STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING _____ B. WING _____	C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

(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 # NJ00172263 CENSUS: 106 SAMPLE SIZE: 5 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
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: COMPLAINT # NJ00172263 Based on interview, record review, and review of other pertinent facility documents on 3/25/24, it was determined that the facility failed to consistently complete the [NJ Ex Order 26.4] communication form and maintain a residents [NJ ex order 26.4b] communication record. This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for [NJ ex order 26.4b]. This deficient practice is evidenced by the following:	F 698	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 was re-assessed. An audit was completed for residents on [NJ ex order 26.4b1] and no other residents were affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice.	4/30/24

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

Electronically Signed | 04/11/2024

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

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F 698	Continued From page 1 1. According to the facility "ADMISSION RECORD" Resident #1 was admitted with diagnosis that included but were not limited to: NJ ex order 26.4b1 The Minimum Data Set (MDS) an assessment tool dated NJ ex order 26.4b Resident #1's NJ ex order 26.4b1 NJ ex order 2 and NJ ex order 26.4b1 The care plan (CP), undated, revealed that Resident #1 NJ ex order 26.4b1 . Interventions included but were not limited to the Resident NJ ex order 26.4b1 The surveyor reviewed Resident #1's NJ ex order 26.4b Communication Binder NJ Ex Order) on 3/25/24 at 10:31 AM. The NJ Ex Orde reflected forms titled "Resident Facility + NJ ex order 26.4b1 Information Exchange NJ Ex Order 26 I)," dated NJ ex order 26.4b1 the NJ Ex Order did not have the following NJ Ex Order 2 I for the following dates NJ ex order 26.4b1 The facility was unable to provide documentation that Resident's condition on the abovementioned dates were communicated to the NJ ex order 26.4b1 NJ ex order 2 During the interview with the surveyor on 3/25/24	F 698	Residents on hemodialysis have the potential to be affected by this deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. Director of Nursing and Educator provided in-service education to nursing staff regarding policy of resident dialysis communication binder and Resident and dialysis information exchange. Unit Manager and nursing staff were educated on steps to take should the resident communication binder not be completed by the dialysis center upon residents return to the facility. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. Director of Nursing or Designee will complete an audit for up to 2 patients on hemodialysis weekly for one month, then 4 residents monthly for an additional two months. The audit will capture the completion of the dialysis communication binder and steps taken to correct, if necessary. Director of Nursing will report results of the audit and it will be reviewed with the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After	

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F 698	Continued From page 2 at 4:16 PM, the US FOIA (b)(6) stated that during the NJ ex order 26.4b1 days, the nurse had to complete the NJ Ex Order 26.4b1 (a communication tool between the facility and the NJ ex order 26.4b1) to be given to the [redacted], the US FOIA (b)(6) gives the NJ Ex Order 26.4b1 the US FOIA (b)(6). The US FOIA (b)(6) further stated that when the resident comes back from the NJ Ex Order 26.4b1, the Nurse would review the NJ Ex Order 26.4b1. The US FOIA (b)(6) added, "if there are no communication form," the nurses are expected to call the NJ Ex Order 26.4b1 had to fax the form to the facility. The US FOIA (b)(6) was unable to explain the missing NJ Ex Order 26.4b1 in Resident #1's NJ Ex Order 26.4b1. The US FOIA (b)(6) acknowledged that some of the NJ Ex Order 26.4b1 were incomplete. A review of the facility policy titled "End-Stage Renal Disease, Care of a Resident with," dated 9/2023, indicated under "Policy Statement Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care...4...How information will be exchanged between the facilities..." A review of the facility policy titled "Dialysis Patients - Hemodialysis (outside), undated, indicated "Each resident assigned to an HD center will have a binder assigned to go take to dialysis with the dialysis form completed by the nurse (center)...The dialysis center is to complete the lower portion of the form upon return to the center from the HD center. If the form is incomplete from the HD Center, the nurse assigned will reach out to the HD Center to communicate the need to have the information to center..." NJAC 8:39-27.1(a)	F 698	discussion, any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315348		5/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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 F0698 Reg. # 483.25(l) LSC	Correction Completed 04/30/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO