STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint#s: NJ182226, NJ180612, NJ179494, NJ176645, NJ175752, NJ174667, NJ174671, NJ173257, NJ171065, NJ169407 Survey Date: 1/22/2025 Census: 278 Sample: 36 residents + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		2/28/25

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

Electronically Signed | 02/10/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of their quality of life specifically by ensuring staff able to communicate with the resident in the language that the resident understood and preferred according to plan of care. This deficient practice was identified for 1 of 2 residents, Resident #158, reviewed for communication. This deficient practice was evidenced by the following: On 1/17/25 at 9:40 AM, the surveyor observed Resident #158 laying on an NJ Ex Order 26. 4B1	F 550	F550 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. The Director of Rehabilitation provided Resident #158 with a communication binder of NJ Ex Order 26.4b1 translations. b. The Recreation Therapist for resident #158 posted a list of NJ Ex Order 26.4b1 channels on the wall under the resident□s television.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 550	Continued From page 2 U.S. FOIA (b) (6) and the resident spoke NJ Ex Order 26.4b1. The surveyor also observed that there was no communication board (alternative communication methods designed to overcome communication barriers) at the bedside and the resident's television (TV) was on the English Channel. On 1/17/25 at 9:56 AM, the U.S. FOIA (b) (6) asked the U.S. FOIA (b) (6) to help her reposition Resident#158 for the surveyor to observe the dressing in the NJ Ex Order 26. 4b1. Inside the resident's room, the surveyor observed the U.S. FOIA (b) (6) were unable to communicate with the resident in NJ Ex Order 26.4b1 for the resident to comply with positioning. Both the U.S. FOIA (b) (6) were unable to understand the resident's request to change the TV channel to NJ Ex Order 26.4b1. The U.S. FOIA confirmed that the resident spoke NJ Ex Order 26.4b1, and that the resident should have a communication board in the room as the facility's practice in order to understand the resident and respond to the resident's needs. The U.S. FOIA further stated that she would notify the Maintenance department to assist the resident to have a NJ Ex Order 26.4b1 channel. On 1/17/25 at 10:14 AM, the surveyor notified the U.S. FOIA (b) (6) regarding the above findings and concerns. Both the surveyor and the U.S. FOIA went inside the resident's room. The U.S. FOIA informed the surveyor that Resident #158 spoke NJ Ex Order 26.4b1 and should have a NJ Ex Order 26.4b1 communication board inside the room as per the facility's practice. She further stated that she was unsure why there was no communication board inside the room.	F 550	c. The Registered Nurse Supervisor was provided with a copy of the list of Bilingual Staff Members□ Translator List that is available in the master Communication Board & Translator List binder on each resident unit in the chart rooms. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside in the facility and communicate in a language other than English or who want an interpreter to communicate with a doctor or health care staff have the potential to be affected by the deficient practice. b. Using a report from the Minimum Data Set to identify residents during the month of January 2025 who communicate in a language other than English the Assistant Nursing Supervisors audited resident records to develop or update a care plan for communication. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Executive Director/LNHA audited all complaints as recorded by the Department of Social Services during the month of January 2025 to review any complaints regarding resident dignity and respect related to communication and that action had been taken to address any concerns that were reported. No	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 550	Continued From page 3 On that same date and time, the surveyor observed the [U.S. FOIA (b)] had difficulty communicating with the resident. The [U.S. FOIA (b)] stated that she was unsure what channel the [NJ Ex Order 26.4B1] channel was. The surveyor observed the [U.S. FOIA (b)] changed the channels multiple times to find a [NJ Ex Order 26.4b1] channel. The surveyor reviewed the medical records of Resident #158 and revealed: A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, [NJ Ex Order 26. 4B1] [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date of [NJ Ex Order 26. 4B], reflected in Section A Identification Information that the resident's preferred language was [NJ Ex Order 26.4B1] and that needed or wanted an interpreter to communicate with doctor or health care staff. Section C Cognitive Patterns reflected that the resident's cognitive skills for decision-making were coded [NJ Ex Order 26. 4B1]. A review of the provided Plan of Care by the [U.S. FOIA (b) (6)] reflected that the resident had difficulty communicating because the resident speaks and understands, was created and updated on [NJ Ex Order 26. 4B]. The interventions included: provide a communication book and provide a translator if needed, were created and updated on [NJ Ex Order 26. 4B].	F 550	complaints were recorded. b. Inservice by the Inservice Instructors and Assistant Nursing Supervisors was provided for all nurses, CNA's, Social Workers, Dietitians and Therapeutic Recreation staff regarding resident dignity and respect to communicate in the preferred language of the resident. c. Staff will continue to receive annual mandatory in-service education during MIST (Mandatory Inservice Training). Training includes communication with residents in their preferred language through the use of communication binders and translators from staff and contracted staff. d. During each admission, quarterly, annual or significant change Interdisciplinary Care Team meeting the Social Worker will ensure there is a care plan for residents who cannot communicate in the English language or who require a interpreter to communicate with the doctor or health professional. The Assistant Director of Nursing / designee (Director of Nursing) will audit the records of five residents/week using a report from the Minimum Data Set to identify residents who communicate in a language other than English or want an interpreter to communicate with a doctor or health professional. The audit will confirm the presence of a care plan and a communication binder if required. e. The Secretary for the Social Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 550	Continued From page 4 A review of the facility's Resident's Rights Policy, with a review date of 1/30/18 that was provided by the [redacted] reflected that it was the facility's policy to protect and promote the rights of each resident, particularly those rights that pertain to a dignified existence, self-determination, and communication with access to persons and services within and outside the facility. On 1/21/25 at 12:19 PM, the survey team met with the [redacted] stated Resident #158 should have a communication board. N.J.A.C. 8:39-4.1	F 550	Department created a Television Guide that includes international (Spanish) international languages and distributed the Guide to residents. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Assistant Director of Nursing / designee (Director of Nursing) will report the findings from the audit of five residents who communicate in a language other than English or want an interpreter to communicate with a doctor or health professional.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made	F 577		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 577	Continued From page 5 respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain the prior year's Federal and State of New Jersey (State) inspection results and post the location of those results in an area that was readily accessible to residents, families, and the public. The deficient practice was evidenced by the following. On 1/16/25 at 8:29 AM, the surveyor observed a binder in the reception desk for Licensure Reports (survey results) which the Security Staff (SS) confirmed that the survey results were for date 8/12/21. On 1/16/25 at 11:08 AM, the surveyor interviewed the U.S. FOIA (b) (6), who stated that the facility's most recent Federal and State surveys were from 2023. He further stated that it was the facility's practice that the survey results should be at the reception desk by U.S. FO and that the 2023 survey results should always be available to residents, staff, and visitors. At that time, the surveyor notified the U.S. FOIA (b) of the above findings and concerns. The U.S. FOIA (b) stated	F 577	1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The Executive Director/LNHA placed the survey documents and Plans of Correction from the most recent licensure survey 9/8/2023 into the Survey Reports binder on the Security desk in the main entrance lobby to the facility. c. A posting notice of the availability of licensure survey results and plans of correction for the preceding three years and the most recent survey results and plan of corrections was posted on the bulletin boards that contain resident information on each resident unit by the Secretary for the Social Services Department. d. The Executive Director/LNHA audited the survey binders on the Security desk in the employee ambulance/rear entrance and the 1-300 lobby to determine if the most recent survey results and plans of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 577	Continued From page 6 that he was not sure why the survey results that were posted was from 2021, and it should be for 2023. The [U.S. FOIA (b) (6)] further stated that he would get back to the surveyor about the policy for posting survey results. On 1/16/25 at 12:57 PM, the [U.S. FOIA (b) (6)] informed the surveyor that the facility had no policy about posting survey results. He further stated that they do follow the regulation that the facility had to post the most recent survey results at the reception desk, which was from [NJ Ex Order 26]. On 1/22/25 at 1:15 PM, the survey team met with the [U.S. FOIA (b) (6)], and there was no additional information provided by the facility. NJAC 8:39-9.4(a, b)	F 577	correction from 9/8/2023 were in the binders. The survey results and plans of correction were present in the binders. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents, family members, visitors or residents, and legal representatives of residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Executive Director/LNHA developed a Licensure Survey Policy. The policy includes the locations of survey binders that include the most recent survey results and plans of correction, the posting notices on each resident unit regarding the availability of survey results from surveys conducted in the preceding three years and plans of correction, the responsibility of the Executive Director and the responsibilities of Security Staff. b. The Executive Director / LNHA revised the Security Department Daily Log Form to include the direction to the security guards to verify on a daily basis at the start of the shift that the results of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 577	Continued From page 7	F 577	surveys and plans of correction are present in the binder as noted in the Table of contents in the binder. c. The Senior Security guard educated the Security staff on their responsibilities to verify on a daily basis at the start of the shift that the results of survey and plans of correction are present in the binder as noted on the table of contents in the binder. d. The Assistant to the Executive Director/ Security Administrator and Senior Security Guard, educated the security staff on the Licensure Survey Policy. Topics included the requirement to make available for inspection by any resident, family member, visitor or legal representative at all times the results of the most recent licensure survey, including plans of correction and all other surveys in the preceding three years, the responsibility of the Executive Director to place the copies of the results of the most recent surveys in the binders located on the security desk at the main entrance, the wall pocket adjacent to the security desk at the employee / ambulance entrance and the lobby wall pocket at the 1-300 lobby, the responsibility of the security guards to verify and document daily on their shift security post logs that the documentation remains located in the binders at each of the three locations, the responsibility of the security guard to replace any missing documentation with the spare copies of the documentation that are located in the security monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 577	Continued From page 8	F 577	room that is staffed 24 hours/day, the responsibility of the security guards to notify the Executive Director/ LNHA if additional copies of the documentation are required and to provide copies of the daily security post logs to the executive Director / LNHA. Each guard was provided with a copy of the Licensure Survey Policy and a copy of the lesson plan. Security staff on "paid time off leave" are educated upon return to work. e. On a daily basis the Security Staff will verify that the survey binders on the security desk in the main entrance lobby, in the wall pocket adjacent to the security desk in the 1-300 lobby, and in the wall pocket adjacent to the security desk in the employee/ambulance rear entrance contain the results of the most recent survey and plans of correction. Security staff were provided with two spare copies of the binders to immediately replace a missing binder's documents. Findings are reported to the Executive Director/designee for review and action. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Executive Director/LNHA/designee will report the findings monthly from the daily security staff verification of the survey documentation in the binders to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 577	Continued From page 9	F 577	Quality Assurance and Performance Improvement Committee.	
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility, it was	F 607	F607 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)	2/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 607	Continued From page 10 determined that the facility failed to ensure reference checks were completed for 10 out of 10 newly hired staff (Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) prior to their start date of employment. This deficient practice was evidenced by the following: The surveyor reviewed 10 randomly selected new employee files for reference checks for 10 of the 10 new employees revealed the following: A review of Staff #1's file, a U.S. FOIA (b) (6), date of hire (doh) on NJ Ex Order 26. 4B1, showed there were no reference checks in their file. A review of Staff #2's file, a U.S. FOIA (b) (6), doh on NJ Ex Order 26. 4B1, showed there were no reference checks in their file. A review of Staff #3's file, a U.S. FOIA (b) (6), doh on NJ Ex Order 26. 4B1, showed there were no reference checks in their file. A review of Staff #4's file, a U.S. FOIA, doh on NJ Ex Order 26. 4B1, showed there were no reference checks in their file. A review of Staff #5's file, a U.S. FOI, doh on NJ Ex Order 26., showed there were no reference checks in their file. A review of Staff #6's file, an U.S. FOIA (b) (6), doh on NJ Ex Order 26. 4B1, showed there were no reference checks in their file. A review of Staff #7's file, a US FOIA (b)(6), doh on NJ Ex Order 26. 4B1, showed there were no reference	F 607	1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The Executive Director/LNHA reviewed the personnel files of staff #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 that did not contain reference checks prior to employment. Criminal background checks were performed for each of the ten staff prior to employment as a reasonable effort to ensure staff providing direct care to residents were screened prior to hire. c. The Confidential Secretary for the County Human Resources Department faxed the Employment Verification reference document to the previous employer of staff#1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 to obtain the reference checks and provided proof of transmission to the County Human Resources director and to the Executive Director/ LNHA. d. The Executive Director/LNHA reviewed resident records and confirmed there weren't any allegations of resident abuse involving the ten staff who did not have reference checks prior to employment. 2. How will the facility identify other residents having the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 607	Continued From page 11 checks in their file. A review of Staff #8's file, a U.S. FOIA (b) (6), doh on NJ Ex Order 26. 4B1, showed there were no reference checks in their file. A review of Staff #9's file, a U.S. FOIA (b) (6), doh on NJ Ex Order 26. 4B1, showed there were no reference checks in their file. A review of Staff #10's file, a U.S. FOIA (b) (6), doh on NJ Ex Order 26. 4B1, showed there were no reference checks in their file. On 1/17/25 at 12:09 PM, the surveyor notified the U.S. FOIA (b) (6) of the concern that there was no documentation of reference checks being completed for 10 of the 10 new hire files. The surveyor asked who was responsible for new hire files. The U.S. FOIA (b) (6) stated the Human Resources (HR) department which was located off the facility campus. The surveyor requested the contact number to speak with HR staff and the policy for new hire screening including reference checks. The U.S. FOIA (b) (6) provided the contact number for HR. On 1/17/25 at 12:53 PM, the surveyor interviewed over the phone with an U.S. FOIA (b) (6) The U.S. FOIA (b) (6) stated that the beginning of last year, the person responsible left and she temporarily took over the responsibility. The U.S. FOIA (b) further explained another staff was currently responsible and was not in the office at the time. The U.S. FOIA (b) stated new hires would list references on their application. The surveyor asked if references were called as part of the new hire process. The U.S. FOIA (b) stated HR	F 607	affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility who are cared for by staff have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Deputy County Administrator directed the Human Resources Confidential Secretary to include employment reference checks prior to employment to screen applicants for hire using the Employment Verification document. b. An Orientation Checklist was developed by the Human Resources Confidential Secretary to verify that all requirements for hire including reference checks are completed prior to hire. The checklist will be provided to the Executive Director/LNHA/designee who will audit and confirm that all requirements are met before new employees may attend orientation. c. Education was provided by the Executive Director / LNHA to the Human Resources Confidential Secretary, Assistant Personnel Technician and the County Human Resources staff regarding the requirement to screen applicants with reference checks and submit the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 607	Continued From page 12 did not follow up with references, criminal background checks were done prior to employment, and references were listed on the application if needed. The [redacted] referred the surveyor to the [redacted] regarding any policy for new hire screening for the facility. On 1/21/25 at 12:23 PM, the *U.S. FOIA (b) (6)* [redacted] met with survey team. The [redacted] stated there were no references for the new hires as per the HR department. The surveyor asked about policy for new hire screening, and the [redacted] replied that the facility referred to their Abuse prevention policy for new hire screening protocol and there was no separate policy. A review of the facility's Abuse Policy indicated that at least one reference should be obtained. The [redacted] confirmed that it was the facility policy and acknowledged it was not completed for the new hires. A review of the facility's Resident Abuse Policy, with a last reviewed date of 9/26/23, under Procedure for Screening revealed, " ...4. Obtain references (one) employment reference of prospective employees from previous and/or current employers ..." N.J.A.C. 8:39-9.3 (a), (b)	F 607	orientation checklist to the County Director of Human Resource and Executive Director / LNHA as proof of compliance. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Executive Director/LNHA/designee will report the findings from the audits of new hire requirements including employment reference checks to the Quality Assurance and Performance Improvement Committee.	
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for	F 640		2/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 640	Continued From page 13 each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 640	Continued From page 14 transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) in accordance with the federal guidelines. This deficient practice was identified for 17 of 17 system selected residents, Resident #2, #12, #34, #38, #46, #48, #69, #70, #139, #166, #199, #205, #209, #220, #233, #267, and #271) and was evidenced by the following: On 1/21/25 at 9:09 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS assessment. The MDS was a comprehensive tool that was federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. After transmission of the MDS, a quality measure will be transmitted to enable a facility to monitor the residents decline or progress. On 1/16/25 at 10:21 AM, the surveyor provided the *U.S. FOIA (b) (6)* with the list of seventeen (17) system-selected residents who had not completed an MDS in over 120 days. The surveyor also requested a copy of the resident's final validation report (a report that generates after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS).	F 640	F640 Encoding/Transmitting Resident Assessments CRF(s): 483.20(f)(1)-(4) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. The Minimum Data Set (MDS) for residents #2, #12, #34, #38, #46, #48, #69, #70, #139, #166, #199, #205, #209, #220, #233, #267 and #271 were encoded and transmitted into the Centers for Medicare and Medicaid Services database, and although validated as late, were accepted, therefore cannot be modified or retransmitted unless corrections need to be made. b. The MDS Consultant provided in-service to the *U.S. FOIA (b) (6)* on the Electronic Transmission of the MDS 3.0 policy. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility and have resident assessments completed by the Interdisciplinary Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 640	Continued From page 15 On 1/21/25 at 10:05 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that she was a U.S. FOIA (b) (6) who reviewed the MDS assessments before transmitting them. The U.S. FOIA (b) (6) also stated there was an U.S. FOI who signed and completed the MDS's. On 1/21/25 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b) (6), who stated that she was aware it was submitted late. The U.S. FOIA (b) (6) added that she tried to submit it at least once every week. The U.S. FOIA (b) (6) further stated that they followed the RAI (Resident Assessment Instrument, a tool that helps gather information about a resident's strengths and needs, which is used to create an individualized care plan) Manual. The surveyor and the U.S. FOIA (b) (6) reviewed the 17 residents MDS assessments that were not submitted within fourteen days of completion as follows: 1. Resident #205 had a comprehensive assessment with an assessment reference date (ARD) of NJ Ex Order 26. 4B1, that was signed as completed on NJ Ex Order 26. 4B1 and was not transmitted until NJ Ex Order 26. 4B1. 2. Resident #209 had a comprehensive assessment with an ARD of NJ Ex Order 26. 4B1, that was signed as completed on NJ Ex Order 26. 4B1, and was not transmitted until NJ Ex Order 26. 4B1. 3. Resident #2 had a comprehensive assessment with an ARD of NJ Ex Order 26. 4B1, that was signed as completed on NJ Ex Order 26. 4B1, and was not transmitted until NJ Ex Order 26. 4B1. 4. Resident #48 had a comprehensive assessment with an ARD of NJ Ex Order 26. 4B1 that was signed as completed on NJ Ex Order 26. 4B1, and was not	F 640	Team have the potential to be affected by the deficient practice. b. Using the Minimum Data Set (MDS) listing by date form for January 2025, the MDS Consultant audited Minimum Data Set dates for encoding and timely transmission within 14 days after resident's assessment is completed, to the Centers for Medicare and Medicaid Services (CMS). 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The MDS Consultant with input from the Minimum Data Set Coordinator and Director of Nursing developed an Electronic Transmission of the MDS 3.0 policy. The policy includes completion and transmission of the MDS's to comply with RAI manual V1.18.11 October 2023 transmission requirements. b. Using the MDS Tracking Form the MDS Consultant will track all MDS's including the transmission deadline. c. The MDS Consultant will notify in writing the Executive Director, Director of Nursing, Assistant Director of Nursing and Minimum Data Set Coordinator responsible for locking Minimum Data Set when active assessments are completed but not locked within two days of the transmission deadline.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 640	Continued From page 16 transmitted until [NJ Ex Order 26. 4B]. 5. Resident #271 had a comprehensive assessment with an ARD of [NJ Ex Order 26. 4B], that was signed completed on [NJ Ex Order 26. 4B], and was not transmitted until [NJ Ex Order 26. 4B]. 6. Resident #38 had a quarterly assessment with an ARD of [NJ Ex Order 26. 4B], that was signed completed on [NJ Ex Order 26. 4B], and was not transmitted until [NJ Ex Order 26. 4B]. 7. Resident #199 had a quarterly assessment with an ARD of [NJ Ex Order 26. 4B], that was signed completed on [NJ Ex Order 26. 4B], and was not transmitted until [NJ Ex Order 26. 4B]. 8. Resident #69 had a quarterly assessment with an ARD of [NJ Ex Order 26. 4B], that was signed completed on [NJ Ex Order 26. 4B], and was not transmitted until [NJ Ex Order 26. 4B]. 9. Resident #34 had a quarterly assessment with an ARD of [NJ Ex Order 26. 4B], that was signed completed on [NJ Ex Order 26. 4B], and was not transmitted until [NJ Ex Order 26. 4B]. 10. Resident #220 had a quarterly assessment with an ARD of [NJ Ex Order 26. 4B], that was signed completed on [NJ Ex Order 26. 4B], and was not transmitted until [NJ Ex Order 26. 4B]. 11. Resident #267 had a quarterly assessment with an ARD of [NJ Ex Order 26. 4B], that was signed completed on [NJ Ex Order 26. 4B], and was not transmitted until [NJ Ex Order 26. 4B]. 12. Resident #233 had a quarterly assessment with an ARD of [NJ Ex Order 26. 4B], that was signed completed on [NJ Ex Order 26. 4B], and was not transmitted until [NJ Ex Order 26. 4B].	F 640	4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly, the MDS Consultant will report the results of the audit from Jan 2025 regarding timely transmission of the MDS to the Quality Assurance and Performance Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly, the MDS Consultant will audit every Minimum Data Set using the Validation Reports and present the findings to the Quality Assurance and Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 640	Continued From page 17 13. Resident #46 had a quarterly assessment with an ARD of [redacted], that was signed completed on [redacted], and was not transmitted until [redacted]. 14. Resident #166 had a quarterly assessment with an ARD of [redacted], that was signed completed on [redacted], and was not transmitted until [redacted]. 15. Resident #139 had a quarterly assessment with an ARD of [redacted], that was signed completed on [redacted], and was not transmitted until [redacted]. 16. Resident #12 had a quarterly assessment with an ARD of [redacted], that was signed completed on [redacted], and was not submitted until [redacted]. 17. Resident #70 had a quarterly assessment with an ARD of [redacted], that was signed completed on [redacted], and was not transmitted until [redacted]. A review of the facility's MDS 3.0 Policy, with a review date of 6/22/23, did not address the transmission of MDS data. On 1/21/25 at 12:29 PM, the survey team met with the [redacted] regarding the above concern. There was no further information provided. NJAC 8:39-11.1	F 640		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 18 §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 record review, it was determined that the facility failed to follow standards of clinical practice to ensure, a.) a physician's order (PO) for a [NJ Ex Order 26. 4B1] 2 of 2 residents, Residents #72 and #158, were followed, and b.) a PO to document weekly vital signs for 1 of 5 residents was followed, Resident #88, reviewed for unnecessary medications. This deficient practice was evidenced by the following: Reference: New Jersey Statues, 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	F658, Services Provided Meet Professional Standards, CFR(s) 483.21(b)(3)(i) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. Resident # 158 was provided with the pressure relieving [NJ Ex Order 26. 4B1]. b. The nurse obtained a physician□s order for resident #72 to reflect the resident□s preference to not wear [NJ Ex Order 2 [redacted] at all times. The physician□s order includes direction to apply [NJ Ex Order 2 under [NJ Ex Order 26. 4B1]. The Interdisciplinary Care Team consisting of the nurse, social worker, dietician, and recreation therapist for resident #72 updated the care plan to reflect the residents□ preferences. c. The LPN #1 for resident #72 who signed the Treatment Administration Record(TAR) that the resident was wearing [NJ Ex Order 26. 4B1] when it was observed that the resident was not wearing [NJ Ex Order 26. 4B1] was in-serviced on the Commitment to Care: Accountability Standards for Nurses and CNAs policy by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 19 responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 1/16/25 at 10:00 AM and 12:15 PM, the surveyor observed the resident in bed, the resident's NJ Ex Order 26.4b1 and was not wearing their *NJ Ex Order 26. 4B1* . A review of the Admission Record (AR, an admission summary) for Resident #72, reflected that the resident was admitted to the facility with diagnoses which included but not limited to; *NJ Ex Order 26. 4B1* . A review of the January 2025 Physician's Order Form revealed a PO, dated NJ Ex Order 26.4b, for *NJ Ex Order 26. 4B1* on at all times. A review of the January 2025 Treatment Administration Record (TAR) reflected that the above PO for *NJ Ex Order 26. 4B1* were transcribed and signed by nurses. The TAR revealed that a nurse signed that the resident was wearing their *NJ Ex Order 26. 4B1* on NJ Ex Order 26.4b during the 7am-3PM shift. On 1/16/25 at 11:44 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1) who acknowledge that the resident was not wearing	F 658	the Director of Nursing. d. The Assistant Nursing Supervisor obtained a physician's order for resident #88 to clarify the order for NJ Ex Order 26.4b1 The day and shift for the weekly vital signs monitor were marked on the Medication Administration Record. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility who have physician's orders including but not limited to pressure relieving devices and vital signs have the potential to be affected by the deficient practice. b. Using a report compiled by the pharmacy provider which indicated all residents in the facility that have an order for heel booties in the month of January 2025, the Assistant Nursing Supervisors conducted an audit to ensure that heel booties are in place per the physician's orders. c. Using a report compiled by the pharmacy provider which indicated all residents in the facility who have an order for vital signs monitoring, Assistant Nursing Supervisors conducted an audit to ensure that vital signs are monitored per the physician order. 3. What measures will be put into place or systemic changes made to ensure the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 20 their [redacted]. LPN#1 also stated that the resident was supposed to always wear their [redacted] due to issues with the resident's [redacted] and according to the PO. On 1/17/25 at 1:30 PM, the surveyor presented the above concerns to the [redacted] A review of the facility's Pressure Injury Prevention and Management Policy that was provided by the [redacted], with a revision date 8/2020, which revealed the following: Under section F. Pressure Injury Preventive Devices; Float Gel Booties, good to prevent pressure injury on heels. Recommended for stage I, stage II and residents with high Braden scale (a validated tool designed to assess a patient's risk of developing pressure ulcers). Under Pressure Injury Documentation: d). Document resident choice or non-compliance, addressing the condition, treatment options, expected outcomes and consequences of refusing treatment or following an appropriate plan of care. Address resident's concerns and offer relevant alternatives. 2. On 1/21/25 at 9:57 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #88. A review of the AR revealed that Resident #88 had diagnoses that included but were not limited to; [redacted].	F 658	deficient practice will not recur? a. The Executive Director, Director of Nursing, Assistant Director of Nursing, Assistant Nursing Supervisor, Infection Preventionist, and Quality Assurance Coordinator reviewed and revised the Pressure Injury Prevention and Management policy with input from the Medical Director. b. The Executive Director, Director of Nursing, Assistant Director of Nursing, Assistant Nursing Supervisor, Infection Preventionist, and Quality Assurance Coordinator created a policy for Resident Refusal or Noncompliance with Care or Treatment with input from the Medical Director. c. The Director of Nursing with input from the Medical Director created a policy for Commitment to Care: Accountability Standards for Nurses and CNAs with input from the Medical Director. d. The Director of Nursing, Infection Preventionist, Quality Assurance Coordinator and Assistant Nursing Supervisor revised the Pharmacy Services policy and reviewed proposed revisions with the Pharmacy Consultant and Medical Director. Revisions included information regarding the following of physician orders. e. Mandatory in-service was provided by Inservice Instructors to all nurses and CNAs on Pressure Injury Prevention and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 21 A review of the PO dated [NJ Ex Order 26.4B1], the order was to Monitor vital signs (VS, are useful in detecting or monitoring medical problems such as temperature, respiration, heart rate, and blood pressure) weekly. A review of the *NJ Ex Order 26. 4B1* [redacted] Medication Administration Record (MAR) revealed the entry for monitoring VS weekly were blank and included no scheduled day or frequency. A review of the VS in the EMR, there were no entries for *NJ Ex Order 26. 4B1* [redacted]. On 1/21/25 at 10:26 AM, the surveyor interviewed LPN#2 who was assigned to care for Resident #88. The LPN stated routine monitoring of VS was done according to the PO and would be documented in the MAR. LPN#2 reviewed with the surveyor the resident's MAR and reviewed the weekly monitoring of VS entry. LPN#2 stated she was unsure why the entry was blank as it was her first time on the assignment and acknowledged that it should indicate when VS should be checked weekly and on which shift. On 1/21/25 at 10:28 AM, the surveyor interviewed the *U.S. FOIA (b) (6)* [redacted] working on the same unit. The [U.S. FOI] [redacted] stated it was expected for nurses to follow PO for routine monitoring of VS. The surveyor reviewed with the [US FOI] [redacted] the MAR of Resident #88. The [U.S. FOI] [redacted] replied, the blank VS entry should have been clarified to indicate what day of the week and what shift VS were to be obtained. On 1/21/25 at 10:30 AM, the surveyor interviewed the *U.S. FOIA (b) (6)* [redacted], about VS protocol. The	F 658	Management policy, Resident Refusal of Care/Treatment policy, Commitment to Care: Accountability Standards for Nurses and CNAs policy and the Pharmacy Services policy. f. Mandatory in-service for all nurses was provided by Pharmacy Consultant and Inservice Instructors on the Pharmacy Service policy. g. Mandatory in-service for all interdisciplinary care team members by Inservice Instructors on the Refusal or Noncompliance with care or Treatment policy was provided. h. The Assistant Nursing Supervisors will observe and audit five residents with heel booties/week for compliance with physician orders immediately correct any issues and report the findings to the Director of Nursing/designee for review and action. i. The Assistant Nursing Supervisors will audit 5 residents/week forcompliance with physician orders for vital signs, immediately correct any issues and report the findings to the Director of Nursing/designee. j. The Consultant Pharmacist will continue to audit all physician orders monthly and upon admission/readmission to the facility. The Consultant Pharmacist will provide Medication Regimen Reviews for all new admissions and monthly reports for all residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 22 U.S. FOIA (b) stated that it was expected for nurses to follow PO for VS. The surveyor reviewed with the U.S. FOIA (b) the MAR of Resident #88 and asked about the blank weekly VS entry. The U.S. FOIA (b) acknowledged the nurses should have clarified the entry to indicate the frequency and should not have left the entry blank. The U.S. FOIA (b) further stated she would clarify the order. On 1/21/25 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b) about VS protocol. The U.S. FOIA (b) stated routine VS monitoring would be entered per PO. The U.S. FOIA (b) further explained VS were documented in the MAR. The surveyor reviewed with the U.S. FOIA (b) the MAR of Resident #88. The U.S. FOIA (b) acknowledged it would be expected for the nurses to clarify the order as there was no frequency indicated and that the entry should have been completed as per PO. On 1/21/25 at 12:37 PM, the surveyor informed the *U.S. FOIA (b) (6)* about the concern that the weekly VS entry were not completed for *NJ Ex Order 26. 4B1* . The surveyor requested any policy regarding VS and PO. On 1/21/25 2:00 PM, the U.S. FOIA (b) informed the surveyor that the weekly VS order was clarified with the physician for the weekly VS to be completed on Wednesday every 3:00 PM-11:00 PM shift. The U.S. FOIA (b) stated there was no VS policy and that a policy for PO would be provided to the survey team. 3. On 1/17/25 at 9:40 AM, the surveyor observed Resident #158 laying on an *NJ Ex Order 26. 4B1* , covered with a blanket,	F 658	4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Director of Nursing will report the findings from the audit of the residents that had an order for heel float booties during the month of January 2025 to the Quality Assurance and Quality Improvement Committee b. The Director of Nursing will report the findings from the audit of the residents during the month of January 2025 who had orders for vital signs monitoring to the Quality Assurance and Quality Improvement Committee. c. The Director of Nursing will report the findings from the audits of five residents/week with orders for heel booties to the Quality Assurance and Quality Improvement Committee. d. The Director of Nursing/designee will report the findings from the audits of five residents/week with orders for vital signs monitoring to the Quality Assurance and Performance Improvement Committee. e. The Pharmacy and Therapeutics Committee meets quarterly. The Consultant Pharmacist will report the findings from Medication Regimen Reviews to the Pharmacy and Therapeutics Committee each quarter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 23 and spoke [redacted]. A review of the AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date of [redacted], reflected in Section C Cognitive Patterns that the resident's cognitive skills for decision-making were coded [redacted]. A review of the PO revealed an order dated [redacted], for [redacted] at all times. On 1/17/25 at 9:56 AM, LPN#3 asked the [redacted] to help her reposition Resident#158 for the surveyor to see the [redacted]. Inside the resident's room, the surveyor observed LPN#3 removed the blanket and Resident #158 had no [redacted] in use. LPN#3 stated that she was unsure why the resident did not have [redacted]. On 1/17/25 at 10:14 AM, the surveyor notified the [redacted] regarding the above findings and concerns. Both the surveyor and the [redacted] went inside the resident's room, and the [redacted] did not find the resident's [redacted]. The [redacted] informed the surveyor that she would ask the Central Supply department to provide [redacted] to the resident.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 24 On 1/21/25 at 12:19 PM, the survey team met with the *U.S. FOIA (b) (6)* stated that the facility developed a policy that both nurses and CNAs were responsible for [redacted] after the surveyor's inquiry. A review of the facility's Prescribing and Ordering of Medications Policy and Procedure Manual (adapted from the pharmacy vendor's policy), revised on February 2023, that was provided by the [redacted], did not include information with regard to following PO. On 1/22/25 at 1:15 PM, the survey team met with the *U.S. FOIA (b) (6)*, and there was no additional information provided by the facility. NJAC 8:39-11.2 (b); 29.2(d); 29.4(a)(b)	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that the resident receive care and treatment in accordance with professional standards of practice by developing and	F 684	F684, Quality of Care, CFR(s) 483.25 1. What corrective actions will be accomplished for those residents affected by the deficient practice?	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 684	Continued From page 25 implementing a comprehensive person-centered care plan (CP), and the resident's choices that included refusal of care. This deficient practice was identified for 1 of 39 residents, (Resident #262), reviewed for quality of care. This deficient practice was evidenced by the following: Reference: New Jersey Statues, 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 1/15/25 at 10:48 AM, the surveyor observed Resident #262 sitting in the chair, [redacted] and [redacted]. The resident stated that they did not feel	F 684	a. The Interdisciplinary Care Team consisting of the Nurse, Social Worker, Dietitian, and Recreation Therapist for resident # 262 created a care plan to address noncompliance with care, including [redacted], medication, and food preferences. b. The Interdisciplinary Care Team consisting of the Nurse, Social Worker, Dietician, and Recreation Therapist met with resident # 262 provided with education regarding noncompliance with care, including [redacted], medication, and diet. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility who are noncompliant with care, including dialysis, medication, and/or diet, have the potential to be affected by the deficient practice. b. The Assistant Nursing Supervisors audited the 24-hour report for the month of January 2025 to identify residents who were noncompliant with care, including dialysis, medication, and/or diet. Any issues were immediately addressed, a care plan developed or updated and findings reported to the Director of Nursing/designee for review and action. 3. What measures will be put into place	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 684	Continued From page 26 like going to [redacted] today. Resident #262 added that they did not like the food served in the facility and sometimes they ordered food outside. On 1/15/25 at 10:58 AM, the surveyor interviewed the [redacted], who confirmed that the resident did not attend [redacted] today. RN#1 stated that Resident #262 was non-compliant with care, including [redacted], medication (med), food preference, and the resident ordered food from outside. On 1/21/25 at 10:46 AM, the surveyor reviewed the medical records of Resident #262, which revealed the following: A review of the Admission Record (an admission summary) reflected that Resident #262, was admitted to the facility with diagnoses that included, but were not limited to, [redacted]. A review of the quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date of [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating intact cognition. Section O-Special Treatments, Procedures, and [redacted]-while a resident was checked. A review of the [redacted] Physician's Order form for Resident #262, reflected a Physician Order (PO) [redacted] order dated [redacted], for [redacted] on Monday-Wednesday-Friday at 5:30 PM pick up at 4:45 PM.	F 684	or systemic changes made to ensure the deficient practice will not recur? a. The Executive Director, Director of Nursing, Assistant Director of Nursing, Assistant Nursing Supervisor, Infection Preventionist, and Quality Assurance Coordinator created a policy for Refusal or Noncompliance with Care or Treatment with input from the Medical Director. b. Mandatory In-service on the policy for Refusal or Noncompliance with Care or Treatment by the Inservice Instructors was provided for all Interdisciplinary Care Team members. c. Assistant Nursing Supervisors will review the 24-hour report each day to identify residents with noncompliance with care, including dialysis, medication, and/or diet. Any issues will be immediately addressed, a care plan developed or updated, and findings reported to the Director of Nursing/designee for review and action. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Director of Nursing will report the findings from the audit of the residents who were noncompliant with care, including dialysis, medication, and/or diet for the month of January 2025 to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 684	Continued From page 27 A review of the Progress Notes in [NJ Ex Order 26. 4B1] revealed that Resident #262, documented a refusal to attend [NJ Ex Order 26. 4B] four times, refused to eat breakfast, lunch, and dinner five times, ordered food outside, and refused med. A review of Resident #262's CP did not reflect a CP for the refusal of care, med, and non-compliance with [NJ Ex Order 26. 4B] and diet. On 1/21/25 at 11:25 AM, the surveyor interviewed the *U.S. FOIA (b) (6)* [redacted], who stated that the resident refused care and was non-compliant with diet. The [U.S. FOIA (] added that that refusal should be documented and added in the CP. On 1/21/25 at 12:29 PM, the survey team met with the *U.S. FOIA (b) (6)* [redacted] to discuss the above concern. No additional information was provided. A review of the facility's MDS 3.0 Policy with a reviewed date of 6/22/23, given by the [U.S. FOIA (b) (6)] on 1/22/25, stated under "Procedure: 12. ... Any changes in the resident's status will be reflected in the Interdisciplinary CP as necessary ..." NJAC 8:39-27.1(a)	F 684	Quality Assurance and Quality Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. On a monthly basis, the Director of Nursing will report the findings from the audits of residents with noncompliance with care, including dialysis, medications and diet to the Quality Assurance and Performance Improvement Committee.	
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	F 690		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 28 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 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, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the [redacted] was stored in a manner to prevent [redacted] for 1 of 4 residents, Resident #77, reviewed for [redacted].	F 690	F690, Bowel/Blader Incontinence, Catheter, UTI CFR(s) 483.25(e)(1)-(3) 1. What corrective actions will be accomplished for those residents affected by the deficient practice?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 29 The deficient practice was evidenced by the following: On 1/17/25 at 9:08 AM, the surveyor observed Resident #77's [redacted] hung from the bed's side rail that was in the up position and not in a [redacted]. The tubing leading to the [redacted] was above the bed. On 1/17/25 at 9:09 AM, the surveyor interviewed the [redacted] after the [redacted] also observed Resident #77's [redacted]. The [redacted] stated that the [redacted] should be lowered. She added that when she had done rounds that morning the resident was sleeping and had not checked that side of the bed and that the [redacted] on the night shift probably placed it there after emptying it. The [redacted] then lowered the [redacted] to the bar that was under the bed. A review of Resident #77's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] A review of Resident #77's most recent comprehensive Minimum Data Set (MDS), an assessment tool, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which	F 690	a. The [redacted] for resident # 77 was placed in a [redacted] and was lowered to a level below the resident's [redacted] b. The Infection Preventionist monitored Resident # 77 for signs and symptoms of a [redacted] for 7 days. [redacted] were reported. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility with an indwelling catheter in place have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Executive Director, Director of Nursing, Assistant Director of Nursing, Assistant Nursing Supervisor, Infection Preventionist, and Quality Assurance Coordinator reviewed and revised the policy for Indwelling Catheters (Foley Catheter/Supra-Pubic Catheter/Nephrostomy Tube) with input from the Medical Director. Revisions include that residents who have an order for an indwelling catheter will have an order included on the CNA Direct Caregiver Books documentation for the resident to ensure the catheter bag is maintained below the level of the bladder.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 30 reflected that the resident's NJ Ex Order 26. 4B1 . Further review indicated the resident had an NJ Ex Order 26. 4B1 . A review of Resident #77's Physician Order Form included an order for NJ Ex Order 26. 4B1 [redacted] . On 1/17/25 at 12:12 PM, the surveyor notified the U.S. FOIA (b) (6) [redacted] the concern that Resident #77's NJ Ex Order 26. 4B [redacted] was observed hanging from the siderail that was up on the bed and the NJ Ex Order 26.4 [redacted] was above the bed. On 1/21/25 at 12:22 PM, in presence of the U.S. FOIA (b) (6) [redacted] stated that the staff were inserviced about the NJ Ex Order 26. 4B1 placement. The facility did not provide any additional information. A review of the facility's Indwelling Catheters Policy with a reviewed date of 5/2019, included the following: 8. Prevention of Catheter-related complications ... B. CNA will secure the catheter to facilitate the flow of the urine and the bag is below the level of the bladder ... N.J.A.C. 8:39-27.1 (a)	F 690	b. Mandatory Inservice for all nurses and CNA's by the Inservice Instructors on the Indwelling Catheters (Foley Catheter/Supra-Pubic Catheter/Nephrostomy Tube) was provided. c. The Infection Preventionist /designee (Assistant Director of Nursing) will audit five residents/week with indwelling catheters to ensure the drainage bag is located below the level of the bladder and in a privacy bag. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Infection Preventionist / designee (Assistant Director of Nursing) will report the findings from the audit of residents/week who have an indwelling catheter to the Quality Assurance and Performance Improvement Committee.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 695	Continued From page 31 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to maintain proper infection control practices during NJ Ex Order 26.4b1 care. This deficient practice was identified for 1 of 1 resident observed for NJ Ex Order 26.4b1 care, (Resident #92), and was evidenced by the following: On 1/15/25 at 10:46 AM, the surveyor observed Resident #92 in a reclined lounge chair in their room. The resident had a *NJ Ex Order 26. 4B1* [redacted], which was attached to a *NJ Ex Order 26. 4B1* [redacted]. The surveyor reviewed the medical record for Resident #92. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility and had diagnoses that included *NJ Ex Order 26. 4B1* [redacted]	F 695	F695, Respiratory/Tracheostomy Care and Suctioning, CFR(s) 483.25(i) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. The Infection Preventionist monitored Resident #92 for signs and symptoms of NJ Ex Order 26.4b1 days. NJ Ex Order 26.4b1 [redacted] were reported. b. The Infection Preventionist provided in-service to the *U.S. FOIA (b) (6)* [redacted] on hand hygiene, Personal Protective Equipment (PPE), and tracheostomy care. A competency assessment with return demonstration of hand hygiene and donning/doffing PPE was successfully completed by the *U.S. FOIA (b) (6)* [redacted]. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 695	Continued From page 32 NJ Ex Order 26. 4B1 [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26. 4B1, reflected that the resident was in a NJ Ex Order 26. 4B1 [redacted]. A further review of "Section GG" reflected that the resident was NJ Ex Order 26.4b1 on all NJ Ex Order 26. 4B1 [redacted]. A review of "Section O" reflected the resident received the following NJ Ex Order 26. 4B1 [redacted]. A review of the Physician Order (PO)forms dated NJ Ex Order 26. 4B1, included the following physician's orders (PO): A PO dated NJ Ex Order 26.4b1, NJ Ex Order 26. 4B1; to change gauze/dressing around the NJ Ex Order 26. 4B1 [redacted] twice daily. A PO dated NJ Ex Order 26.4b, to change NJ Ex Order 26. 4B1 [redacted] twice weekly, on Mondays and Thursdays, and when dirty as needed. On 1/17/25 at 9:45 AM, the surveyor observed the U.S. FOIA (b) (6) [redacted] provide NJ Ex Order 26. 4B1 for Resident #92 and observed the following: The U.S. FO [redacted] gathered the NJ Ex Order [redacted] supplies from the dresser in the room, which included a NJ Ex Order 26. 4B1 clean and care tray, normal saline vials, four packages of drain sponge gauze, and the NJ Ex Order [redacted], and placed them on top of the dresser.	F 695	a. All residents who reside at the facility who require respiratory care for a tracheostomy have the potential to be affected by the same deficient practice. b. The Infection Preventionist provided mandatory in-service to all respiratory therapists on hand hygiene, PPE, and tracheostomy care with return demonstration. c. The Infection Preventionist observed tracheostomy care by all respiratory therapists. Competency assessments for handwashing and the use of equipment were completed by all respiratory therapists. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Infection Preventionist / designee (Assistant Director of Nursing) will audit one respiratory therapist per week performing tracheostomy care, address any issues and report the findings to the Respiratory Manager and Director of Nursing. b. Mandatory in-servicing on hand hygiene and personal protective equipment will continue to be completed on hire and annually for all staff. 4. How will the corrective actions be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 695	Continued From page 33 The [U.S. FO] performed hand hygiene: He turned on the water, wet his hands with soap, and lathered by rubbing his hands. Then, using his wet, bare hands, he turned the water faucet off and dried his hands with a paper towel. The [U.S. FO] donned [NJ Ex Order 26. 4B1] a plastic gown and a pair of gloves, gathered the equipment, and placed it on the overbed table. The [U.S. FO] then used disinfecting cleaning wipes to wipe the table, moving the supplies on the table while wiping the table and placing the equipment back down on the table. The [U.S. FO] opened the sterile [NJ Ex Order] clean and care tray with the same gloved hands removed the sterile waterproof drape and placed the drape on the resident's chest under the [NJ Ex Order 26. 4B1]. The [U.S. FO] also untied the [NJ Ex Order 26. 4B1] and removed the gauze between the [NJ Ex Order] and the neck with the same gloved hands. The [U.S. FO] opened the drain sponge gauze and moistened it with the normal saline vial, cleansing the right side of the resident's [NJ Ex Order] and [NJ Ex Order]. Then, the same gauze was moistened with normal saline to cleanse the left side of the resident's [NJ Ex Order] and around the [NJ Ex Order 26. 4B1]. The [U.S. FO] [NJ Ex Order 26.4b1] and doffed [NJ Ex Order 26. 4B1] the gloves and gown. The [U.S. FO] performed hand hygiene, using a 10-second lather and scrub with soap and water. He then rinsed his hands and turned the water off by touching the faucets with his bare hands. He then removed a piece of paper towel while touching the paper towel dispenser and dried his hands with a paper towel.	F 695	monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Infection Preventionist / designee (Assistant Director of Nursing) will report the findings from mandatory in-services and return demonstration of tracheostomy care of all respiratory therapists to the Quality Assurance and Quality Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Infection Preventionist /designee (Assistant Director of Nursing) will report the findings of the audit of tracheostomy care of one respiratory therapist per week to the Quality Assurance and Quality Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 695	Continued From page 34	F 695		

The [U.S. FO] donned gloves and a plastic gown, returned to the overbed table, wiped the table with disinfectant wipes, opened two drainage sponges, and replaced the [NJ Ex Order] gauze dressing around the [NJ Ex Order 26.].

The [U.S. FO] disconnected the NJ Ex Order 26. 4B1, removed the NJ Ex Order 26. 4B1, opened a new [NJ Ex Order 26. 4B1], and replaced it without changing gloves. The [U.S. FO] then secured the ties to the [NJ Ex Order 26. 4B1].

The [U.S. FO] moved the overbed table toward the window, used the bed controller, and then touched the wall switch to turn off the lights. The [U.S. FO] doffed his gloves and plastic gown and performed hand hygiene. He touched the faucets to turn off the water and touched the paper towel dispenser while removing a piece of paper towel to dry his hands.

On 1/17/25 at 10:15 AM, the surveyor interviewed the [U.S. FO], who stated that he should have used a paper towel to shut off the water and changed his gloves between cleansing the overbed table with the disinfectant wipes. The [U.S. FO] further stated that he believed he did not have to use different pieces of gauze when cleaning each side of the resident's [NJ Ex Order 26. 4B1] because the [NJ Ex Order] was one area.

On 1/17/25 at 11:25 AM, the surveyor interviewed the U.S. FOIA (b) (6), who stated that the [U.S. FO] should use an alcohol-based hand rub (ABHR) before entering the resident's room. The [U.S. FO] should have gathered the equipment and put on gloves, wiped the overbed table, removed gloves, used ABHR, put new gloves on, opened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 695	Continued From page 35	F 695		

the kit, removed the drape, covered the table, and placed the [redacted] onto the drape. He further stated that the gloves that disconnected the [redacted] or the gauze that was removed made the gloves dirty, and that the [redacted] should have used hand hygiene and changed the gloves after each time that would happen. The [redacted] further stated that when washing hands, the [redacted] should not touch the faucets with bare hands and should use a paper towel to turn them off. The [redacted] stated that [redacted] should have been performed this way because of infection control and patient safety and acknowledged that the [redacted] did not perform [redacted] correctly.

On 1/17/25 at 12:10 PM, the surveyor notified the [redacted] of the concerns with [redacted] care observation.

On 1/22/25 at 9:39 AM, the surveyor interviewed the [redacted] who stated that he was disappointed the [redacted] would have performed [redacted] that way. The [redacted] further stated that [redacted] was not performed that way, that the staff were given in-services and with demonstrations return demonstrations from the staff, and that the [redacted] was in-serviced on the proper [redacted] care techniques to prevent the spread of infections.

A review of the facility's RT Practice Resource Guide, Tracheostomy and Transtracheal Care document dated 6/2013, included ... the staff should use proper hand washing technique and don personal protective equipment.

A review of the Clinical Competency Validation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 695	Continued From page 36 NJ Ex Order 26. 4B1 care form, revised on 1/23, included that the [redacted] met all the critical elements, including cleansing hands and maintaining standard precautions on NJ Ex Order 26.4b1. A review of the facility's Handwashing/Hand Hygiene policy with a revision date of 8/19/24, included ...the facility's staff follow the handwashing/hand hygiene procedures to prevent the spread of infections to other staff, residents, and visitors ... facility staff must perform hand hygiene ...before and after direct contact with residents, before handling clean or soiled dressing, gauze pads, before and after removal of gloves, and before and after aseptic procedures ...when washing hands ...use a new dry paper towel to turn off the faucet ...never turn off the faucet with clean, washed hands ... NJAC 8:39-25.2(b), (c)4	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 and record review, it was determined that the facility failed to; a) complete the Hemodialysis Communication Record (HCR) to include a signature by the facility nurse that acknowledged review of the HCR for 14 of 14 days reviewed; b) document a complete assessment of vital signs and/or	F 698	F698, Dialysis CFR(s): 483.25(1) 1. What corrective actions will be accomplished for those residents affected by the deficient practice?	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 698	Continued From page 37 disposition of access site post dialysis treatment in the medical record; c) follow a recommendation for a change in medication; and d) had a diet order for 1 of 3 residents, Resident #169. This deficient practice was evidenced by the following: On 1/15/25 at 10:52 AM, the surveyor observed Resident #169 lying in bed, who stated that they were going to [redacted] today and that they had a communication binder (binder for HCRs) that they took with to [redacted]. A review of Resident #169's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] A review of Resident #169's most recent comprehensive Minimum Data Set (MDS), an assessment tool, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #169's was [redacted]. Further review of the MDS indicated the resident received [redacted]. On 1/17/25 at 9:29 AM, the surveyor interviewed	F 698	a. An Assistant Nursing Supervisor reviewed resident # 169, Daily Communication Progress Notes Binder, Electronic Medical Record and Physician's order sheet. The [redacted] was notified, and an order was received to change the [redacted] to be administered three times weekly during [redacted]. The physician ordered a [redacted]. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility who receive hemodialysis have the potential to be affected by the deficient practice. b. An audit was conducted by an Assistant Nursing Supervisor of residents who receive hemodialysis. The audit included reviewing the Daily Communication Progress Notes Binder and Electronic Medical Record documentation of each resident returning from dialysis during the preceding 30 days. Issues were immediately identified and reported to the Director of Nursing for review and action. 3. What measures will be put into place or systemic changes will be made to ensure the deficient practice will not recur?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 698	Continued From page 38 the U.S. FOIA (b) (6) regarding the process for a resident that received NJ Ex Order 26. 4B1. The U.S. FOI stated that the HCR was filled out by the facility nurse prior to going to NJ Ex Order 26. 4B and that when the resident returned the HCR should be reviewed and should be signed by the facility nurse. He added that vital signs were taken and the NJ Ex Order 26. 4B1 was checked and documented in the medical record. On 1/17/25 at 10:03 AM, the surveyor reviewed Resident #169's binder that contained the HCR's which indicated the following: HCRs dated NJ Ex Order 26. 4B1 [redacted], did not have a facility nurse signature to acknowledge that the HCR was reviewed. The HCR did not have a section on the form for an assessment of vital signs and disposition of NJ Ex Order 26. 4B1. Further review of the HCR's reflected the following: NJ Ex Order 26.4b1 HCR included 'NJ Ex Order 26. 4B1 [redacted]." NJ Ex Order 26.4b1 HCR included under med: given NJ Ex Order 26. 4B1. A review of Resident #169's Physician Order Form (POF) and Med Administration Record reflected an order for NJ Ex Order 26. 4B1	F 698	a. Upon return of the resident, the receiving nurse will review the Daily Communication Progress Notes Binder for any recommendations, notify the attending physician and carry out orders approved by the attending physician. The receiving nurse will carry out the order and document on the resident electronic medical record and on the twenty-four-report. b. The receiving nurse will review the hemodialysis treatment information including pre and post dialysis notes and sign/date to acknowledge that a review of dialysis communication record was done upon the resident's return to the facility. c. The receiving nurse will assess the dialysis site and obtain the resident's vital signs and document on the resident's electronic records and on the Twenty-Four-Hour Report if information is missing from the Dialysis Communication Progress Note and will document actions taken to obtain the information. The receiving nurse will initial the treatment book acknowledging the assessment of the dialysis site and auscultation of the dialysis site for bruit and thrill. d. Mandatory in-service by Staff Inservice Instructors and Assistant Nursing Supervisors for all Nurses was provided regarding the proper procedure for documenting the return of dialysis residents and completing the necessary assessments, which includes documenting the resident's vital signs,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 698	Continued From page 39 NJ Ex Order 26. 4B1 three times weekly NJ Ex Order 26. 4B1 at NJ Ex Order 26. 4B. Further review of the POF did not have a diet order. A review of Resident #169's progress notes (PN) in the electronic medical record indicated the following: NJ Ex Order 26.4b1 did not include vital signs or disposition of NJ Ex Order 26. 4B1 upon return to the facility from NJ Ex Order 26. 4B. NJ Ex Order 26.4b1, did not include disposition of NJ Ex Order 26. 4B upon return to the facility from NJ Ex Order 26. 4B. NJ Ex Order 26.4b1, did not include vital signs or disposition of NJ Ex Order 26. 4B1 upon return to the facility from NJ Ex Order 26. 4B. NJ Ex Order 26.4b1, there was no note NJ Ex Order 26. 4B1. NJ Ex Order 26.4b1, there was no note NJ Ex Order 26. 4B1. On 1/17/25 at 10:53 AM, the surveyor interviewed the NJ Ex Order 26. 4B1 regarding HCRs. The NJ Ex Order stated that the resident would bring the binder with HCRs to NJ Ex Order 26. 4B and that NJ Ex Order 26. 4B would write in it vital signs and any recommendations. She added if anything urgent they would call us. The U.S. FOIA (b) stated that the U.S. FOIA (b) would review the HCR. The U.S. FOIA (b) was not sure if there was a section NJ Ex Order 26. 4B1 for the facility to write the assessment but that the nurse would document the vital signs and site check in the medical record. The surveyor showed the U.S. FOIA (b) Resident #169's HCRs that did not have a U.S. FOIA (b) (6) signature. The U.S. FOIA (b) stated that there should be a signature for accountability that it was reviewed. On 1/17/25 at 11:04 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding Resident	F 698	dialysis site assessment, and auscultation for bruit and thrill in the EMR in a timely manner upon the resident's return. e. The Assistant Nursing Supervisors will review each resident Daily Communication Progress Notes Binder and EMR documentation upon resident's return to the facility from dialyses, and submit a weekly audit to the Assistant Director of Nursing / designee (Director of Nursing). Audit includes the dialysis recommendations, assessments, and corrective actions. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Assistant Director of Nursing / designee (Director of Nursing) will report the results from the audits of residents who returned from dialysis during the preceding 30 days to the Quality Assurance and Performance Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Assistant Director of Nursing / designee (Director of Nursing) will report results from the weekly audits of the Dialysis Communication Progress Notes and EMR documentation by the Assistant Nursing Supervisors to the Quality Assurance and Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 698	Continued From page 40 #169's diet. The [U.S. FOIA] confirmed that there was no diet order on the POF and that there should be an order for the resident's diet. On 1/17/25 at 12:10 PM, the surveyor notified the [U.S. FOIA (b) (6)] the concerns that Resident #169's HCRs were not signed as reviewed, there was no documented evidence that the vital signs and/or [NJ Ex Order 26.4b1] was assessed upon return to facility on 4 days of the 14 days reviewed, that a recommendation for a med change was not followed and there was no diet order on the POF/POS. On 1/21/25 at 12:21 PM, in the presence of the survey team, [U.S. FOIA (b) (6)] stated that they inserviced all nurses on the policy when a resident returned from [NJ Ex Order 26. 4B] to check the HCR and carry out any recommendations. The facility did not provide any additional information. A review of the facility's Dialysis Care of Resident on Hemodialysis with End Stage Renal Disease (ESRD) Policy, with a reviewed date of 4/18/23, included the following: Procedure: 6. The nurse updates the attending physician of any new recommendation from dialysis center and obtains the physician's orders from the dialysis center to the P.O.S. (Physician Order Set) and implements accordingly. Care of Resident with ESRD 4. Obtain and document vital signs pre and post dialysis in the medical record on dialysis days.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 698	Continued From page 41 5. Observe the access site post dialysis and document results in the Interdisciplinary PN of the Medical Record. Dialysis Progress Notes Binder 1. Daily Communication PN Binder is sent will all residents to Hemodialysis. 2. When the resident returns from hemodialysis, the receiving nurse must review the Dialysis Communication PN for any recommendations and sign to acknowledge that the notes have been reviewed. N.J.A.C. 8:39-27.1 (a)	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 42 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that due to a shortage of staff, the facility failed to a.) honor the resident's shower schedule for 1 of 5 residents, Resident #141 and b.) ensure residents were provided morning care in a timely manner for 2 of 5 residents, Residents #141 and #213 of Resident Council group. This deficient practice was evidenced by the following: On 1/17/25 at 11:01 AM, the surveyor conducted a resident group meeting with five residents who were NJ Ex Order 26.4b1 and were selected by the facility to attend the group meeting. Resident#141 informed the surveyor that two weeks ago, not this past Monday NJ Ex Order 26. 4B1, the resident did not get showered. Resident #141 did not mention the name of the *U.S. FOIA (b) (6)* who told them that it was because of the shortage of staff which was why the resident did not get a shower. On that same date and time, Resident #141 informed the surveyor that there were concerns with short staff that affected the timeliness of care and caused the resident to be late for the NJ Ex Order 26. 4B1 lunch meal. Resident #141 stated that on NJ Ex Order 26. 4B1, 7:00 AM-3:00 PM (7 AM-3 PM) shift, there was one staff in each wing on the NJ Ex O floor. Resident #141 further stated that they notified the	F 725	F725 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. The Director of Nursing interviewed resident #141 who was not offered a shower but received NJ Ex Order 26.4b1 which was not resident #141's preference. The Director of Nursing met with the resident and discussed that resident may request a shower on another day. The Director of Nursing in-serviced NJ Ex Order 26.4b1 for resident #141 that the nurse should have offered the resident a shower on another day. b. On December 25, 2024, the facility had a luncheon for residents and their guests in the main dining room. Resident #141 arrived in the dining room at 11:55am and spoke with the Executive Director/ LNHA at 12:13pm, in the dining room as recorded on the security video recording(video not audio). c. The Executive Director/LNHA reviewed the staffing for 12/25/24 for resident #141's unit that has two sections. The census was 35 residents, 4 CNAs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 43 U.S. FOIA (b) (6) about the concerns at that time, and the U.S. FOIA (b) (6) did not say anything about it. At that same time, Resident #213 informed the surveyor that the facility needed more CNAs because it affected care. Resident #213 stated that this weekend NJ Ex Order 26. 4B1, morning care was late in their unit, and that there was a total of four CNAs for the entire NJ Ex O floor. A review of Resident #141's most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of NJ Ex Order 26. 4B1, revealed a brief interview for mental status (BIMS) score of NJ Ex out of 15, and reflected that the resident's NJ Ex Order 26. 4B1. A review of Resident #213's most recent quarterly MDS, with an ARD of NJ Ex Order 26. 4B1, revealed a BIMS score of NJ Ex out of 15. On 1/17/25 at 11:50 AM, the surveyor asked the NJ Ex Order 26. 4B1 for the last two weeks' and NJ Ex Order 26. 4B1 CNAs' assignments and the NJ Ex Order 2 responded that he would get back to the surveyor. On 1/21/25 at 9:35 AM, the surveyor asked Secretary #1 (S#1) for the NJ Ex Orde loor unit showers for the last 2 months, and she stated that she would get back to the surveyor. On 1/21/25 at 10:01 AM, the surveyor interviewed the 1st floor U.S. FOIA (b) (6) about the shower, and the U.S. FOI stated that showers were given once a week and that if the resident requested more than once a week, it would be	F 725	were assigned to the unit. The Executive Director reviewed the staffing schedule to identify reasons for the staffing deficiencies and solutions to address the deficiencies. d. The Executive Director/LNHA reviewed the staffing for January 11, 2025 and January 12, 2025, for resident #213□s unit that has three sections. The census was 53 residents. 6 CNAs were assigned and worked on January 11, 2025. 5 CNAs were assigned and worked on January 12, 2025. The Executive Director reviewed the staffing schedule to identify reasons for the staffing deficiencies and solutions to address the deficiencies. e. The Director of Nursing reviewed the progress notes for resident #141 for whom body assessments were not completed. There weren't any indications that the missed assessments had an impact on the resident's NJ Ex Order 26.4b1. f. The Executive Director reviewed the staffing schedules for the three-day shifts on 12/23/24, 1/11/25 and 1/12/25 that did not meet the required minimum staff-to-resident ratio to identify reasons for the staffing deficiencies and solutions to address the deficiency. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 44 provided. The [U.S. FOI] provided the surveyor unit's shower book for [NJ Ex Order 26. 4B1]. The surveyor asked for the [NJ Ex Order 26. 4B1] shower book, and the [U.S. FOI] responded that she would get back to the surveyor. On [NJ Ex Order 26. 4B1] at 10:07 AM, S#2 informed the surveyor that a shower was provided once a week and as needed if requested for more showers according to the resident's care plan. S#2 also stated that the other months' showers were filed in the resident's medical records. Both the surveyor and S#2 reviewed the medical records and found that the weekly Body Inspection paper for [NJ Ex Order 26. 4B1] had the 3rd-week missing signatures while [NJ Ex Order 26. 4B1] had the 3rd and 4th-week missing signatures for both CNAs and Nurses. On that same date and time, S#2 informed the surveyor that the Weekly Body Inspection paper should have been signed by nurses and CNAs when showers or bed baths were provided or refused as indicated in the paper. She further stated that she had to get back to the surveyor as to why there was no signature to reflect that showers were provided on those dates. On 1/21/25 at 11:28 AM, the surveyor interviewed CNA#1 who stated that she was the aide on [NJ Ex Order 26. 4B1] assigned to Resident#141. The surveyor notified CNA#1 of the above findings and concern that on [NJ Ex Order 26. 4B1], Resident #141 did not get a shower, and there was no documented evidence that the shower was provided. CNA#1 responded that on [NJ Ex Order 26. 4B1], the shower was "[NJ Ex Order 26. 4B1]" not provided due to short staff. A review of the provided Nursing Home Resident	F 725	a. All residents who reside at at the facility have the potential to be affected by the deficient practice. b. Using the weekly Body Assessment forms for the month of January, the 11 pm to 7 am nurses audited the records to identify residents who did not receive a shower or bed bath as per resident's preference and to identify missed body assessments. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Director of Nursing, Infection Preventionist and an Assistant Nursing Supervisor reviewed and revised the Showers, Residents policy. Revisions include offering a shower at a later time or, on the following day if not given on the preferred day/time. b. The Director of Nursing with input from the Medical Director developed a policy for Commitment to Care: Accountability Standards for nurses and CNAs. The policy includes accountability for nurses and CNA's such as care plan interventions, and resident assessments. c. Mandatory in-service by the Inservice Instructors and Assistant Nursing Supervisors was provided for all nurses, Certified Nursing Assistants, Assistant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 45 Care Staffing Report revealed: Monday, [NJ Ex Order 26. 4B1] for the Day Shift, 7 AM-3 PM, revealed a ratio of 1 CNA:9.6 Residents. Saturday, [NJ Ex Order 26. 4B] for the Day Shift, 7 AM-3 PM, revealed a ratio of 1 CNA:8.7 Residents. Sunday, [NJ Ex Order 26. 4B] for the Day Shift, 7 AM-3 PM, revealed a ratio of 1 CNA:10 Residents. A review of the 7 AM-3 PM Unit 1-200 schedule for the date [NJ Ex Order 26. 4B1] revealed that CNA#2 had a total of 11 residents including Resident #141. On [NJ Ex Order 26. 4B] at 12:19 PM, the survey team met with the *U.S. FOIA (b) (6)* [redacted], and the surveyor notified the above findings and concerns. On [NJ Ex Order 26. 4B] at 11:08 AM, the survey team met with the *U.S. FOIA (b) (6)* [redacted] stated, "*NJ Ex Order 26. 4B1* [redacted]." A review of the facility's Residents Showers Policy with a review date of 4/19/18 that was provided by the [U.S. FOIA (b)] revealed: Policy: All residents will receive showers at least once per week in accordance with resident's preference unless the resident declines a shower. Procedures: 5. Weekly skin assessment will be done by a nurse in the shower room and with the help of the [U.S. FOIA (b)]. Findings will be documented by the nurse on the Weekly Body Inspection Form ...	F 725	Nursing Supervisors on the Shower Policy and Commitment to Care: Accountability Standards for nurses and CNAs. d. To meet the required minimum staff-to-resident ratios, a Sidebar Agreement was negotiated for the Collective Bargaining Agreement that includes Certified Nursing Assistants to offer incentive pay for CNAs who voluntarily work additional day or evening shifts on a weekend to ensure adequate staffing for vacant shifts. The Sidebar Agreement was implemented on January 25, 2025, and is effective for calendar year 2025. e. The Collective Bargaining Agreement that includes Certified Nursing Assistants was renegotiated and ratified on August 6, 2024, and is effective through June 30, 2028. Included are wage increases for full-time, part-time and per-diem staff, salary step level increases for Certified Nursing Assistants and a stipend for Certified Nursing Assistants during the first twelve months of their initial employment. f. The Executive Director LNHA, the Director of Nursing and Assistant Director of Nursing monitor Certified Nursing Assistant staffing ratios and will continue to augment Certified Nursing Assistant staffing levels by retaining agency Certified Nursing Assistant staff and offering additional shifts and/or overtime to employed Certified Nursing Assistant staff who wish to work additional shifts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 46 On 1/22/25 at 1:15 PM, the survey team met with the U.S. FOIA (b) (6) for an exit conference, and there was no additional information provided by the facility. NJAC 8:39-25.2(b)	F 725	and/or overtime. g. The facility increased the number of staffing agencies to fourteen staffing agencies to provide nursing staff including Certified Nursing Assistants. Staffing agencies will continue to be contacted to fill vacant Certified Nursing Assistant positions while the Executive Director continues to advertise to hire Certified Nursing Assistants. h. Agency staff are contracted through a Request for Qualification procurement process. The County Administrator approved including multi-year contracts as an option in the future solicitations to address agency staff year end turnover. The Executive Director/LNHA will continue to work with County Procurement Director/ LNHA to issue Requests for Qualification to expand the pool of staffing agency providers for Certified Nursing Assistants. i. The Staffing Coordinator or Assistant Nursing Supervisor will continue to update the Director of Nursing/designee at the beginning of each shift if the CNA to resident ratio has not been met. Efforts will be made to address the CNA shortage for the shift. Non-nursing staff who have successfully completed the Dining Assistant curriculum assist to feed residents who need assistance. j. Resident census and nursing staffing including Certified Nursing Assistant staff schedules are reviewed daily by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 47	F 725	Director of Nursing/designee and the Executive Director to monitor Certified Nursing Assistant staff to resident ratios. Assignments are reviewed to assure residents requiring total assistance are not all on one assignment. k. The Staffing Coordinator will continue to establish a pool of Certified Nursing Assistants who are willing/available to fill in the vacant shifts in the event of call-outs by Certified Nursing Assistants. l. The Executive Director/ LNHA will continue to use digital, social and print media and to assign staff to attend job fairs and community events with County Human Resources personnel to recruit Certified Nursing Assistants. m. The Executive Director/ LNHA will continue to work with Passaic County Human Resources Director to review staffing levels and recruitment efforts. n. The Executive Director/ LNHA, Director of Nursing, Assistant Director of Nursing and Staffing Coordinator will continue to meet on a weekly basis to review Certified Nursing Assistant staffing levels for the next days, the next weeks, vacant positions, agency staff availability and recruitment efforts. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. Staffing levels of Certified Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 48	F 725	Assistants and recruitment efforts are reviewed by the Executive Director/LNHA and the Director of County Human Resources. Staffing levels including compliance with PL 2020 c112 NJSA 30:13-18, vacancy rates and trends of Certified Nursing Assistants will continue to be reported by the Executive Director/ LNHA monthly to the Quality Assurance and Performance Improvement Committee that meets monthly for review and recommendations.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		2/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 755	Continued From page 49 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure accurate documentation of the receipt of a controlled substance for 4 of 4 Schedule II controlled substance medications ordered and received by the facility for use as an emergency backup supply, on three Drug Enforcement Agency (DEA) 222 Forms (a form used to order controlled substances from a provider) reviewed. The deficient practice was evidenced by the following: Reference: 21 CFR 1305.13 Procedure for filling DEA Forms 222. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by	F 755	F755 Pharmacy Services/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The Executive Director and Director of Nursing confirmed that packing lists of controlled medications were attached to the DEA222 forms for orders #[redacted] that did not have Section 5 of the DEA222 form completed by the Director of Nursing or Assistant Director of Nursing who received the medications. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who receive medications	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 755	Continued From page 50 a licensed or otherwise legally authorized physician or dentist." On 1/17/25, the surveyor reviewed a binder provided by the [redacted] containing, but not limited to; facility DEA 222 Forms, copies of medical director state and federal controlled substance registration certificates, and packing slips associated with the DEA 222 Forms for controlled substance deliveries. A review of the facility DEA 222 Forms that were filled out and used to order controlled substances (CDS) revealed the following: DEA 222 Form with order form # [redacted] dated 5/5/24, for one package of 20 morphine sulfate 10 mg (milligram)/0.5 ml (milliliters) syringes (a schedule II-CDS used for pain) with the section Part 5: to be filled in by purchaser, number received, date received, not filled in. A supplier packing slip for the items was present. DEA 222 Form with order form # [redacted] dated 7/25/24, for one package of 20 morphine sulfate 10 mg/0.5 ml syringes with the section Part 5: to be filled in by purchaser, number received, date received, not filled in. A supplier packing slip for the items was present. DEA 222 Form with order form # [redacted] dated 9/4/24, for one package of 30 oxycodone 5 mg/325 mg (a schedule II-CDS used for pain) and one (1) package of 10 oxycontin 10 mg (a schedule II-CDS used for pain) with the section Part 5: to be filled in by purchaser, number received, date received, not filled in. A supplier packing slip for the items was present,	F 755	may be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Pharmacy Consultant provided mandatory in-service on the required documentation on the DEA222 forms to the [redacted]. Topics included that the number of medications received and the date received must be indicated in Section 5. b. The Consultant Pharmacist will audit the DEA222 forms on a monthly basis for completion and report any incomplete information to the Executive Director/LNHA and Medical Director. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Pharmacy and Therapeutics Committee meets quarterly. The Consultant Pharmacist will report the findings from the monthly audits of the DEA222 forms quarterly to the Pharmacy and Therapeutics Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Executive Director will report the findings from the monthly audits of the DEA222 forms to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 755	Continued From page 51 On 1/21/25 at 11:15 AM, the surveyor met with the facility [redacted] to discuss the concerns with the completion of the DEA 222 forms. The [redacted] stated the facility must have missed those and they do know how to fill them in since they did so on others. On 1/21/25, at 12:15 PM, the surveyor met with the [redacted] to discuss the concerns with the DEA 222 forms. The [redacted] acknowledged that Part 5 on the forms were not filled in and should be completed when the items were received. On 1/22/25 at 11:08 AM, the survey team met with the [redacted] stated that the incomplete information will be addressed and agreed that the forms should be completed per the instructions, but there were packing slips showing delivery attached. The facility offered no further pertinent information. A review of the instructions for completing the DEA 222 Forms located in the Code of Federal Regulations at 21 CFR1305.13, revealed the following: Section (e) "The purchaser must record on its copy of the DEA Form 222 the number of commercial or bulk containers furnished on each item and the dates on which the containers are received by the purchaser." A review of the facility's Policy and Procedure Manual, revised February 2023, revealed:	F 755	Assurance and Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 755	Continued From page 52 5. Prescribing and Ordering of Medications 5.6 Controlled Dangerous Substance Inventory for Backup Box and Emergency Kits. The policy reflected under section 5.6, Policy, A. (Provider Pharmacy name redacted) and the facility will properly distribute, maintain and dispense controlled substances that are stored within the backup box and emergency kit. All CDS are dispensed and handled in accordance with state and federal regulations. The policy also reflected under Procedure, A. CDS Inventory in Back Up Supply- Schedule II CDS: 1. The DEA form 222 must be completed to obtain the par level quantity of Schedule II CDS in back up supply. Upon signature of the Medical Director or his/her designee, the facility makes a copy then sends the original to the pharmacy to the attention of the Pharmacist In Charge. NJAC 8:39-29.3(a)6, 29.4(g), 29.7(c) 21 CFR 1305.13(e)	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 757	Continued From page 53 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for 1 of 7 residents, Resident #43. The deficient practice was evidenced by the following: The surveyor reviewed Resident #43's medical record (MR) and revealed the following: A review of Resident #43's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26. 4B1 [redacted]. A review of Resident #43's Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26. 4B1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex [redacted] out of 15, which indicated that Resident #43 was NJ Ex Order 26. 4B1 [redacted].	F 757	F757, Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. The attending physician for resident #43 reviewed the medication orders and discontinued the order for NJ Ex Order 26. 4B1. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility who are prescribed medications have the potential to be affected by the same deficient practice. b. Using a report obtained from the pharmacy services provider that indicates any resident who has two or more as needed orders with the same	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 757	Continued From page 54 A review of the resident's list of medications (meds) reflected a Physician's order (PO) for [redacted], 1 tablet (tab) orally every 6 hours as needed (PRN) for [redacted], and a PO for [redacted] intramuscularly every 6 hours PRN for [redacted], with a date of [redacted]. Further review of the MR, revealed a Medication Regimen Reviews (MRR) from the facility's [redacted]. The MRR reflected a recommendation by the [redacted] to the [redacted] dated [redacted], to discontinue both meds due to not being used in over 60 days. The MR reflected that the [redacted] indicated on the [redacted] recommendation "[redacted]" There was no reason given on the sheet by the [redacted] which revealed dates of [redacted] by the [redacted] and [redacted], by the MD signature. On 1/17/25 at 12:09 PM, the survey team met with the [redacted] to discuss the concerns with the duplicate meds. On 1/17/25 at 1:23 PM, the surveyor interviewed the [redacted] on the unit where the resident resided. The surveyor asked the [redacted] how they would tell which of the meds that both PRN for [redacted] to give if the resident was experiencing those symptoms. The [redacted] stated that he knows the resident. The surveyor asked what would happen if they were not there, or other staff that were not familiar with the resident were on duty and the resident required medication (med). The [redacted] stated they would have to call the [redacted] to	F 757	indication/use for the month of January 2025, the Assistant Nursing Supervisors performed an audit to ensure that there are specific instructions for administration of each medication order. Any issues will be immediately addressed, and the findings will be reported to the Director of Nursing/ designee. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Director of Nursing, Infection Preventionist, Quality Assurance Coordinator, and Assistant Nursing Supervisor revised the Pharmacy Services policy for review by the Pharmacy Consultant and Medical Director. Proposed revisions included drug regimens that are free from unnecessary drugs and the sequencing of two or more medications with the same indication/use. b. The Consultant Pharmacist will continue to perform a Medication Regimen Review on all residents monthly and on admission/readmission to the facility. c. Using a report provided by the Pharmacy Services Provider, the Assistant Nursing Supervisors will conduct a daily audit of the new medication orders to ensure that residents who are prescribed two or more as needed medications with the same indication of use specify on each	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 757	Continued From page 55 clarify, so it might not be right away. The surveyor asked if the treatment would end up being delayed. The [U.S. FOI] stated, yes, it was possible it could be. On 1/21/25 at 12:03 PM, the surveyor met with the [U.S. FOI] in person to discuss the concerns with duplicate meds, and the [U.S. FOI] stated that they were aware of the concern as the facility had contacted them. The [U.S. FOI] was able to provide to the surveyor, evidence, that the [U.S. FOI] had recommended to the [U.S. FOI], dated [NJ Ex Order 26. 4B], a request to indicate how the meds should be given, which to administer first or second. The MR did not reflect any response by the [U.S. FOI] to that recommendation. On 1/21/25 at 12:19 PM, the survey team met with the [U.S. FOIA (b) (6)] stated that the [U.S. FOI] was called and informed of the concern and the [U.S. FOI] was called and discontinued (d/c) the [NJ Ex Order 26. 4B] order. The surveyor reviewed the resident's MR that reflected a telephone PO to d/c the [U.S. FOIA (b) (6)], dated [NJ Ex Order 26. 4B], after the surveyor's inquiry. A review of the facility's Department: Nursing, Subject: Pharmacy Services Policy, last review date 6/14/16, under page 1, Policy: number 11. Each drug regimen must be free of unnecessary drugs. Page 5, L. Sequencing Med Orders, 1. When a resident has 2 or more med orders with the same indication of use (i.e. pain, constipation, nausea/vomiting, cough, etc,) indicate on each med order the specific instruction of use. The facility did not provide any further pertinent information.	F 757	medication order the instructions and sequencing of use. Any issues will be immediately addressed, and the findings will be reported to the Director of Nursing/designee. d. Mandatory in-service for all nurses on review of the Medication Regimen Review and the sequencing of two or more medications with the same indication/use was provided by the Inservice Instructors. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Director of Nursing /designee (Assistant Director of Nursing) will present the findings from the audit of residents who have two or more orders with the same indication/use from January 2025 to the Quality Assurance and Quality Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Director of Nursing/designee (Assistant Director of Nursing) will report the findings from the daily audits of new medication orders to the Quality Assurance and Performance Improvement Committee. c. The Pharmacy and Therapeutics Committee meets quarterly. The Consultant Pharmacist will report the findings from the monthly medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 757	Continued From page 56 N.J.A.C. 8:39-27.1(a)	F 757	regimen reviews and reviews of all resident admissions/readmissions quarterly to the Pharmacy and Therapeutics Committee.	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more during the medication administration, 4 nurses administered medications to 5 residents. There were 25 opportunities for error, 2 errors were observed which calculated to a medication administration error rate of 8%. This deficient practice was identified for 2 of 5 residents, (Resident #55 and Resident #122), that were administered medications by 2 of 5 nurses that were observed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential	F 759	F759 Free of Medication Error Rates 5% or More CFR(s): 483.45(f)(1) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. A medication error report was completed by the Assistant Director of Nursing for the Licensed Practical Nurse for resident #55 who administered [redacted] crushed although there was a cautionary warning to swallow whole or sprinkle capsule contents on small amount of food. The physician was notified and did not give any orders. The resident [redacted] because the [redacted] was provided crushed with other medications. b. A medication error report was completed by the Assistant Director of	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 759	Continued From page 57 physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 1/17/25 at 8:40 AM, the surveyor observed the U.S. FOIA (b) (6) prepare medications (meds) for Resident #55. The meds included an active physician's orders (PO) for the NJ Ex Order 26. 4B1 sprinkle give 2 capsules (caps) orally twice daily (AM [morning]-HS [bedtime]) for NJ Ex Order 26. 4B1. The U.S. FOIA stated that the resident needs their meds crushed and given with pudding or applesauce to NJ Ex Order 26.4b1. The surveyor observed the U.S. FOIA appropriately open the caps but empty them in a pouch used for crushing meds with other meds. The U.S. FOIA then proceeded to crush the contents of the pouch, including the	F 759	Nursing for the Registered Nurse for resident #122 who was prepared to administer one tablet of NJ Ex Order 26. 4B1 rather than NJ Ex Order 26. 4B1 □ . The physician was not notified because the NJ Ex Order 26. 4B1 medication was not given to the resident. The resident was not affected because the resident received the NJ Ex Order 26. 4B1. c. The agency for the contracted Registered Nurse for resident #12 was informed that the Registered Nurse was not to be scheduled to work at the facility, pending the outcome of the review of the medication error. d. The Pharmacy Consultant assessed the competency of the Licensed Practical Nurse to administer medications using the Medication Pass Competency Assessment. The Licensed Practical Nurse NJ Ex Order 26.4b1 the Medication Competency Assessment. The Director of Nursing provided education to the U.S. FOIA (b) (6) on Med Pass with emphasis on why certain medications are not meant to be crushed. e. The Pharmacy Consultant assessed the competency of the Registered Nurse to administer medications using the Medication Competency Assessment. The Registered Nurse NJ Ex Order 26.4b1 the Medication Competency Assessment. Education was provided to the U.S. FOIA (b) (6) by the Inservice Instructor. The Registered Nurse is required to successfully pass two random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 759	Continued From page 58 contents of the NJ Ex Order 26. 4B1. The surveyor asked the [redacted] to check the cautionary warning under the med order. The [redacted] stated that it said "NJ Ex Order 26. 4B1 [redacted]" but thought it meant not to crush the whole capsule. The surveyor completed the med pass observation. On 1/17/25, the survey team met with the U.S. FOIA (b) (6) [redacted] to discuss the concerns with the med pass that the contents of the capsule should not be crushed or chewed per the cautionary warning on the Resident #55's Medication Administration Record (MAR). On 1/21/25, the survey team met with the [redacted] for responses to concerns. The [redacted] stated that the nurses in question were observed for med pass and 1 of 2 did not pass. The facility did not provide any further pertinent information. The surveyor reviewed the facility policy manual titled: Dept: Nursing, Subject: Pharmacy Services, Last review date 6/14/16. The manual revealed, under page 1, Policy: 2. Med administered is free of significant error rate of 5% or greater. Page 6 II. A. Med Administration. 7. Meds should not be crushed unless the manufacturer allows it to be crushed .... 2. On 1/17/25 at 8:25 AM, during the med	F 759	medication competency assessments conducted by the Inservice Instructor during the month of February. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility who have medications prescribed and administered have the potential to be affected by the deficient practice. b. The Assistant Nursing Supervisors provided mandatory in-service on Med Pass to nurses. Topics included Medication Verification, Medication Precautions, the seven rights of medication administration and discussion of Depakote sprinkles and Senna Plus, a combination medication. c. Annual medication competency assessments of all nurses employed or contracted will continue to be completed by the Consultant Pharmacist, In-Service Instructors, and Assistant Nursing Supervisors. The findings from the assessments are presented to the Director of Nursing for review and action. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. Using the Medication Pass Competency Assessment, the Consultant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 759	Continued From page 59 administration observation, the surveyor observed the U.S. FOIA (b) (6) preparing to administer meds to Resident #122. The surveyor observed the resident's MAR which reflected an order for NJ Ex Order 26. 4B1 [redacted], give 1 tablet (tab) by mouth every 12 hours for NJ Ex Order 26. 4B1. The surveyor observed the U.S. FOI prepare 1 tab of NJ Ex Order 26. 4B1 for Resident #122. The surveyor observed the U.S. FOI looked at the NJ Ex Order 26. 4B1 bottle and pointed to the MAR and stated that the resident was supposed to get NJ Ex Order 26. 4B1 and that she pulled the correct med. The surveyor continued to observe the U.S. FOI enter Resident #122's room and just prior to administering the med asked the U.S. FOI if she could step outside of the resident's room with the med. The U.S. FOI reviewed the resident's MAR and acknowledged that the resident had an order for NJ Ex Order 26. 4B1. The surveyor observed the U.S. FOI pull out of the med a bottle of NJ Ex Order 26. 4B1 and a bottle of NJ Ex Order 26. 4B1 from the med cart. The U.S. FOI compared the ingredients of both bottles with the MAR and stated that she should have prepared NJ Ex Order 26. 4B1 for Resident #122 instead of NJ Ex Order 26. 4B1. On 1/17/25 at 1:30 PM, the surveyor discussed the above concerns with the U.S. FOIA (b) (6). No further information was provided. A review of the facility's Med Administration Policy, with a revision date of 2/2023, and was provided by the U.S. FOIA (b) revealed the following: 3. Nurse reviews each resident's MAR to	F 759	Pharmacist, Inservice Instructors, Assistant Director of Nursing, and Assistant Nursing Supervisors assess the competency of all nurses once / year. All nurses will continue to be required to successfully complete one medication pass competency assessment with an error rate of less than five per cent upon hire and annually. The findings of the assessments are presented to the Director of Nursing/designee for review and action. b. Mandatory in-service education by the Consultant Pharmacist and Inservice Instructors for all nurses was provided. Topics include but are not limited to medication administration and proper crushing of medications. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Director of Nursing/designee will report the results of medication pass competency assessments monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Pharmacy and Therapeutics Committee. b. The Pharmacy and Therapeutics Committee meets quarterly. The Director of Nursing/designee will continue to report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 759	Continued From page 60 determine which meds need to be administered at the given time. The nurse observes the six rights in administering each med; a. The right resident b. The right time c. The right med d. The right dose e. The right route of administration f. documentation. N.J.A.C 8:39-29.2 (d)	F 759	medication errors and corrective actions taken to the Pharmacy and Therapeutics Committee.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 761	Continued From page 61 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly a.) label, dispose and secure medications in 3 of 9 medication carts inspected and b.) store medication for 1 of 4 medication carts inspected according to facility's policy and standard of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally	F 761	F761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The opened, undated vial of Novolog insulin in 2-300 Medication Cart A was removed and discarded. The opened bottle of blood glucose strips was removed and discarded. c. The opened bottle of blood glucose strips in 2-300 Medication Cart B was removed and discarded. d. The opened foil package of Arformoterol inhalation solution in 1-300 Medication Cart A was removed and discarded. e. The 14 loose tablets, capsules, and pieces of paper on the bottom rear of the drawer in 1-300 Medication Cart A were removed and discarded. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 761	Continued From page 62 authorized physician or dentist." 1. On 1/17/25 at 10:45 AM, the surveyor inspected the 2-300 medication (med) cart A in the presence of the U.S. FOIA (b) (6). The surveyor observed an opened and undated vial of Novolog insulin that had a pharmacy date of 12/31/24, and was stored in the med cart. The surveyor also observed an opened bottle of blood glucose test strips that was undated. At that time, the surveyor interviewed the [redacted] who acknowledged that both the Novolog insulin vial and a bottle of blood glucose test strips should have been dated once opened. On 1/17/25 at 11:00 AM, the surveyor inspected the 2-300 med cart B in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened and undated bottle of blood glucose test strips. At that time, the surveyor interviewed LPN#1 who stated that once a bottle of blood glucose test strips was opened that it should have been dated. A review of the manufacturer's specifications for the following medications (meds) revealed that the bottle of blood glucose test strips had an expiration date of 90 days once opened and Novolog Insulin Pen had an expiration date of 28 days once opened. On 1/21/25 at 1:30 PM, the survey team met with the U.S. FOIA (b) (6) [redacted] to discuss the above concerns. There was no additional information provided.	F 761	a. All residents who receive medication have the potential to be affected by the deficient practice. b. Using the Consultant Pharmacists Unit Inspection Report the Consultant Pharmacist checked all medication carts and medication refrigerators for opened medication that was not dated and checked for the presence of loose tablets, capsules and pieces of paper. Findings were reported to the Director of Nursing for review and action. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. Nurses on the night shift check on a daily basis that medication in medication carts and medication refrigerators is properly stored and labeled. Any issues are immediately corrected and reported to the Assistant Nursing Supervisors on 24-hour report and the monitoring of Med Carts/Med Refrigerator audit checklist. Checks include the dating of open vials, glucose strips and solutions. Findings are reported to the Director of Nursing/designee. b. Using the Consultant Pharmacists Unit Inspection Report the Consultant Pharmacist will continue to check all medication carts and medication refrigerators for proper label & storage. Findings are reported to the Director of Nursing/ designee for review and action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 761	Continued From page 63 A review of the facility's Med Storage Policy that and a revision date of 2/2023, and was provided by the [redacted] revealed that the meds will be stored in a manner that maintains the integrity of product, ensures the safety of the customers, in accordance with state department of Health guidelines and are accessible only to be licensed nursing and pharmacy personnel. 2. On 1/17/25 at 10:20 AM, the surveyor began to inspect selected med storage areas in the facility. The surveyor observed the following: The surveyor in the presence of LPN#2, the surveyor inspected the med cart identified as Cart A located on the 1-300 Unit. The surveyor observed a box containing a foil package of Arformoterol inhalation solution (an inhaled med used to open lung passages) that did not reflect a date when the foil was originally opened. The manufacturer labeling on the box reflected: Store unopened pouched unit-dose vials in a refrigerator. Unopened pouched unit dose vials can also be stored at room temperature (temp) for up to 6 weeks. Do not use past the expiration date or after 6 weeks storage at room temp, whichever is sooner. Keep refrigerated or store at room temp for up to 6 weeks. The surveyor asked LPN#2 if the box or foil should have a date when it was opened on it. LPN#2 stated, yes we usually date nebulizer solutions. The surveyor asked LPN#2 if there was	F 761	c. Mandatory in-service for all nurses on the proper storage and labeling of medications by the Consultant Pharmacist and Inservice Instructor was provided. Topics included medication administration, proper storage, and labeling of medication. d. Using the Unit Inspection monitoring of Med Carts/Med Refrigerator audit form the Assistant Nursing Supervisor / designee (Assistant Director of Nursing) will audit the medication carts, medication refrigerators, and medication storage rooms on one nursing unit/week. Findings are reported to the Director of Nursing/designee. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Pharmacy and Therapeutics Committee meets quarterly. The Consultant Pharmacist will continue to report the findings from the monthly unit inspections quarterly to the Pharmacy and Therapeutics Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Director of Nursing/designee will report the findings from the daily audits by nurses on the night shifts of the storage and labeling of medications to the Quality Assurance and Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 761	Continued From page 64 no date on it, could it be easily determined how long it was in the cart. LPN#2 stated not, not really. The surveyor also observed, in the 2nd drawer of the med cart a quantity of loose tablets and capsules on the bottom rear of the drawer along with scraps of papers. The surveyor counted the loose meds which amounted to 14 items. The surveyor asked LPN#2 if they could positively identify any of the meds. LPN#2 stated they could not. The surveyor asked LPN#2 if meds should be stored that way. LPN#2 stated, no they should be disposed of. The surveyor observed LPN#2 disposed of the loose med in the drug disposal device located in the bottom of the med cart. On 1/21/25 at 1:30 PM, the surveyor met with the U.S. FOIA (b) (6) for responses related to concerns with med storage. The U.S. FOIA (b) stated for the storage of meds that were not dated and opened and the loose meds, we are just going to inservice the staff and move forward with that. The facility did not provide any further pertinent information. A review of the facility's policy manual titled: Dept: Nursing, Subject: Pharmacy Services, Last review date 6/14/16. The manual revealed, under POLICY: 7. Drugs and biologicals used in the facility must be labeled in accordance with the currently accepted professional principles and include the appropriate accessory and cautionary instructions and expiration date when applicable. A review of the facility's Policy and Procedure Manual, revised February 2023, page 84, Section 6.8 Med Storage. Which reflected under:	F 761	c. The Quality Assurance and Performance Improvement Committee meets monthly. The Director of Nursing/designee will report the findings from the unit inspection by the Assistant Nursing Supervisors to the Quality Assurance and Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 761	Continued From page 65 Med Storage, Policy, A. Meds will be stored in a manner that maintains the integrity of the product, ensures the safety of the customers, in accordance with the state Department of Health guidelines and are accessible to only licensed nursing and pharmacy personnel. Procedure: C. Meds will be stored in an orderly, organized manner in a clean area. E. Meds will be stored in in the original, labeled containers received from the pharmacy. G. Meds will be stored at the appropriate temp in accordance with the pharmacy and/or manufacturer labeling.	F 761		
F 812 SS=F	NJAC 8:39-29.4 (a)(d)(g)(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 812	Continued From page 66 by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 1/15/25 at 9:24 AM, the surveyor in the presence of the Dietary Supervisor (DS#1) and the U.S. FOIA (b) (6) observed the following during the kitchen tour: 1. The surveyor observed in the dry storage room: a dented can of sliced potatoes in the regular rotation of non-dented canned goods; 3 boxes stored above 18 inches (in) from the ceiling, and the following items were observed opened without an open/use by label: one 3 pound (lb.) bag of tri-color pasta, 1 gallon container of white vinegar, one 32 oz (ounces) bottle of imitation vanilla, one 32 oz bottle of green food coloring, three 16 oz containers of chili powder, one 16oz container of ground thyme, one 16 oz container of Italian seasoning, one 16 oz container of oregano, one 16 oz container of sage, and one 32 oz bottle of egg yellow food coloring. Neither the DS#1 or U.S. FOI could explain why the dented can was not placed in the dented can area or why the opened items had not been labeled with an open/use by labels. 2. The surveyor observed a four-shelf bread storage rack located outside the dry storage room with four opened bags of bread without an open/use by labels. The breads that were observed were: 1 bag of white bread, 2 bags of	F 812	F812, Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. The Infection Preventionist audited the 24 hr. reports for residents who are not fed by feeding tube or who are not NPO in the month of January 2025, for symptoms of food borne illness in residents. No symptoms were reported. b. The dented can of sliced potatoes in the dry storage room in the regular rotation of non-dented canned goods was removed and discarded by the Food Service Supervisor. c. The one 3 pound bag of tri-color pasta, the one gallon container of white vinegar, the one 32 ounce bottle of imitation vanilla, the one 32 ounce bottle of green food coloring, the three 16 ounce containers of chili powder, the one 16 ounce container of ground thyme, the one 16 ounce container of Italian seasoning, the one 16 ounce container of oregano, the one 16 ounce container of sage, and the one 32 ounce bottle of egg yellow food coloring that were in the dry storage room and were opened and not labeled with an open/use by date were discarded by the Food Services Supervisors and Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 812	Continued From page 67 wheat bread, and 1 bag of rye bread. DS#1 stated the bags of bread should have been labeled once they were opened. 3. The surveyor observed in the combined walk-in refrigerator and freezer #1. The combined walk-in refrigerator fans was observed with a black colored debris on the fan cover and freezer #1 had multiple boxes stored above 18 in from the ceiling. 4. The surveyor observed in the combined walk-in refrigerator and freezer #2. Freezer #2 had multiple boxes stored above 18 in from the ceiling. 5. The surveyor observed the combined walk-in refrigerator and freezer #4. The combined walk-in refrigerator had 3 boxes stored above 18in from the ceiling. 6. The surveyor observed the cooking area with a double stacked steamer and a 3 standing dual ovens, all had a sticky brown colored substance on the top on the cooking equipment. DS#1 could not provide information when the equipment was last cleaned. On 1/16/25 at 10:52 AM, in the presence of the Dietary Supervisor #2 (DS#2) observed the following during the follow up kitchen tour: 7. The surveyor observed DS#2 and the [redacted] both wearing a large hooped earrings. The surveyor asked DS#2 and the [redacted] about dress code for the kitchen regarding jewelry. DS#2 stated the earrings that both DS#2 and the [redacted] were wearing were not allowed in the kitchen.	F 812	of Dietary/RD. d. The one bag of white bread, the two bags of wheat bread and one bag of rye bread that were opened and not labeled with an open/use by date were discarded by the Food Service Supervisor. e. The fans in the walk-in refrigerator/freezer #1 that were observed with black covered debris on the fan cover were cleaned by the Building Maintenance Worker. f. The boxes that were stored above 18" from the ceiling in freezer #1, freezer #2, and refrigerator/freezer #4 were removed and stored below 18" from the ceiling by the stock clerks. g. The cooking area with a double stacked steamer and three standing dual ovens that had a sticky brown colored substance on the top of the cooking equipment were cleaned by the Environmental Services Supervisor and Building Maintenance Worker. h. The [redacted] who were observed wearing large hoop earrings received education from the Director of Dietary/RD regarding the dress code that includes directions regarding jewelry. i. The [redacted] who checked the temperature of the pork chop without sanitizing the thermometer received education from the Dietary Director/RD	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 812	Continued From page 68 8. The surveyor observed the [redacted] checked the temperature of the pork chop without sanitizing the thermometer prior to use. The [redacted] stated they had sanitized the thermometer earlier but acknowledged once the thermometer was set down on the counter, the thermometer was considered contaminated and should be sanitized prior to use. On 1/17/25 at 12:09 PM, the survey team met with the [redacted] to review kitchen observation concerns. On 1/21/25 at 12:20 PM, [redacted] provided the surveyor with multiple facility policies for the kitchen. A review of the Dented Cans policy with a revised date of 1/20/25, stated under the procedure section, 4. If any dented cans are observed, they will be deposited in a crate which will be labeled dented cans only, and Do Not Use. A review of the Spices policy with a revised date of 1/20/25, stated under the procedures section, 2. Once opened the spice container with be dated, closed, wiped cleaned, and place back on the shelf. 3. No more than one spice of the same kind will be opened and placed back on the shelf. A review of the Food Storage policy with a revised date on 1/20/25, stated under the procedure section on the policy, 5. Store food away from the walls and at least six inches off the floor and at a height of 18" or below the ceiling line. This applies to storage in storerooms, freezers, walk-in boxes/refrigeration.	F 812	regarding Food Thermometer Sanitization Policy. The pork chops were discarded by the Food Service Supervisor. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility who consume foods prepared by the facility have the potential to be affected by the deficient practice. b. The Food Services Director/RD inspected all cans stored in the storage areas for dents, removed and discarded cans with dents. Results were provided to the Executive Director. c. The Food Services Director/RD inspected all refrigerators/freezers and storage areas to determine if all opened food was labeled with an open/expiration date. Results were provided to the Executive Director. d. The Environmental Services Supervisors inspected the kitchen including equipment to identify areas or equipment to be cleaned. Results were provided to the Executive Director. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 812	Continued From page 69 A review of the Large Kitchen Equipment Cleaning and Handling policy stated under the procedure section, Ovens, 4. Wipe down the outside of then oven with a clean washcloth wrung out with a detergent solution. Rinse and wipe dry. Refrigerator, 2. At least once a month or as needed, dust off compressor, condenser, coiled, motor and related areas. A review of the Dress Code for Food Service Workers policy with a revised date of 1/20/25, stated under the procedure section, Jewelry, waring jewelry is not permitted except for a plain ring. Employees with pierced ears may wear small post earrings. A revie of the Food Thermometer Sanitization policy with a revised date of 1/21/25, stated under the procedure section, 1. Prior to thermometer use, ensure it is clean and free from any debris. Sanitize using an alcohol prep pad or an approved food-safe sanitizer. On 1/22/25 at 12:30 PM, the survey team met with the U.S. FOIA (b) (6) . The facility did not provide any further information. NJAC 8:39-17.2(g)	F 812	a. The Executive Director and Director of Dietary/RD reviewed and revised the Dented Cans Policy to include the responsibility of Dietary Supervisors to check for dented cans on a daily basis in addition to the stock clerks who check on a daily basis. b. The Executive Director and Director of Dietary/RD reviewed and revised the Spices Policy to include the dating of opened spice containers. c. The Executive Director and Director of Dietary/RD reviewed and revised the Food Storage Policy to clarify height restrictions for the storage of food. d. The Executive Director, Director of Dietary/RD, Director of Environmental Services, and Infection Preventionist developed the policies for Kitchen Equipment Cleaning and Handling and Small Kitchen Equipment Cleaning and Handling. The policies include cleaning of the fans in the refrigerator/freezers and cleaning of cooking areas. e. The Executive Director and Director of Dietary/RD reviewed the dress code for Food Service Workers that prohibits the wearing of jewelry except plain rings and small post earrings. f. The Executive Director and Director of Dietary/RD developed a policy for Food Thermometer Sanitization that includes sanitizing the thermometer with alcohol	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 812	Continued From page 70	F 812	pads between use. g. Inservice by the Dietary Director/RD, the Director of Environmental Services, and the Food Service Supervisors was provided. Topics included Dented Cans Policy, Spices Policy, Food Storage Policy, Cleaning Policy, Dress Codes, and Food Thermometer Sanitation. h. Using the Kitchen Inspection Sheet, the Dietary Director/RD, Infection Preventionist, and Executive Director will conduct monthly documented rounds to audit sanitation and food storage practices. Any issues will be immediately corrected. i. Using the Kitchen Inspection Sheet, Food Services Supervisors will conduct daily documented rounds to audit food storage practices, equipment condition, sanitation and Infection Prevention practices such as thermometer sanitation and visually observe staff performing their duties to ensure policies and procedures are followed. Any issues identified will be immediately corrected. Findings will be presented to the Dietary Director / RD & Executive Director/ LNHA for review and action. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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 812	Continued From page 71	F 812	meets monthly. The Dietary Director/RD will report the findings from the daily documented rounds using the Kitchen Inspection Sheet by the Food Service Supervisors to audit sanitation and food storage to the Quality Assessment and Performance Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Infection Preventionist will report the findings from the monthly documented rounds by the Dietary Director/RD, Executive Director, and the Infection Preventionist to the Quality Assessment and Performance Improvement Committee.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061617	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

(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 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 720	8:39-7.3(d) Mandatory Resident Activities Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to provide residents two evening activity programs per week. This deficient practice was identified for 1 of 1 month reviewed, January 2025. This deficient practice was evidenced by the following: On 1/15/25 at 10:19 AM, the surveyor observed an activity calendar posted on the 2-200s unit on the wall across from the nurse's station. The surveyor observed that there was only two	S 720	S720 8:39-7.3(d) Mandatory Resident Activites 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The Director of Therapeutic Recreation developed a facility-wide program calendar for all residents that includes the specific locations of at least	2/10/25

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

Electronically Signed | 02/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061617	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

(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 720	Continued From page 1 evening activities listed for the entire month. The calendar did not have two evening activities each week of the month. On 1/17/25 at 9:46 AM, the surveyor interviewed the Director of Therapeutic Recreation (DoTR) regarding the facility's activity program. The DoTR stated that each unit had their own activity calendar. She stated that the dementia unit had more than two evenings per week but that the other units had two evening activities per month. The DoTR stated that the residents usually stayed on their unit but that anyone can go anywhere. 1-400 has somewhere there in the activity. all the other unit get two late nights a month. Four times a week, there was someone that works late. On 1/17/25 at 11:30 AM, the DoTR confirmed that the residents did not receive a calendar that listed the activities that were on the other units. She added that each unit had their own calendar on the wall of that unit's activities for the month. She further that the residents may not see the other unit's calendars but that the residents could go to the other units. On 1/17/25 at 12:10 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant DON (ADON) the concern that the facility did not have a facility wide program calendar for all residents that included two evening activities a week. On 1/21/25 at 12:20 PM, in the presence of the survey team, DON and ADON, the LNHA stated that the facility did not have a policy regarding activities and that they created a policy and provided the surveyor with a copy. The LNHA stated that they now created and posted a	S 720	two evening activities per week and posted the facility-wide calendar adjacent to the monthly activity calendar on each resident unit . 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Executive Director and the Director of Therapeutic Recreation developed an Activities/Therapeutic Recreation policy. The policy includes that activities are offered at a variety of times throughout the day, including morning, afternoon, weekends, and at least two evenings/week and the locations. A monthly calendar of activities is posted by the first of each month on each resident unit. b. The Director of Therapeutic Recreation/designee will continue to attend the Activity Subcommittee meetings of the Resident Council to obtain feedback and suggestions for activities including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061617	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

(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 720	Continued From page 2 calendar with the schedule of the activities on every unit that contained the times and where the activity was located. The facility did not provide any additional information.	S 720	evening activities. c. A facility-wide program calendar for all residents that includes at least two evenings/week is posted on each resident unit adjacent to the monthly activity calendar on each resident unit. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. Each week the Director of Therapeutic Recreation/designee will audit the facility-wide program schedule to monitor that at least two evening activities are conducted each week. The findings will be reported weekly to the Executive Director/LNHA and monthly to the Quality Assurance and Performance Improvement Committee.	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a [redacted] with five [redacted]. The only exceptions shall be employees with documented [redacted] within the last year, employees with a documented [redacted], employees who have received appropriate medical treatment for [redacted], or when medically contraindicated. Results of the	S1410		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061617	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

(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
S1410	Continued From page 3 NJ Ex Order 26. 4B1 tests administered to new employees shall be acted upon as follows: 1. If the first step of the NJ Ex Order 26. 4B1 result is less than 10 millimeters of induration, the second step of the NJ Ex Order 26. 4B1 test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation it was determined that the facility failed to ensure newly hired employees completed the required NJ Ex Order 26. 4B1 screening upon hire. The deficient practice was identified for 2 of 10 randomly selected new employees (Staff #1 and Staff #2). This deficient practice was evidenced by the following: The surveyor reviewed 10 randomly selected newly hired employee files. The review for NJ Ex screening upon hire for 2 of the 10 new employees revealed the following: Staff #1, a U.S. FOIA (b) (6), hired on NJ Ex Order 26. 4B1, had a physical exam, dated NJ Ex Order 26. 4B1, which indicated a NJ Ex Order 26. 4B1 test was completed in NJ Ex Order 26.4b1. There was no additional	S1410	S1410, 8:39-19.5(b)(1) Mandatory Infection Control and Sanitation 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. The Infection Preventionist reviewed the 24-hour report for the month of January 2025 to identify any residents who presented with signs and symptoms of tuberculosis. No symptoms were reported. b. Staff member #1 resigned from the facility. Staff member #2 completed a NJ Ex Order 26. 4B1 Symptom Evaluation and does not have any symptoms of NJ Ex Order 26. 4B1. Staff #2 scheduled an appointment to have a NJ Ex Order 26. 4B1 completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061617	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

(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
S1410	Continued From page 4 documentation in the file to indicate that a NJ Ex Order 26. 4B1 test or an alternative NJ Ex O screening was completed prior to hire. Staff #2, a NJ Ex Order 26. 4B1, hired on NJ Ex Order 26. , had a completed first step of a NJ Ex Order 26. 4B1 on NJ Ex Order 26.4B. There were no additional documentation in the file to indicate any other NJ Ex Order or alternative NJ Ex O screening was completed. On 1/17/25 at 12:09 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Assistant DON (ADON) of the concern for the the NJ Ex O screening not completed for Staff #1 and Staff #2. On 1/17/25 at 12:53 PM, the surveyor interviewed over the phone the Human Resources Secretary (HRS), who stated human resources instructed new hires that a medical exam was required, and they would have to go to their personal physicians or an urgent care center. The HRS stated they would let the facility know if a physical was not completed and if the new hire had a NJ Ex Order completed. The HRS further explained that the new hire should have first NJ Ex Order prior to start and if not, the facility would provide. The HRS referred the surveyor to the facility for policy regarding NJ Ex Order for new hires. On 1/17/25 at 1:01 PM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who confirmed he was responsible for ensuring NJ Ex Order were completed for new hires. The IP/RN stated he would receive physical, including NJ Ex Order paperwork from the HR office. The IP/RN further explained the paperwork would include if the new hire had a NJ Ex Order 26. 4B1 test for NJ Ex O screening. For new hires with no	S1410	2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility have the potential to be affected by the same deficient practice. b. The Infection Preventionist will audit the Employee Health Records of all staff hired or retained through contract during the month of January 2025 to ensure that all staff complied with tuberculosis screening and testing. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Executive Director, Director of Nursing, Assistant Director of Nursing, Assistant Nursing Supervisor, Infection Preventionist, and Quality Assurance Coordinator reviewed and revised Employee Health policy with input from the Medical Director and Infectious Disease Consultant Physician. Revisions include alternative tuberculosis screening including a negative TB blood test or chest x-ray (also known as Interferon Gamma Release Assay of IGRA). b. The Infection Preventionist / designee (Director of Nursing) will audit the Employee Health Records of all new hires to ensure compliance with tuberculosis screening and testing. Findings will be reported to the Executive Director and County Human Resources	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061617	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

(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
S1410	Continued From page 5 [redacted] screening, a [redacted] would be provided and if contraindicated a [redacted] test would be completed. The IP stated acceptable [redacted] screening included, a [redacted] 2 weeks prior to employment, and other [redacted] screening, such as [redacted] within the year. The IP kept filed for new hire physical exams, [redacted] screenings and immunizations. At that time, the surveyor discussed concerns for the [redacted] screening for Staff #1 and Staff #2. The IP/RN stated he was looking through the staff files. The IP/RN acknowledged there was concern for Staff #2 as additional [redacted] results could not be found. The IP/RN further explained that Staff #2 started as volunteer, started as volunteer in [redacted] in which first of [redacted] was completed. The IP/RN would provide documentation found. On 1/17/25 at 1:30 PM, the IP/RN provided the surveyor additional [redacted] screening documentation for the new hire staff. For Staff #1, a [redacted] test (Quantiferon) from May 2022. For Staff #2 [redacted] test completed on [redacted] and a [redacted] test on [redacted]. On 1/21/25 at 12:23 PM, the LNHA, the DON, and the ADON met with the survey team. The stated the IP/RN provided the additional information for [redacted] screening of identified new hire staff. The surveyor informed the facility the concern for 2 of the 10 staff remained as Staff #1 had a [redacted] test result more than a year prior to employment and Staff #2 did not have a [redacted] consecutively done. There was no additional response provided by the facility. A review of the facility's Employee Health Policy, last reviewed on 3/6/23, Under Procedure	S1410	Director for review and action. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meet monthly. The Infection Preventionist will report the findings from the audit for compliance with tuberculosis screening and testing for staff hired and retained during January 2025 to the Quality Assurance and Performance Improvement Committee. b. The Infection Preventionist will report the findings of the audit of new staff hired or retained the Quality Assurance and Quality Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061617	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD WAYNE, NJ 07470**

(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
S1410	Continued From page 6 revealed, ...4.) Each new employee, shall receive a[redacted] Test. The only exceptions shall be employees with a documented [redacted] (0-9 mm) within the last year, employees with a documented [redacted] (10 or more mm), employees who have received appropriate treatment for [redacted], or those employees for whom the test is medically contraindicated. Employees with two [redacted] test results shall be screened annually in accordance with the [redacted] testing policy and procedure ... The policy did not further address alternative [redacted] screening such as [redacted] test.	S1410		

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
315361 Y1	A. Building B. Wing Y2	3/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

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 F0577	Correction	ID Prefix F0607	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(10)(11)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed
LSC	02/28/2025	LSC	02/28/2025	LSC	02/21/2025
ID Prefix F0640	Correction	ID Prefix F0658	Correction	ID Prefix F0684	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25	Completed
LSC	02/10/2025	LSC	02/28/2025	LSC	02/28/2025
ID Prefix F0690	Correction	ID Prefix F0695	Correction	ID Prefix F0698	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed
LSC	02/28/2025	LSC	02/14/2025	LSC	02/28/2025
ID Prefix F0725	Correction	ID Prefix F0755	Correction	ID Prefix F0757	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(d)(1)-(6)	Completed
LSC	02/28/2025	LSC	02/21/2025	LSC	02/28/2025
ID Prefix F0759	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	02/28/2025	LSC	02/28/2025	LSC	02/28/2025

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? ☐ YES ☐ NO
1/22/2025	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061617 Y1	A. Building B. Wing Y2	3/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

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 S0720	Correction	ID Prefix S1410	Correction	ID Prefix	Correction
Reg. # 8:39-7.3(d)	Completed	Reg. # 8:39-19.5(b)(1)	Completed	Reg. #	Completed
LSC	02/10/2025	LSC	02/28/2025	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/22/2025	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 This facility is NOT in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		2/28/25

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

Electronically Signed | 02/10/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 037	Continued From page 1 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 037	Continued From page 2 (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 01/17/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to: A. ensure initial training in Emergency Preparedness (EP) policies and procedures to all new staff and B. provide EP training to all staff at least annually, in accordance with Appendix Z, Requirements for Long-Term Care (LTC) Facilities. This deficient practice had the potential to affect all residents and was evidenced by the following: A.) A record review at 9:00 AM of the facilities EP manual revealed an orientation training checklist for new employees showing the training provided. The orientation did not have EP policies and procedures training consistent with expected roles in the EP plan.	E 037	E037 Emergency Preparedness Training Program CFR: 483.73 (d)(1) 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The Executive Director/LNHA, Director of Staff Development/Inservice Instructor, Quality Assurance Coordinator and Safety Coordinator developed an Emergency Preparedness Training Program and added it to the Emergency Preparedness manual.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 037	Continued From page 5 In an interview at 1:45 PM the U.S. FO[redacted] provided 2 training documents containing fire and fire extinguisher training only. The U.S. FO[redacted] stated the 2 documents contain the training conducted at staff orientations. B.) A record review at 12:28 PM of the facilities employee annual Mandatory In Service Training (MIST) 1 and 2 revealed that it did not include EP policies and procedures training consistent with the staffs expected roles other than fire safety and what code identifications. In an interview at 1:45 PM, the U.S. FO[redacted] confirmed the record review and stated that going forward they would include documented EP training in the mandatory in-services. The facility's U.S. FOIA (b) (6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 2:30 PM. N.J.A.C 8:39-31.6	E 037	2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Emergency Preparedness training program includes but is not limited to incident command, hazard assessments, communications, policies for internal and external disasters and expected roles. b. The Emergency Preparedness training program was added to the orientation program for new staff hired or retained through contract and volunteers. c. The initial training for the Emergency Preparedness training program was added to the schedule of mandatory training for existing staff hired or retained through contract and volunteers. d. The annual training for the Emergency Preparedness training program was added to the schedule of mandatory training for existing staff hired	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 037	Continued From page 6	E 037	or retained through contract and volunteers. e. Inservice by the Safety Coordinator and the Inservice Instructors was provided for new staff, hired or retained through contract and volunteers regarding incident command, hazard assessments, communications, policies for internal and external disasters and expected roles. f. Inservice by the Safety Coordinator, Assistant to the Executive Director/LNHA and the Inservice Instructors was provided for existing staff hired or retained through contract and volunteers, who had not received the training upon hire or annually regarding Emergency Prepared ness. Topics included incident command, hazard assessments, communications, policies for internal and external disasters and expected roles. g. Using the Inservice Attendance report the Inservice Instuctor /designee (Confidential Secretary to the Executive Director / LNHA) will audit on a monthly basis, staff attendance at the inservice on Emergency Preparedness upon hire and annually and report the findings to the Safety Coordinator and the Executive Director / LNHA for review and action. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 037	Continued From page 7	E 037	Performance Improvement Committee meets monthly, The Inservice Instructor/ designee (Confidential Secretary to the Executive Director / LNHA will report the findings from the Emergency Preparedness monthly training attendance audits, to Quality Assurance and Performance Improvement Committee.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations between 01/15/2025 and 01/17/2025. Preakness Healthcare Center 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. Preakness Healthcare Center is a three-story building with a basement that was built in 1988 with an addition in 2009. It is composed of Type II protected construction. The facility is divided into 32-smoke zones. The generator powers approximately 70% of the building per the Maintenance Director.	K 000		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically	K 223		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 223	Continued From page 8 closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview between 01/15/2025 and 01/17/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that doors in exit stairway enclosures were equipped with smoke-resistant doors that were positive latching and either self-closing or automatic-closing in accordance with NFPA 80:2010 Edition, Section 5.2.4.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 01/16/2025 at 10:32 AM revealed that the door on Stairway 5 in the 3-200 building did not close and positive latch when tested by the [redacted]. In an interview at the time, the [redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 01/17/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 80	K 223	K223 Doors with Self-Closing Devices CFR(s): NFPA 101 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The smoke-resistant door in stairway 5 exit enclosure in the 3-200 section of the facility that did not close and positive latch was repaired by the maintenance repair/electrician. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility have the potential to be affected by the deficient practice. b. The maintenance repair/electrician inspected all smoke resistant doors in exit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 223	Continued From page 9	K 223	enclosures to verify that all stairway doors close and positive latch. Any doors that did not close and positive latch were immediately repaired. Findings were reported to the Chief Custodian for review and action. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. Safety rounds will continue to be conducted weekly on one resident unit/week. Participants include but are not limited to the Safety Coordinator, Chief Custodian /designee, Director of Environmental Services, Assistant Executive Director and the Assistant Nursing Supervisor. Smoke resistant doors in stairway exit enclosures will be inspected to ensure the doors close and positive latch. Doors that do not close and positive latch will be immediately repaired. Findings from the safety rounds are distributed by the Safety Coordinator to the Executive Director, Assistant Executive Director, Chief Custodian, Director of Environmental Services, Director of Nursing for review and action. b. The door contractor will continue to inspect stairway doors on an annual basis and present the report to the Chief Custodian and Executive Director for review and action. 4. How will the corrective actions be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 223	Continued From page 10	K 223	monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian/designee will report the findings from the inspection of all stairway doors by the maintenance repair/electrician to the Quality Assurance and Performance Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Safety Coordinator will report the findings regarding stairway doors from the weekly safety rounds to the Quality Assurance and Performance Improvement Committee. c. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian/designee will present the results of the annual door inspections by the door contractor to the Quality Assurance and Performance Improvement Committee.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 351		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 11 In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 01/15/2025 and 01/17/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure: A) that it was protected throughout by an approved automatic sprinkler system and B) that all sprinklers were provided with escutcheons or covers in accordance with NFPA 101:2012 Edition, Sections 19.3.5.1, 9.7 , NFPA 13, Standard for the installation of Sprinkler Systems and NFPA 25. These deficient practices had the potential to affect all residents and were evidenced by the following: An observation on 01/16/2025 at 11:05 AM revealed the concealed sprinkler was missing its cover in the nurse's storage room on H-wing in the 2-200 building. An observation at 1:01 PM revealed the coat closet in the 1-300 nurses' station was not provided with a sprinkler. An observation at 1:07 PM revealed a 64-inch by 24-inch closet and a 36-inch by 24-inch closet	K 351	K351 Sprinkler System Installation CFR(s): NFPA 101 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The cover on the sprinkler in the nurse's storage room on the H-wing in the 2-200 section of the facility was installed by the Supervisor of Maintenance Repair. c. A sprinkler was installed in the coat closet in the 1-300 nurses station by the sprinkler contractor. d. A sprinkler was installed in the 64-inch x 24-inch closet near the ice machine in the 1-300 nurses station by the sprinkler contractor. e. A sprinkler was installed in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING 04 B. WING _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 12 near the ice machine in the 1-300 nurses' station were not provided with sprinkler protection. An observation on 01/17/2025 at 9:56 am revealed a white piece of electrical tape was used to secure the cover of the concealed sprinkler located in the corridor near the external feeding room in the 2-400 building. In interviews at the time, the U.S. FOIA confirmed the observations. The facility's *U.S. FOIA (b) (6)* was informed of the deficient practices at the Life Safety Code exit conference on 01/17/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 13	K 351	36-inch x 24-inch closet near the ice machine in the 1-300 nurses station by the sprinkler contractor. f. The white electrical tape used to secure the cover of the sprinkler head located in the corridor near the enteral feeding room in the 2-400 section of the facility was removed by the Supervisor of Maintenance Repair and a cover was installed by the Supervisor of Maintenance Repair. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside in the facility have the potential to be affected by the deficient practices. b. The Assistant Maintenance Supervisor will inspect all areas of the facility for the presence of escutcheons or covers on sprinklers and protection by an automatic sprinkler system. Findings will be reported to the Chief Custodian/designee for review and action. 3. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. The sprinkler contactor will continue to inspect the sprinkler system quarterly. Inspections include that all sprinklers have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 13	K 351	escutcheons or covers. Findings are reported to the Chief Custodian/designee for review and action. b. Safety rounds will continue to be conducted weekly on one resident unit/week. Participants include but are not limited to the Safety Coordinator, Chief Custodian /designee, Director of Environmental Services, Assistant Executive Director and the Assistant Nursing Supervisor. Sprinklers will be inspected for the presence of escutcheons or covers on sprinklers and protected by an automatic sprinkler system. Findings from the safety rounds are distributed by the Safety Coordinator to the Executive Director, Assistant Executive Director, Chief Custodian, Director of Environmental Services, Director of Nursing. 4. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian/designee will report the findings from the inspection by the Assistant Maintenance Supervisor of all areas of the facility for the presence of escutcheons or covers on sprinklers and protection by an automatic sprinkler system to the Quality Assurance and Performance Improvement Committee. b. The Quality Assurance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 14	K 351	Performance Improvement Committee meets monthly. The Chief Custodian/designee will present the findings from the quarterly inspections by the sprinkler contractor to the Quality Assurance and Performance Improvement Committee. c. The Quality Assurance and Performance Improvement Committee meets monthly. The Safety Coordinator will present the findings from the weekly safety rounds regarding the presence of escutcheons or covers on sprinklers and protection by an automatic sprinkler system to the Quality Assurance and Performance Improvement Committee.	
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.	K 353		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 15 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 01/15/2025 and 01/17/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that fire sprinkler systems gauges were changed or recalibrated every five years in accordance with NFPA 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 01/16/2025 at 10:45 AM revealed the gauge on the sprinkler systems standpipe in stairway 4 was dated 2019. An observation at 12:55 PM revealed the gauges on the dry sprinkler system in the 1-300 building were dated 2019. An observation at 1:28 PM revealed the gauge on the sprinkler systems standpipe in the 3-400 stairway was dated 2017. An observation on 01/17/2025 at 11:29 AM revealed the kitchen dry sprinkler system contained gauges that were dated 2018 and 2019. In interviews at the time, the U.S. FOI confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 01/17/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 25	K 353	K353 Sprinkler System Maintenance and Testing CRF(s): NFPA 101 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The gauge on the sprinkler system standpipe in stairway 4 that was dated 2019 was replaced by the sprinkler contractor. c. The gauge on the dry system in the 1-300 section of the facility that was dated 2019 was replaced by the sprinkler contractor. d. The gauge on the sprinkler system standpipe in the 3-400 stairway that was dated 2017 was replaced by the sprinkler contractor. e. The gauges on the kitchen dry sprinkler system that were dated 2018 and 2019 were replaced by the sprinkler contractor. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 16	K 353	a. All residents who reside in the facility have the potential to be affected by the deficient practice. b. The Chief Custodian and the sprinkler contractor inspected all sprinkler system gauges to ensure all gauges were changed or recalibrated within five years. Gauges that had not been changed or recalibrated every five years were replaced. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The Chief Custodian / designee (Maintenance Supervisor) will inspect the sprinkler system gauges during quarterly inspections performed by the sprinkler contractor. Gauges that have not been changed or recalibrated every five years will be replaced. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian/designee (Maintenance Supervisor) will present the results from the inspection with the sprinkler contractor to ensure all gauges were changed or calibrated within five years to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 17	K 353	Assurance and Performance Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian/designee (Maintenance Supervisor) will present the results from the quarterly sprinkler inspections to the Quality Assurance and Performance Improvement Committee.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 363	Continued From page 18 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 01/15/2025 and 01/17/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to: A) ensure that resident room doors were not blocked open, B) ensure the clearance between the bottom of the door and the floor did not exceed 1-inch and C) ensure that when closed, resident room doors stayed closed if a force of 5 LBS is applied at the latch edge of the door in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.10, 19.3.6.3.4 and 19.3.6.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 01/16/2025 between 10:35 AM and 12:52 PM revealed: 1. The door to resident room 3-215 was being held open by a trash bin. 2. The door to resident room 3-204 was being held open by a trash bin.	K 363	K363 Corridor Doors CFR(s): NFPA 101 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The trash can was removed by the Chief Custodian from the door to resident room 3-215 that held the door open. c. The trash can was removed by the Chief Custodian from the door to resident room 3-204 that held the door open. d. A door sweep was installed on the door to room 3-209 to reduce the gap under the door from 1 1/4 inch to 1 inch or less. e. The trash can was removed by the Chief Custodian from the door to room 2-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 363	Continued From page 19 3. The door to resident room 3-209 had a 1-1/4-inch clearance gap under the door. 4. The door to resident room 2-214 was being held open by a trash bin. 5. The door to resident room 2-202 was being held open by a trash bin. 6. The door to resident room 2-206 was being held open by a door stop. 7. When closed, the door too resident room 1-330 could not stay closed when force was applied by the [redacted] to the latch edge of the door. In interviews at the time, the [redacted] confirmed the observations. The facility's *U.S. FOIA (b) (6)* was informed of the deficient practices at the Life Safety Code exit conference on 01/17/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K 363	214 that held the door open. f. The trash can was removed by the Chief Custodian from the door to room 2-202 that held the door open. g. The doorstop was removed by the Chief Custodian from the door to 2-206 that held the door open. h. The Maintenance Repairer/Electrician replaced the door strike for resident room 1-330 to enable the door to stay closed when force was applied. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility have the potential to be affected by the deficient practice. b. The Assistant Maintenance Supervisor will inspect all resident room doors to ensure the resident room doors are not blocked open, that the clearance between the bottom of the door and floor does not exceed one inch and that the door when closed stays closed. Any items that hold the resident room door open will be immediately removed. Findings will be provided to the Chief Custodian for review and action. 3. What measures will be put into place	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 363	Continued From page 20	K 363	or systemic changes made to ensure the deficient practice will not recur? a. Safety rounds will continue to be conducted weekly on one resident unit/week to ensure resident room doors are not blocked, that the clearance between the bottom of the door and floor does not exceed one inch and that the door when closed stays closed. Participants include but are not limited to the Safety Coordinator, Chief Custodian/designee, Director of Environmental Services, Assistant Executive Director and the Assistant Nursing Supervisor. Findings from the safety rounds are distributed by the Safety Coordinator to the Executive Director, Assistant Executive Director, Chief Custodian, Director of Environmental Services, Director of Nursing. b. The Chief Custodian added the inspection of all resident room doors to the monthly preventive maintenance schedule. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian will report the findings from the inspection of all resident room doors to the Quality Assurance and Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 363	Continued From page 21	K 363	b. The Quality Assurance and Performance Improvement Committee meets monthly. The Safety Coordinator will present the findings from the weekly safety rounds regarding resident room doors to the Quality Assurance and Performance Improvement Committee.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview between 01/15/2025 and 01/17/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 372	K372 Subdivision of Building Spaces □ Smoke Barrier CFR(s): NFPA 101 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The two, three-inch unprotected	2/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 22 An observation on 01/16/2025 revealed the fire/smoke barrier in the 3-200 building on G wing contained two 3-inch unprotected penetrations. An observation at 11:31 AM revealed the fire/smoke barrier in the 1-200 building on H wing contained two 3-inch unprotected penetrations. An observation at 12:00 PM revealed the fire/smoke barrier in the 200-building basement contained two 3-inch unprotected penetrations. An observation at 12:30 PM revealed the fire/smoke barrier in the 1-300 building on B wing contained a 1-inch unprotected penetration. In interviews at the time, the [redacted] confirmed the observations. The facility's *U.S. FOIA (b) (6)* was informed of the deficient practices at the Life Safety Code exit conference on 01/17/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 80, 105	K 372	penetrations in the fire/smoke barrier in 3-200 section on the G wing were sealed with fire barrier/fire stop sealant by the Chief Custodian and the Assistant Maintenance Supervisors. c. The two, three-inch unprotected penetrations in the fire/smoke barrier in 1-200 section on the H wing were sealed with fire barrier/fire stop sealant by the Chief Custodian and the Assistant Maintenance Supervisors. d. The two, three inch unprotected penetrations in the fire/smoke barrier in 200 basement the basement were sealed with fire barrier/fire stop sealant by the Chief Custodian and the Assistant Maintenance Supervisors. e. The one-inch unprotected penetrations in the fire/smoke barrier in 1-300B section was sealed with fire barrier/fire stop sealant by the Chief Custodian and the Assistant Maintenance Supervisors. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside in the facility have the potential to be affected by the deficient practice. b. The Chief Custodian and Assistant Maintenance Supervisor inspected all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 23	K 372	fire/smoke barriers over corridor doors and sealed unprotected penetrations with fire barrier/fire stop sealant. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The inspection of fire/smoke barriers over corridor doors to ensure penetrations through smoke/fire barriers are protected by a material capable of restricting the transfer of smoke on a quarterly basis was added to the prevention maintenance schedule. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian/designee will present the findings from the inspection of the fire/smoke barriers over corridor doors to the Quality Assurance and Performance Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian/designee will present the findings from the quarterly inspections of the fire/smoke barriers over corridor doors to the Quality Assurance and Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 374	Continued From page 24	K 374		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interview between 01/15/2025 and 01/17/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that the clearance between the meeting edges of fire/smoke doors did not exceed 1/8-inch in accordance with NFPA 80 2010 Edition, Section 6.3.1.7.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 01/16/2025 at 12:52 and 1:14 PM revealed the fire/smoke barrier doors leading into the 1-300 resident room corridors both contained a 1/2-inch space between the meeting edge of the pair of doors. In interviews at the time, the U.S. FOI confirmed the observation.	K 374	K374 Subdivision of Building Spaces □ Smoke Barrier CFR(s): NFPA 101 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The door contractor installed astragal seal to decrease the gap from 1/2 inch to 1/8 inch between the meeting edges of the pair of doors on each of the double doors leading into the two resident room corridors of 1-300. 2. How will the facility identify other	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 374	Continued From page 25 The facility's *U.S. FOIA (b) (6)* was informed of the deficient practices at the Life Safety Code exit conference on 01/17/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 80	K 374	residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility have the potential to be affected by the deficient practice. b. The door contractor inspected all fire/smoke barrier doors to ensure the clearance between the meeting edges of fire/smoke doors did not exceed 1/8 inch. The contractor installed astragal seals to decrease any gaps that exceeded 1/8 inch. Results of the inspection were provided to the Chief Custodian. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. The door contractor will continue to conduct semi annual inspections of doors. Inspections include verifying that clearances between the meeting edges of fire/smoke doors do not exceed 1/8 inch. b. Safety rounds will continue to be conducted weekly on one resident unit/week. Participants include but are not limited to the Safety Coordinator, Chief Custodian/designee, Director of Environmental Services, Assistant Executive Director and the Assistant Nursing Supervisor. Inspections will include verifying that clearance between meeting edges of fire/smoke doors do not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 374	Continued From page 26	K 374	exceed 1/8 inch. Findings from the safety rounds are distributed by the Safety Coordinator to the Executive Director, Assistant Executive Director, Chief Custodian, Director of Environmental Services, Director of Nursing for review and action. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian/designee (Maintenance Supervisor) will report the findings from the semiannual inspection of doors by the door contractor to the Quality Assurance and Performance Improvement Committee . b. The Quality Assurance and Performance Improvement Committee meets monthly. The Safety Coordinator /designee (Assistant Executive Director) will report the findings from the weekly Safety Rounds, inspections of doors, to the Quality Assurance and Performance Improvement Committee.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in	K 521		2/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 521	Continued From page 27 accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 01/15/2025 and 01/17/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that ventilation and air conditioning complied with NFPA 101:2012 Edition, Sections 19.5.2.1 and 9.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 01/16/2025 at 10:50 AM revealed the bathroom ventilation in room 3-209 was not functioning when tested by the U.S. FOI. An observation at 11:13 AM revealed the bathroom ventilation in room 2-213 was not functioning when tested by the U.S. FOI. An observation at 11:19 AM revealed the bathroom ventilation in room 2-202 was not functioning when tested by the U.S. FOI. An observation at 1:20 PM revealed the bathroom ventilation in room 3-410 was not functioning when tested by the U.S. FOI. An observation on 01/17/2025 at 9:42 AM revealed the bathroom ventilation in room 2-407 was not functioning when tested by the U.S. FOI. In interviews at the time, the U.S. FOI confirmed the	K 521	K521 HVAC CFR(s): NFPA 101 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The Assistant Maintenance Supervisor and the fire alarm contractor corrected the wiring to the relay for the damper for exhaust fan #6 and verified that exhaust fan #6 was functioning to provide bathroom ventilation in rooms 3-410 and 2-407. c. The Assistant Maintenance Supervisor and the fire alarm contractor rewired exhaust fan # 3 and verified that the exhaust fan # 3 was functioning to provide bathroom ventilation in rooms 2-213 and 2-202. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 521	Continued From page 28 observations. The facility's *U.S. FOIA (b) (6)* was informed of the deficient practices at the Life Safety Code exit conference on 01/17/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K 521	a. All residents who reside in the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? a. Safety rounds will continue to be conducted weekly on one resident unit/week. Participants include but are not limited to the Safety Coordinator, Chief Custodian/designee, Director of Environmental Services, Assistant Executive Director and the Assistant Nursing Supervisor. The functioning of bathroom ventilation in resident rooms will be tested by placing paper on the exhaust register. Findings from the safety rounds are distributed by the Safety Coordinator to the Executive Director, Assistant Executive Director, Chief Custodian, Director of Environmental Services, Director of Nursing for review and action. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Safety Coordinator will report the findings from the weekly safety rounds including the testing of bathroom ventilation in resident rooms to the Quality Assurance and Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 01/15/2025 and 01/17/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that the emergency backup generator was provided with a remote manual stop station in accordance with NFPA 101:2012 Edition, Sections 9.1.3.1 and NFPA 110:2010 Edition, Sections 5.6.5.6, A 5.6.5.6 and 5.6.5.6.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 1/17/2025 revealed the emergency backup generator was not provided with a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. For systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. In an interview at the time, the U.S. FOI confirmed the observations.	K 911	K911 Electrical Systems □ Other CFR(s): NFPA 101 1. What corrective actions will be accomplished for those residents affected by the deficient practice? a. No residents were identified. b. The service contractor for the emergency generator installed a remote manual stop station external to the weatherproof enclosure. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents who reside at the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure the	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 911	Continued From page 30 The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 01/17/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 110	K 911	deficient practice will not recur? a. The emergency generator service contractor will continue to provide monthly service. The emergency generator service contractor will verify that the manual stop station is intact during each monthly service. Findings will be reported to the Chief Custodian/designee for review and action. b. The Maintenance Supervisor/ designee(Assistant Maintenance Supervisor) will verify that the manual stop station is intact once a week. Findings will be reported to the Chief Custodian / designee (Executive Director) for review and action. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? a. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian / designee (Maintenance Supervisor) will report the findings from the monthly verification by the emergency generator service contractors to the Quality Assurance and Performance Improvement Committee. b. The Quality Assurance and Performance Improvement Committee meets monthly. The Chief Custodian / designee (Maintenance Supervisor) will report the findings from the weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. BUILDING **04** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	**305 OLDHAM ROAD** **WAYNE, NJ 07470**

(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 911	Continued From page 31	K 911	verification by the Maintenance Supervisor / designee (Assistant Maintenance Supervisor) that the manual stop station is intact.	

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
315361 Y1	A. Building B. Wing Y2	3/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

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 E0037	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(d)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/28/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/22/2025	☐ 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
315361 Y1	A. Building 04 - BUILDING 03A B. Wing Y2	3/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREAKNESS HEALTHCARE CENTER	305 OLDHAM ROAD WAYNE, NJ 07470

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0223	02/14/2025	LSC K0351	02/14/2025	LSC K0353	02/28/2025
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 K0372	02/21/2025	LSC K0374	02/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0521	02/21/2025	LSC K0911	02/28/2025	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	
1/22/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO