STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315367	A. BUILDING _____ B. WING _____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	380 DEMOTT LANE SOMERSET, NJ 08873

(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 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Complaint #: NJ163525, NJ179143, NJ162866, NJ171841, NJ161011, NJ168161 Survey Dates: 04/23/24 - 04/26/24. Survey Census: 195 Sample Size: 42 Supplemental Residents: 0 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		5/24/24

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

Electronically Signed | 05/17/2024

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 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review, the facility failed to notify the resident's responsible party regarding a new diagnosis of	F 580	1. a. LPN2 was immediately counseled and reinserviced one to one on notification of	

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F 580	Continued From page 2 NJ Ex Order 26.4b1 and a NJ Ex Order 26.4b1 for one (Residents (R) 434) of three resident reviewed for change in condition. Findings include: Review of R434's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed admission to the facility on NJ Ex Order 26.4b1 with diagnosis including NJ Ex Order 26.4b1 Review of R434's quarterly "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of NJ Ex Order 26.4b1, revealed a "Brief Interview for Mental Status (BIMS)," score of NJ Ex Order out of 15 which indicated NJ Ex Order 26.4b1 . Review of R434's "Care Plan," located under the "Care Plan" tab of the EMR and dated NJ Ex Order 26.4b1, revealed "The resident was care planned for presence of NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 Interventions in place were to note any abnormalities in the NJ Ex Order 26.4b1, assess for NJ Ex Order signs or symptoms of NJ Ex Order 26.4b1 and monitor temperature. Review of "Physician Orders," dated NJ Ex Order 26.4b1 in the EMR under the "Orders" tab revealed, NJ Ex Order 26.4b1 oral tablet by mouth twice a day. Review of a "Nurses Notes," in the EMR, under the "Resident Services" tab by Licensed Practical Nurse (LPN) 2 dated NJ Ex Order 26.4b1 indicated, results of NJ Ex Order 26.4b1 and NJ Ex Order . Review of a "Nurses Notes," in the EMR, under	F 580	change in a patient status to Responsible party and Physician and documenting same inn the Electronic medical record. b. no negative outcomes were observed. 2. a. All residents with changes in status have the potential to be affected. 3. a. A facility wide inservice was conducted on 5/3/2024 by Director of Nursing/Assistant Director of Nursing on notification of patient status change/What a change of status is and notification of family and MD must be documented in the electronic medical record b.The Assistant Director of Nursing will review this policy with all nurses monthly for 6 months c.The Assistant Director of Nursing will review this policy on hire, annually and as needed, thereafter. d. The assistant Director of Nursing/Director of Nursing will update the policies and procedures and inservice nursing staff as needed. 4. a. The ADON will review 5 different nurses documentation on residents with status change, weekly for one month and monthly thereafter for an additional 5 months for compliance and submit a report to the Don for a total of 6 months	

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F 580	Continued From page 3 the "Resident Services" tab by LPN2 dated NJ Ex Order 26.4b1 indicated, received call from pharmacy stating that resident has an NJ Ex Order 26 to NJ Ex Order 26.4b1 and should not be taking NJ Ex Order 26.4b1 A call was made to the physician and order was received to discontinue NJ Ex Order 26.4b1 and to start resident on NJ Ex Order 26.4b1 now and NJ Ex Order 26.4 by mouth for five days. During an interview on 04/25/24 at 11:13 AM, LPN2 said as soon as staff identified anything different in a resident's condition, they were to notify the family. They would be expected to notify the family after a resident was diagnosed with NJ Ex Order 26.4b1 or after any change in a resident's medication. That should be documented in a nurse progress note. She said she remembered R434 had NJ Ex Order 26.4b1 but could not remember anything specific. After reviewing the progress note dated NJ Ex Order 26.4b1 she remembered there was a NJ Ex Order 2 who was R434's responsible party (RP) and she said she tried to call the NJ Ex Order 2 but there was no answer, so she just left a message to call back. She said she never spoke with the RP. She said she should have documented that attempt it in progress note. She also said she tried to call the RP after there was a change in the NJ Ex Order 26.4b1 that R434 was prescribed but she did not document that either but should have. She said there was no documentation to show she tried to inform the RP about the residents change in condition. During an interview on 04/26/24 at 12:50 PM, the US FOIA (b)(6) said staff should make sure the family was notified within 24 hours after a resident's change in condition and it should be documented in the nurse's notes. The US FOIA (b) stated that there was no documentation in the	F 580	b.A quarterly QAPI report will be submitted to QA committee for discussion and compliance and measure of success to QA quarterly.	

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F 580	Continued From page 4 EMR that the family was made aware of the NJ Ex Order 26.4b1 or the change in NJ Ex Order 26.4b1 medication. Review of the facility's policy titled "Notification of change in Patient's Status" updated 07/20/2023 revealed to keep the responsible party fully aware of a resident's status. It will be the policy for the facility to notify the following when there is a significant change in a patient's physical status. Family or Power of Attorney (POA) will be notified of any changes in a resident's physical status. Proper documentation will be entered on the residents' chart. Notification to family will be done within 24 hours from the time of condition of change.	F 580		
F 645 SS=D	NJAC 8:39-13.1(C) PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		5/24/24

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F 645	Continued From page 5	F 645		

services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this

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F 645	Continued From page 6 section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that an accurate Preadmission Screening and Resident Review (PASARR) Level I assessment was completed after admission for three (Resident (R)154, R61 and R84) out of 12 residents reviewed for PASARR I. Findings include: 1. Review of R154's "Admission Record," located in the "Resident Information" tab of the electronic medical record (EMR) revealed admission to the facility on NJ Ex Order 26.4b1 and a readmission on NJ Ex Order 26.4b1 with diagnoses including NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. Review of R154's "PASARR I" located under the "Resident Documents" tab in the EMR and dated NJ Ex Order 26.4b1 did not indicate any NJ Ex Order 26.4b1 diagnosis. Review of R154's "Diagnosis List," located under the "Medical Diagnosis" tab of the EMR and dated NJ Ex Order 26.4b1, revealed diagnoses of NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1.	F 645	1. a.Admissions Director and Social service Director were reinserviced on the importance of PASARR accuracy on admission and update when a new diagnosis is added. b. -Resident R154 PASARR updated -Resident R61 PASARR updated -Resident R84 PASARR updated 2. a.All residents in the facility have a potential to be affected. 3. a.A facility wide review conducted on all residents to assure the accuracy of the Current PASARR. Corrections to be made as needed b. reinervice was conducted on the PASARR policy to Admissions, social services, MDS and nursing administration. c. the admissions director /social service director will review with social service, nursing, admissions and MDS monthly,	

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F 645	Continued From page 7 During an interview on 04/25/24 at 2:21 PM, the US FOIA (b)(6) stated that it was her responsibility to review the PASARR level 1 and ensure it was completed accurately. She said she had all the resident's medical records information on admission to know what information should be on the PASARR I. She was aware that R154 had several NJ Ex Order 26.4b1 diagnoses but she did not complete another PASARR level I since she did not think R154 would have NJ Ex Order 26.4b1 for a NJ Ex Order 26. . She did think another PASARR level I needed to be completed with all the correct NJ Ex Order 26.4b1 information. During an interview on 04/26/24 at 12:46 PM the US FOIA (b)(6)) stated any NJ Ex Order 26 diagnosis should be listed on the PASARR I. 2. Review of R61's "Admission Record" located in the EMR under the "Resident Information" tab indicated admission date of NJ Ex Order 26.4b . Review of R61's "Diagnosis List," located under the "Medical Diagnosis" tab of the EMR revealed diagnosis of NJ Ex Order 26.4b1 . Review of R61's PASARR Level I Screen dated NJ Ex Order 26.4b1 located under the "Resident Documents" tab in the EMR indicated no NJ Ex Order 26 and did not list a diagnosis of NJ Ex Order 26.4b1 Interview on 04/25/24 at 02:12 PM, the US FOIA (b) stated that the PASARR Level I screen is required for each admission from the hospital and should be reviewed for accuracy by the admissions coordinator. 3. Review of R84's "Face Sheet" located in the	F 645	annually and as needed the PASARR policy d. the admission director and social service director will update the PASARR policy and procedure and inservice staff as needed. 4. a.Admissions director will review all admissions for accuracy of PASARR monthly for 6 months for compliance and submit a report to the administrator. Corrections to be made as needed. b.Social service director will review any change of condition accuracy monthly for 6 months for compliance and submit a report to the administrator. c.MDS will review on a monthly basis PASARR and assure it is accurate on admission for 6 months. When completing Quarterlies, annuals, significant change and any new diagnosis that would affect the passer. d.A quarterly QAPI report will be submitted to QA committee for discussion and compliance and measure of success to QA quarterly	

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F 645	Continued From page 8 electronic medical record (EMR), "resident's information" tab, revealed an initial admission date of [redacted] with diagnoses of [redacted] and [redacted]. Review of R84's PASARR located under the "Resident Documents" tab in the EMR revealed the document did not indicate a date. In addition, the document did not identify R84's diagnoses of [redacted] and [redacted]. During an interview with the [redacted] on 04/26/24 at 12:46 PM, she stated the [redacted] would be responsible for completing the PASARR I and ensuring the document was accurate on admission of a resident to the facility. She stated that the [redacted] would be responsible for checking all of the residents' PASARR I for accuracy. NJAC 8:39-5.1(a)	F 645		

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	061801	A. BUILDING: _____ B. WING _____	C 04/26/2024

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	1. Immediate movement of ancillary staff to units to assist with tasks: call bells, trays, phones, transport, to enable nursing staff to concentrate on patient care. 2.a.All residents have the potential to be affected. 3. a. Administrator/Designee will review staffing and utilize available resources to ensure mandatory staffing is maintained. As needs change, immediate response by adjusting schedules and use of other departments to answer phones, call bells, deliver trays and transport.	5/24/24

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

Electronically Signed | 05/17/24

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S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 01/29/2023 to 02/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/29/23 had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs. -01/30/23 had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs. -01/31/23 had 15 CNAs for 164 residents on the day shift, required at least 20 CNAs. -02/01/23 had 14 CNAs for 164 residents on the day shift, required at least 20 CNAs. -02/02/23 had 17 CNAs for 169 residents on the day shift, required at least 21 CNAs. -02/03/23 had 14 CNAs for 169 residents on the day shift, required at least 21 CNAs. -02/04/23 had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs. 2. For the week of Complaint staffing from	S 560	b. Administration to focus on mandatory staffing and hiring by: -Utilizing agency to increase staffing numbers -Ads placed on several job sites and attendance to job fairs -Facility to offer incentives, increase rates, bonuses and food allowance -Facility to utilize other departments to answer call bells, pass trays, answer phones and transport residents. 4. -the administrator will review staffing ratios and acuities monthly for 6 months to determine the efficacy of the interventions and adjust as needed, results will be submitted to QA quarterly for review and discussion. -the administrator will also review the use of resources, agency, ancillary staff and overtime to determine the effectiveness of ads, incentives, rate increases, bonuses and food allowance monthly for 6 months and make changes as needed, results will be submitted to QA quarterly for review and discussion.	

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REGENCY HERITAGE NURSING AND REHABILITATIO	380 DEMOTT LANE SOMERSET, NJ 08873

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S 560	Continued From page 2 10/01/2023 to 10/07/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/01/23 had 17 CNAs for 172 residents on the day shift, required at least 21 CNAs. -10/02/23 had 17 CNAs for 170 residents on the day shift, required at least 21 CNAs. -10/03/23 had 17 CNAs for 170 residents on the day shift, required at least 21 CNAs. -10/04/23 had 17 CNAs for 170 residents on the day shift, required at least 21 CNAs. -10/05/23 had 17 CNAs for 170 residents on the day shift, required at least 21 CNAs. -10/06/23 had 17 CNAs for 169 residents on the day shift, required at least 21 CNAs. -10/07/23 had 17 CNAs for 169 residents on the day shift, required at least 21 CNAs. 3. For the 2 weeks of Complaint staffing from 02/25/2024 to 03/09/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/25/24 had 17 CNAs for 181 residents on the day shift, required at least 23 CNAs. -02/26/24 had 16 CNAs for 181 residents on the day shift, required at least 23 CNAs. -02/27/24 had 16 CNAs for 181 residents on the day shift, required at least 23 CNAs. -02/28/24 had 17 CNAs for 181 residents on the day shift, required at least 23 CNAs. -02/29/24 had 16 CNAs for 181 residents on the day shift, required at least 23 CNAs. -03/01/24 had 17 CNAs for 187 residents on the day shift, required at least 23 CNAs. -03/02/24 had 17 CNAs for 187 residents on the day shift, required at least 23 CNAs. -03/03/24 had 16 CNAs for 187 residents on the day shift, required at least 23 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061801	A. BUILDING: _____ B. WING _____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATIO	380 DEMOTT LANE SOMERSET, NJ 08873

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 -03/04/24 had 16 CNAs for 184 residents on the day shift, required at least 23 CNAs. -03/05/24 had 17 CNAs for 184 residents on the day shift, required at least 23 CNAs. -03/06/24 had 17 CNAs for 184 residents on the day shift, required at least 23 CNAs. -03/07/24 had 16 CNAs for 183 residents on the day shift, required at least 23 CNAs. -03/08/24 had 17 CNAs for 183 residents on the day shift, required at least 23 CNAs. -03/09/24 had 17 CNAs for 183 residents on the day shift, required at least 23 CNAs. 4. For the week of Complaint staffing from 03/26/2024 to 04/01/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/26/24 had 10 CNAs for 174 residents on the day shift, required at least 22 CNAs. -03/27/24 had 16 CNAs for 173 residents on the day shift, required at least 22 CNAs. -03/28/24 had 17 CNAs for 172 residents on the day shift, required at least 21 CNAs. -03/29/24 had 16 CNAs for 167 residents on the day shift, required at least 21 CNAs. -03/30/24 had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs. -03/31/24 had 17 CNAs for 164 residents on the day shift, required at least 20 CNAs. -04/01/24 had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs. 5. For the 2 weeks of staffing prior to survey from 04/14/2024 to 04/27/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -04/14/24 had 17 CNAs for 190 residents on the day shift, required at least 24 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061801	A. BUILDING: _____ B. WING _____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATIO	380 DEMOTT LANE SOMERSET, NJ 08873

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 -04/15/24 had 17 CNAs for 190 residents on the day shift, required at least 24 CNAs. -04/16/24 had 17 CNAs for 190 residents on the day shift, required at least 24 CNAs. -04/17/24 had 17 CNAs for 190 residents on the day shift, required at least 24 CNAs. -04/18/24 had 16 CNAs for 194 residents on the day shift, required at least 24 CNAs. -04/19/24 had 16 CNAs for 194 residents on the day shift, required at least 24 CNAs. -04/20/24 had 17 CNAs for 194 residents on the day shift, required at least 24 CNAs. -04/21/24 had 18 CNAs for 195 residents on the day shift, required at least 24 CNAs. -04/22/24 had 18 CNAs for 193 residents on the day shift, required at least 24 CNAs. -04/23/24 had 18 CNAs for 193 residents on the day shift, required at least 24 CNAs. -04/24/24 had 18 CNAs for 193 residents on the day shift, required at least 24 CNAs. -04/25/24 had 18 CNAs for 193 residents on the day shift, required at least 24 CNAs. -04/26/24 had 18 CNAs for 193 residents on the day shift, required at least 24 CNAs. -04/27/24 had 18 CNAs for 193 residents on the day shift, required at least 24 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315367 Y1	A. Building B. Wing Y2	6/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	380 DEMOTT LANE SOMERSET, NJ 08873

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 F0580	Correction	ID Prefix F0645	Correction	ID Prefix	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.20(k)(1)-(3)	Completed	Reg. #	Completed
LSC	05/24/2024	LSC	05/24/2024	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	
4/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061801 Y1	A. Building B. Wing Y2	6/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	380 DEMOTT LANE SOMERSET, NJ 08873

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/24/2024	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	
4/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315367	A. BUILDING **01** B. WING _____	**04/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	**380 DEMOTT LANE** **SOMERSET, NJ 08873**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 04/26/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 04/26/24 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. Regency Heritage Nursing & Rehabilitation Center is a two-story building built in 1950's and is composed of Type II protected construction. The facility is divided into 18 - smoke zones. The generator does approximately 60 % of the building per the US FOIA (b)(6) . The current occupied beds are 198 of 265.	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K 761		5/24/24

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

Electronically Signed | 05/17/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315367	A. BUILDING **01** B. WING _____	**04/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	**380 DEMOTT LANE** **SOMERSET, NJ 08873**

(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 761	Continued From page 1 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 198 residents who resided at the facility. Findings include: A review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence that the facility's fire doors were inspected. Observations on 04/26/24 from 11:45 AM to 2:15 PM of the facility's fire doors revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of each observation, the US FOIA (b)(6) confirmed the fire doors had not been inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	1.All fire rated doors that are required to be inspected annually were identified. 2. All residents have the potential to be affected. 3. a. The maintenance director created an inspection form to be used for the inspection of each fire rated door. b. Inspections will be scheduled and conducted annually and each fire rated door will be signed and dated on an inspection tag. c. A log of all fire rated doors and inspections will be filed and kept in the maintenance office 4. a. The assistant Administrator will review the log books and audit 12 doors monthly for six months. b. A quarterly QAPI report will be submitted to the QA committee for discussion, review and measure of success.	

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
315367 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	380 DEMOTT LANE SOMERSET, NJ 08873

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0761	05/24/2024	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	
4/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO