 1992. It is composed of Type V- 111 protected construction. The facility is divided into nine smoke zones. The generator powers 100 % of the building as per the Maintenance Director. The current occupied beds are 162 of 200.	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual	K 281		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING 02 B. WING	01/23/2025

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K 281	Continued From page 8 intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/16/25 in the presence of the [redacted] was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 1 of 4 areas, had the potential to affect 25 residents and was evidenced by the following: An observation at 11:09 AM revealed in the West-wing occupied day room that 2 (two) light switches shutoff all 6 (six)ceiling light fixtures. In an interview, the [redacted] both confirmed the findings at the time of observations. The [redacted] was informed of the deficient practice at the Life Safety Code survey exit conference on 1/17/25 at 12:45 PM. NJAC 8:39-31.2(e)	K 281	K281 SS=D 1. Vendor came in to rewire West wing Day Room so that one light fixture remains illuminated even when both switches are turned off. 2. All residents have the potential to be affected by this deficient practice. 3. The [redacted] was in serviced by the Administrator on the importance of making sure all means of egress are illuminated in accordance with NFPA Code. The Maintenance Director or Designee will audit monthly for 3 months all means of egress to ensure that they are properly illuminated according to code. 4. The results of these audits will be brought to the monthly QAPI Committee x3 months and reviewed to determine the necessity of future audits.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		2/28/25

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K 345	Continued From page 9 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interviews on 1/15/25, 1/16/25 and 1/17/25 in the presence of the US FOIA (b)(6) [redacted] a). it was determined that the facility failed to ensure all components of the fire alarm system were fully operational in accordance with NFPA 70 and 72. b.) it was determined that their fire alarm system was inspected on a semi-annual basis in accordance with NFPA 70 and 72. This deficient practice had the potential to affect all residents and was evidenced by the following: a). An observation at 9:15 AM revealed the lobby fire alarm annunciator panel was in trouble mode indicating: issues in the "main dining room (north)". The fire alarm panel was observed to be in trouble mode all 3-days of the facility Recertification survey. In an interview at 9:40 AM, the US FOIA (b)(6) both confirmed the fire alarm annunciator panel was in trouble mode and did not provide any further documentation. b.) At approximately 09:50 AM, the surveyor reviewed all documentation from the fire alarm vendor. The document indicated date of inspection: 3/12/24 only and was not performed on a semi-annual basis in accordance with NFPA 70 and 72. The fire alarm system has sealed lead acid batteries and required a semi-annual inspection.	K 345	K345 SS=F 1. The semi annual Fire Alarm inspection was completed on 1/22/25. The Final Mapping fault related to the smoke detector was cleared 2/28/25. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] was in serviced by the Admin on the required schedules of inspections and the importance of ensuring the Fire panel is cleared of any faults. The Maintenance Director/Designee will audit monthly x3 months to ensure all inspections are done timely and that the Fire Panel is clear of any faults. 4. Results of these audits will be presented to the Monthly QAPI Committee for 3 months to determine necessity of future audits.	

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K 345	Continued From page 10 In an interview during record review, the US FOIA (b)(6) [redacted] both stated that the semi-annual fire alarm inspection was not conducted after 3/12/24 (almost 10 months ago), and they could not provide any further documentation for review. * it was noted that the fire alarm panel indicated trouble mode. The US FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 1/17/25 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		2/24/25

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K 353	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 1/16/25 in the presence of the US FOIA (b)(6) [redacted] a). it was determined that the facility failed to have three (3) of three (3) observed private fire hydrants inspected annually according to NFPA 25. b). it was determined that the facility failed to ensure fire sprinkler inspections were conducted on a quarterly basis as per NFPA 25. This deficient practice had the potential to affect all residents at the facility and was evidenced by the following: a) At 10:30 AM, the surveyor reviewed all related documentation from the fire sprinkler vendor. The most recent report dated: 8/13/24 did not indicate when the last private fire hydrant inspection was conducted. In an interview, the US FOIA (b)(6), both confirmed the review. b). A document review at 10:48 AM revealed that the last quarterly fire sprinkler vendor inspection report was dated: 8/13/24 over 5-months ago. In an interview at 11:15 AM, the US FOIA (b)(6) both confirmed the above observations. The US FOIA (b)(6) confirmed the most recent report was dated: 8/13/24 and no further documentation was provided. The U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 1/17/25 at 12:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353	K353 SS=F 1. The facility immediately called our vendor to come in to perform the missing quarterly inspection which was completed 1/22/25. The Fire Hydrant inspection was completed on 2/24/25. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] was in serviced on the required quarterly Sprinkler inspection and Annual Fire Hydrant inspection schedule. The Admin or Designee will audit quarterly the Inspection Binder to ensure all inspections are properly in place and scheduled. 4. The results of these audits will be brought to the QAPI Committee quarterly x3 quarters for review and to determine necessity of future audits.	

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K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		2/14/25

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K 363	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/16/25 in the presence of the[US FOIA (b)(6) redacted] it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101: 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 5 of 37 resident rooms observed, had the potential to affect 50 residents and was evidenced by the following: Observations from 9:15 AM to 12:45 PM in the presence of the[US FOIA (b)(6)] revealed resident room doors did not operate properly as follows: - Room #116 - the top of the door was warped approximately 3/4 gap. - Room #117 - the top of the door was warped approximately 3/4 gap. - Room #329 - the door would not latch into its frame. - Room #428 - the door would not latch into its frame. - Room #432 - the door would not latch into its frame. In an interview at 12:00 PM, the[US FOIA (b)(6)] confirmed the above findings. The[US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 1/17/25 at 12:45 PM.	K 363	K363 SS=E 1. Room #116,117 door frames were adjusted so there is no 3/4" gap. Rm #329,428,432 the door handles were replaced and now properly latch. 2. All residents have the potential to be affected by this deficient practice. 3. The[US FOIA (b)(6)] was in serviced by the Admin on the importance of ensuring all doors properly close and latch to avoid any smoke penetration . The Maintenance Director or Designee will audit 1 unit monthly x3 months to ensure that all doors properly latch. 4. The results of these audits will be brought to the monthly QAPI Committee meeting x3 months to review and determine necessity of future audits. .	
K 741 SS=F	NJAC 8:39-31.1(c), 31.2(e) Smoking Regulations	K 741		2/14/25

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K 741	Continued From page 14 CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 1/16/25 in the presence of the [redacted] a). it was determined that the facility failed to ensure that metal containers with self-closing cover devices were readily available to all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. b). it was determined that	K 741	K741 SS=F 1. The smoking area was immediately cleaned. Metal containers with self closing cover devices were put in place in smoking area.	

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K 741	Continued From page 15 the smoking area was not maintained free of combustible dried grass, leaves and cigarette butts. This deficient practice had the potential to affect all residents and was evidenced by the following: a). An observation at 1:30 PM revealed a metal container with a self-closing cover device into which ashtrays can be emptied was not provided or readily available to the smoking area. In an interview at the time, the US FOIA (b)(6) both confirmed the observation. b). Observations at approximately 1:00 PM with the US FOIA (b)(6) revealed that at the outer perimeter of the smoking area was dried grass and leaves. The surveyor observed 100-plus cigarette butts in that area, along with cigarette butts on the occupied concrete pad. The occupied resident smoking area was provided with 4-oasis type ashtrays. The outside area of the smoking courtyard was observed to have cigarette burn marks on the white siding. In an interview, both the US FOIA (b)(6) confirmed the observations in smoking courtyard. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 1/17/25 at 12:45 PM. N.J.A.C 8:39-31.2(e)	K 741	2. All residents have the ability to be affected by this deficient practice. 3. Housekeeping and smoking monitor were in serviced on the importance of ensuring the smoking area is clean and free of any cigarette butts. Maintenance Director was in serviced on the importance of having adequate Metal containers with self closing cover devices for our smoking area. The Maintenance Director/Smoking Monitor or designee will conduct weekly rounds x12 weeks to ensure the smoking area is clean of all cigarette butts and the metal containers are in place. 4. Results of these audits will be presented to the monthly QAPI Committee x3 months for review and determine need of future audits.	
K 791 SS=E	Construction, Repair, and Improvement Operati CFR(s): NFPA 101 Construction, Repair, and Improvement	K 791		2/14/25

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K 791	Continued From page 16 Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and interview on 1/16/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to conduct inspections of exit areas while renovations were in progress in accordance with NFPA 241-19.7.9, 4.6.10, 7.1.10.1. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following: An observation at 9:15 AM revealed that the East-wing was being renovated including resident rooms: 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, and 212. In an interview at 9:50 AM, the US FOIA (b)(6) [redacted] indicated that the renovation daily inspections were not logged and conducted by the facility to ensure its ability to be used instantly in case of emergency. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 1/17/25 at 12:45 PM.	K 791	K791 SS=E 1. Daily Inspections of the Improvement operations area Egress were immediately logged. 2. All residents have the potential to be affected by this deficient practice. 3. The New U.S. FOIA (b) (6) [redacted] was in serviced on the importance of logging daily rounds of clear egress paths in areas that improvements are being done. The Administrator or Designee will audit weekly for 12 weeks to ensure rounds are being logged. 4. The results of these audits will be brought to the monthly QAPI Committee meeting x3 months for review and to determine necessity of future audits.	
K 908 SS=F	NJAC 8:39-31.2(e) Gas and Vacuum Piped Systems - Inspection and CFR(s): NFPA 101	K 908		2/25/25

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K 908	Continued From page 17 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 1/16/25 in the presence of the US FOIA (b)(6) it was determined that the facility failed to inspect and test the piped-in Oxygen system annually as part of a maintenance program in accordance with the guidelines of NFPA 99. This deficient practice was identified in the East wing of the facility and had the potential to affect all future residents in that area and was evidenced by the following: A documentation review of the facility's piped-in oxygen system inspections revealed that the last inspection of the system by a licensed vendor was not conducted since 2020. An observation at 10:00 AM revealed that the East-wing was being renovated and currently unoccupied. In an interview at 10:10 AM, the US FOIA (b)(6) confirmed the observations and could not provide any documents indicating when the last time the system was checked as per NFPA 99 guidelines. The U.S. FOIA (b) (6) was informed of the deficient	K 908	K908 SS=F 1. The unused Gas and Vacuum Piped System was professionally shutdown on 2/25/25. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) was in serviced that all systems, even if they are not in use/or have never been in use still need to be professionally maintained yearly or professionally shutdown. Maintenance Director/Designee will audit annually any systems that need inspection to ensure they are properly inspected and tested. 4. Results of these audits will be brought to the quarterly QAPI committee x4 quarters for review and to determine the need of future audits.	

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K 908	Continued From page 18 practice during the Life Safety Code exit conference on 1/17/25 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 908		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	K 921		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING 02 B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 1/16/25 in the presence of the Maintenance Director (MD) and Administrator (ADMIN), it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations from 9:35 AM to 12:15 PM revealed that all resident room electric beds had no annual inspection stickers throughout the facility. In an interview at the time, the US FOIA (b)(6) both confirmed the findings. A documentation review revealed no policy on patient care related electric beds and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 1/17/25 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	K921 SS=F 1. All resident room Electric Beds were inspected and logged. 2. All residents have the potential to be affected by this deficient practice. 3. The new U.S. FOIA (b) (6) was in serviced on the importance of inspecting all resident room Electric Beds yearly and logging the results. Maintenance Director or Designee will audit annually all electrical equipment to ensure they are inspected and logged. 4. The results of these audits will be presented to the QAPI Committee quarterly x4 quarters for review and to determine the need for future audits.	

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
315293 Y1	A. Building B. Wing Y2	3/5/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

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 E0020 Reg. # 483.73(b)(3) LSC	Correction Completed 02/13/2025	ID Prefix E0025 Reg. # 483.73(b)(7) LSC	Correction Completed 02/13/2025	ID Prefix E0041 Reg. # 483.73(e) LSC	Correction Completed 02/13/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/23/2025	☐ 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
315293 Y1	A. Building 02 - WHITING 02 B. Wing Y2	3/5/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITING GARDENS REHABILITATION AND NURSING CENTER	3000 HILLTOP ROAD WHITING, NJ 08759

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	02/13/2025	LSC K0345	02/28/2025	LSC K0353	02/24/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	02/14/2025	LSC K0741	02/14/2025	LSC K0791	02/14/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0908	02/25/2025	LSC K0921	02/14/2025	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	
1/23/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO