STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT REHABILITATION AND HEALTHCARE CENTER	**633 STATE ROUTE 28 RARITAN, NJ 08869**

(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 #: NJ156044, NJ156831, NJ156071, NJ158502, NJ159060, NJ159357, NJ163707, NJ167630, NJ170400, and NJ170582. Survey Dates: 05/27/24 - 05/30/24. Survey Census: 115 Sample Size: 26 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 550 SS=E	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.	F 550		7/19/24

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

Electronically Signed | 06/23/2024

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §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 facility policy review, the facility failed to ensure seven of eight residents (Resident (R)10, R77, R9, R45, R25, R57, and R83) reviewed for [NJ Exec Order 2] were treated in a dignified manner out of 26 sampled residents. The facility failed to promote a dignified dining experience which included timely meal service, eating food at the same time as tablemates, and items served in non-disposable dishes for six of six residents (Resident (R)10, R77, R9, R45, R25, and R57) reviewed for [NJ Ex Order 26.4] in dining. Additionally, the	F 550	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Inventory was taken of needed dishware for Dietary Department. An order was placed for these items to eliminate the use of plastic bowls and cups. A seating chart was established for both the Rotunda and the Main Dining Room.	

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F 550	Continued From page 2 facility failed to honor R83's right to a dignified existence and self-determination by making [redacted] wear an identification wrist band after [redacted] made staff aware that [redacted] preferred not to wear the band. Findings include: 1. Review of R10's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date ARD of [redacted], located in the electronic medical record (EMR) under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated R10 had NJ Exec Order 26.4b1 . During an observation on 05/27/24 at 12:52 PM, R10 was seated at a dining room table with R58. R10 had not been served [redacted] lunch meal tray and R58 was eating [redacted] lunch meal and R10 had not been served [redacted] lunch tray yet. Observation on 05/27/24 at 12:55 PM revealed R58 finished eating [redacted] lunch meal and R10 still had not been served [redacted] meal. Continuous observations on 05/27/24 from 12:55 PM to 1:21 PM revealed R10 remained seated at the dining room table with R58, and [redacted] was not served [redacted] lunch meal. During an interview on 05/27/24 at 1:21 PM, R10 stated NJ Exec Order 26.4b1 and stated that [redacted] was [redacted]. During an observation on 05/27/24 at 1:32 PM, staff served R10 [redacted] lunch meal and [redacted] began to eat [redacted] meal NJ Exec Order 26.4b1 A beverage observed on R10's lunch meal tray was served in a disposable plastic cup. On 05/27/24 at 1:44 PM, R10 was observed to finish [redacted] lunch meal and [redacted] ate 100 percent of the foods and beverages	F 550	The Dietary trucks will be arranged to have tablemate trays arrive at the same time on the same truck to allow trays to be passed out at the same time. Dietary staff was educated on the meal truck delivery times and to start the line on time to avoid late tray deliveries. The Activities staff was educated regarding not starting activities until meals are complete and to not remove any trays or rearrange furniture while meals were still in progress. R83 was care planned for [redacted] preference not to wear [redacted] identification badge on [redacted] wrist. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential to be affected by these deficient practices. The facility will ask all cognitively intact residents regarding their preference for wearing identification bands on their wrists. They will be educated on the benefits of the use of the bands for identification. If the resident chooses not to wear the band he or she will be care planned for this as a preference. 3) What measures will be put into place or	

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F 550	Continued From page 3 served on [NJ Exec] meal tray. During an interview on 05/30/24 at 9:21 AM, R10 stated that [NJ Exec] ate [NJ Exec] meals in the dining room and preferred to be served and to eat [NJ Exec] meals with [NJ Exec] tablemates. R10 also stated that [NJ Exec] beverages and desserts were usually served in disposable plastic cups, and [NJ Exec] preferred for [NJ Exec] food and beverages to be served in regular non-disposable bowls and cups. During an interview on 05/29/24 at 9:30 AM, the U.S. FOIA (b)(6) stated the expectation was for residents who ate in the dining room to eat their meals with their tablemates. 2. Review of R77's quarterly "MDS" with an ARD of [NJ Exec Order 26.4b1] located in the EMR under the "MDS" tab, revealed a "BIMS" score of [NJ Exec Order 26.4b1], which indicated R77 was U.S. FOIA (b)(6). During an observation on 05/29/24 at 1:13 PM, R77 was served [NJ Exec] lunch meal in his room. Observation of food served on R77's meal tray revealed [NJ Exec] juice was served in a disposable plastic cup and watermelon was served in a disposable plastic cup. During an interview on 05/29/24 at 1:13 PM, R77 stated [NJ Exec] beverages and dessert were frequently served in disposable plastic cups and [NJ Exec] would prefer to be served [NJ Exec] food and beverages in regular non disposable cups and dishware. 3. During the resident group interview on 05/28/24 at 10:00 AM, residents reported concerns with [NJ Exec Order] during dining as follows: -R10 stated not all the residents sitting at the same tables were served their meals at the same	F 550	systematic changes to ensure that the deficient practice would not recur The Facility Administrator or desognee will conduct full house education with all departments on Dignity and Resident Rights to include the areas of residents being served food and beverages in non-disposable dishware, residents eating at the same time as their tablemates, residents being served timely, residents being able to finish their meals before activities start and not having to move spots to accommodate activities, and the right to refuse the use of Identification bands on their wrists. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change Dietary Director or designee will audit meal trays weekly for three months and then monthly for three months at different times to ensure no disposable dishware is being used. Dietary Director or designee will randomly audit meals being served in the dining room weekly for three months and then monthly for three months to ensure the seating chart for residents are being followed and the residents are being served at the same time as tablemates.	

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F 550	Continued From page 4 time. -R9, R45, and R25 stated the staff frequently provided plastic silverware for eating and disposable small plastic cups for beverages at meals and they did not like to be served with disposable silverware or cups. All three residents also stated the cups were tiny in size; observations during lunch on 05/27/24 at 1:19 PM revealed there were small disposable plastic souffle cups that were not intended to be used as cups for drinking. 4. During an observation on 05/29/24 from 8:10 AM to 8:44 AM, dietary staff was preparing resident breakfast meals from the kitchen tray line. The dietary staff was observed placing disposable cups of juice, applesauce, and watermelon cubes on resident meal trays. During an interview on 05/29/24 at 9:30 AM, the [redacted] stated resident beverages and foods were served in plastic disposable cups because the kitchen did not have enough regular non disposable bowls and cups available to serve to all residents at meals. 5. Review of the undated "Admission Record," provided by the facility, revealed R57 was admitted to the facility on [redacted] Review of the annual "MDS" with an ARD of [redacted] in the EMR under the "MDS" tab, revealed R57's had a BIMS score of [redacted] which indicated R57 had [redacted]. During an observation 05/27/24 at 1:16 PM, R57 was sitting at a table in the central area dining room waiting for lunch. R57 had been waiting for lunch in the dining room for over 40 minutes; the	F 550	Dietary Director or designee will randomly audit the meal tray line at different times weekly for three months and then monthly for three months to ensure the tray line is starting on time and the meal delivery schedule is being followed. The Activity Director or designee will randomly audit the start time of activities weekly for three months and then monthly for three months to ensure the activity staff is waiting until meals are complete to move any needed furniture and start the activities. The Nurse Unit Manager or designee will audit those residents whose preference is to not wear identification bands on their wrist weekly for three months and monthly for three months to ensure their preference is being followed. The Dietary Director, Activity Director, and Unit Manager or designees will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meeting.	

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F 550	Continued From page 5	F 550		

meal was late. The US FOIA (b)(6) came to where R57 was sitting at the table and moved the table out from under [redacted] R57 had a stunned look on [redacted] face and then wheeled NJ Exec Order 26 in NJ Exec wheelchair to the cart in the corner of the dining room where meal trays were located. R57 asked the staff for NJ Exec tray, and they handed it to [redacted] NJ Exec placed the tray on top of [redacted] wheelchair arm rests and wheeled to a different table in the dining room, place the tray on the table and began eating.

On 05/27/24 at 1:18 PM, the U.S. FOIA (b)(6) assisted several residents to sit where R57 had been sitting and waiting for NJ Exec meal. A musician began to play NJ Exec guitar and sing; a music activity began at this time. The table where R57 had been waiting for NJ Exec lunch was located where residents were to sit to listen to the music activity.

During an interview on 05/29/24 at 8:32 AM, R57 stated [redacted] did not like the table being pulled out from under [redacted] while NJ Exec was waiting for lunch on NJ Exec Order 26.4b. R57 stated the incident NJ Exec Orde [redacted] and the table was removed without explanation.

During an interview on 05/28/24 at 4:29 PM, the US FOIA (b)(6) stated she moved the table on NJ Exec Order 26.4b while R57 was sitting there due to the entertainer being scheduled to play. The U.S. FOIA (b)(6) [redacted] stated it looked like some of the residents had not been served lunches yet stating she did not know or ask if R57 had eaten. The U.S. FOIA (b)(6) [redacted] stated she told R57 she had to move the table and then moved it.

During an interview on 05/30/24 at 5:27 PM, the U.S. FOIA (b)(6) [redacted]) stated it was not dignified to haul the table off if R57 was sitting

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F 550	Continued From page 6 there and waiting for [redacted] meal. 6. Review of the undated "Admission Record," provided by the facility, revealed Resident (R) 83 was admitted to the facility on [redacted]. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] in the electronic medical record (EMR) under the "MDS" tab revealed R83 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. During an interview on 05/29/24 at 9:23 AM, R83 pointed to [redacted] and stated, "They (nurses) put the band on me today. I told them I did not want it ... I don't think I should have to have it." R83 stated [redacted] resented having to wear the wrist band stating [redacted] did not want to reveal [redacted] identity to the world. R83 was wearing a plastic identification wrist band that had [redacted] name and room number on it. During an interview on 05/29/24 at 10:39 AM, Certified Nurse Assistant (CNA) 3 stated R83 was [redacted] and [redacted]. [redacted] stated she did not know why R83 had to wear the identification wrist band. During an interview on 05/29/24 at 11:41 AM, the [redacted] stated residents were required to wear identification wrist bands because it was part of the resident identifier system so staff would not give medications to the wrong resident for example. They stated there were a lot of new and agency nursing staff who did not know the residents. The [redacted] stated residents	F 550		

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F 550	Continued From page 7 constantly removed the wrist bands and the nursing staff replaced them when they noticed the bands were missing. The U.S. FOIA (b)(6) stated the facility had to weigh safety versus dignity. The U.S. FOIA (b)(6) verified resident's photographs were included in the EMR which was also an identification system. During an interview on 05/30/24 at 9:06 AM, Licensed Practical Nurse (LPN) 3 stated R83 took NJ Exec wrist band off when NJ Exec was completing NJ Exec Order 26.4b1 with the resident the day before. LPN3 stated all residents were supposed to have wrist bands on; however, sometimes they came off, or residents took them off. LPN3 removed a wrist band out of her medication cart and stated this one was for a different resident whose band was missing. LPN3 stated and showed the surveyor the identification band that had the resident's name and room number on it. LPN3 verified R83 did not like NJ Exec wrist band, further stating a lot of residents did not like them. R83 stated LPN1 reapplied R83's new wrist band yesterday after the resident removed it. LPN3 stated the nurses reapplied new wrist bands on residents if they noticed the wrist bands were missing. Review of the facility's policy titled, "Dignity," dated February 2021 and provided by the facility, revealed "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem." Review of the facility's policy entitled, "Promoting/Maintaining Resident Dignity During Mealtimes," dated 11/29/23, indicated "It is the practice of this facility to treat each resident with	F 550		

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F 550	Continued From page 8 respect and dignity and care for each resident in a manner and in an environment that maintain or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident ...1. All staff members involved in providing feeding assistance to residents promote and maintain resident dignity during mealtimes." NJAC 8:39- 4.1(A)(12)	F 550		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the	F 551		7/19/24

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F 551	Continued From page 9 resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure guardianship documentation to support advanced directive decision making was in place for one of	F 551	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 551	Continued From page 10 three residents (Resident (R) 66) reviewed for advanced directives of 26 sampled residents. R66 was NJ Ex Order 26.4b1 and was documented as having a legal guardian. The facility did not have the guardianship documentation for R66. Findings include: Review of the undated "Admission Record," provided by the facility, revealed R66 was admitted on NJ Exec Order 26.4b1 with diagnoses including NJ Exec Order 26.4b1 R66's family member (F) 66 was noted to be R66's responsible party and guardian. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 in the electronic medical record (EMR) under the "MDS" tab, revealed R66 was unable to complete the Brief Interview for Mental Status (BIMS) and was documented with NJ Exec Order 26.4b1 NJ Exec Order 26.4b Review of the EMR revealed no guardianship documentation in place. Review of the "Pennsylvania Orders for Life-Sustaining Treatment (POLST)" form, dated NJ Exec Order 26.4b1 in the EMR under the "Miscellaneous" tab, revealed R66's NJ Exec Order 26.4b1 status was NJ Exec . R66's guardian was noted on the document to have given verbal consent; there was no signature from the guardian (F66).	F 551	The signed Guardianship documents for R66 were obtained and uploaded into the electronic record for R66. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The Social Worker or Designee will audit all current resident charts who have Guardianship or Power of Attorney□s (POA) in place to ensure the signed documents are uploaded in the residents□ medical record. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Facility Administrator or designee will educate the US FOIA (b)(6) and facility Social Workers that the signed POA or Guardianship papers must be obtained upon admission and uploaded into the resident□s electronic medical record. Admissions Director has put in place a process to obtain a signed copy of POA or Guardianship paperwork as part of the admissions process and uploads it into the electronic medical record. During quarterly MDS and care plan reviews the Social Worker will review the POA and Guardianship status of each	

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

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WATERFRONT REHABILITATION AND HEALTHCARE CENTER	633 STATE ROUTE 28 RARITAN, NJ 08869

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F 551	Continued From page 11 Review of the "Order Summary," dated [NJ Exec Order 26.4b] in the EMR under the "Orders" tab, revealed the Physician's order on this date for [NJ Exec Ord] and [NJ Exec] [redacted] During an interview on 05/29/24 at 9:07 AM, the U.S. FOIA (b)(6) [redacted] stated she had been employed by the facility for approximately [NJ Exec Order 26.4b1] and was not familiar with R66. The [U.S. FOIA (b] reviewed R66's EMR and stated she did not see the guardianship papers in the record. The [U.S. FOIA (b] stated the facility should have had a copy of the guardianship papers. During an interview on 05/29/24 at 1:34 PM, the U.S. FOIA (b)(6) [redacted] stated when new residents admitted to the facility she asked about power of attorney (POA), living will etc. The U.S. FOIA (b)(6) [redacted] stated these documents should have been uploaded in the EMR. The U.S. FOIA (b)(6) [redacted] stated she did not let families sign the admission agreement until the facility received the POA papers. During an interview on 05/30/24 at 10:07 AM, the U.S. FOIA (b)(6) [redacted] stated she called R66's guardian yesterday and was told F66 gave the guardianship papers to the previous [US FOIA (b)(6)] [redacted]. The U.S. FOIA (b)(6) [redacted] stated, "I looked in the medical chart and we don't have it." The U.S. FOIA (b)(6) [redacted] stated she had been employed by the facility for [NJ Ex Order 26.4b1] During an interview on 05/30/24 at 4:10 PM, the US FOIA (b)(6) stated advanced directives, including documents such as guardianship papers, should have been uploaded on admission. The U.S. FOIA (b)(6) verified the facility did not have a copy of R66's guardianship	F 551	patient and ensure signed paperwork is included in the medical record. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change The Director of Social Service or designee will audit the medical record of residents with a POA or Guardian in place monthly for six months to ensure the signed paperwork is included in the electronic medical record. The Director of Social Service or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meeting.	

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F 551	Continued From page 12 papers. Review of the facility's policy titled, "Advance Directives," dated 09/22 and provided by the facility, revealed "If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents' medical record and are readily retrievable by any facility staff."	F 551		
F 584 SS=E	NJAC 8:39-4.1(a)(34)(b) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		7/19/24

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F 584	Continued From page 13 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was an adequate supply of linens for 10 (R9, R25, R45, R75, R33, R7, R15, R94, R74, and a resident requesting to remain anonymous) out of 26 sampled and 25 supplemental residents. Specifically, there was an insufficient supply of towels to meet residents' needs. Findings include: 1. During the Resident Council Group interview on 05/28/24 at 10:00 AM, three of five residents who attended stated there was a problem with the availability of towels: -R9 and R25 stated there were not enough towels (bath towels and wash cloths) available. R9 and R25 stated they waited for the clean linen cart to be delivered to their halls and immediately got their own towels because if they did not, there	F 584	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Par levels for hand towels and bath towels were reviewed and updated according to the census. A new Par Level Sheet was created and indicates how many types of towels should be provided based on the census on each unit. Additional hand towels and bath towels were put into circulation based on these par levels to meet the needs of each unit and shift. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 584	Continued From page 14 would not be any towels available. -R45 stated [NJ Exec] used [NJ Exec] terry cloth bathrobe as a towel because [NJ Exec] did not have any towels in [NJ Exec] room. 2. During an interview on 05/29/24 at 9:31 AM, a resident who requested to remain anonymous stated there were not enough towels. The resident stated there were no towels currently available. The resident stated [NJ Exec] had missed showers due to not having any towels to dry off with. The resident stated [NJ Exec] had been given a washcloth to dry off with after taking a shower. 3. During observation on 05/29/24 starting at 3:56 PM, the linen carts on each hall were checked for availability of towels: During an interview on 05/29/24 at 3:56 PM, Certified Nursing Assistant (CNA) 3, working on the [NJ Exec]-hall, stated she had passed out towels to the specific residents who would be receiving showers on the evening shift on the [NJ Exec]-hall. CNA3 stated the residents' rooms were not stocked with towels. She stated towels were obtained off the clean linen cart for residents as they were needed. The linen cart was observed on the [NJ Exec]-hall with Registered Nurse (RN) 2 on 05/29/24 at 3:35 PM. There were no hand towels or bath towels on the clean linen cart. There was a total of three wash cloths on the cart. RN2 stated the linen cart was distributed at around 3:00 PM, at the start of the afternoon shift and this was the supply of towels for the evening/night shifts. Review of the "Daily Census," dated [NJ Exec Order 28.4b] revealed that there were 30 residents residing on this hall.	F 584	The facility recognizes that all residents have the potential to be affected by this deficient practice. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Maintenance Director educated Laundry, Housekeeping, and Nursing staff members on the newly created Par Level Sheet which includes all yowels and the increased amount of hand towels and bath towels based on the census and needs of the unit. The new par levels will be posted in the laundry room for laundry staff to follow to provide the specific amount of each type of towels including the increased amount of hand towels and bath towels to each unit based on the census of each unit. When Laundry staff delivers the linens for each shift the Par Level Sheet will be attached to the linen cart and signed off by each unit nurse to verify they received the correct amount of hand towels and bath towels. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change	

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F 584	Continued From page 15 Observation of the supply of towels on the clean linen cart for the [redacted]-hall on 05/29/24 at 3:58 PM revealed there was a total of three bath towels on the cart. There were no hand towels or wash cloths. Review of the "Daily Census," dated [redacted], revealed that there were [redacted] residents residing in this hall. Observation of the supply of towels on the clean linen cart for the [redacted]-hall on 05/29/24 at 3:59 PM revealed there were no towels of any size on the cart. Review of the "Daily Census," dated 05/26/24, revealed that there were 28 residents residing in this hall. Observation of the supply of towels on the clean linen cart for the [redacted]-hall on 05/29/24 at 4:01 PM revealed there were seven bath towels and five wash cloths/hand towels. Review of the "Daily Census," dated 05/26/24, revealed that there were 23 residents residing in this hall. 4. During an interview on 5/30/24 at 8:35 AM, the [redacted]) stated the facility had about 250 bath towels in circulation at any given time and a total of approximately 500 bath towels. The [redacted] stated towels were delivered to each hall on the clean linen carts twice daily, in the morning and in the afternoon. The [redacted] stated the CNAs got towels from the clean linen carts for residents' use. The [redacted] stated residents' bathrooms were not stocked with towels; staff retrieved towels as they were needed from the clean linen carts on the halls. The [redacted] stated the stocked clean linen carts had already gone to each hall with this morning's supply of clean towels. 5. During an observation with the [redacted] on 05/30/24	F 584	The Maintenance Director or designee will perform random audits of linen carts weekly for three months and then monthly for three months to ensure the proper amount of towels are being delivered to the units. The Maintenance Director or designee will randomly interview at least five alert and oriented residents weekly for three months and monthly for three months using a questionnaire asking them if they are receiving the appropriate amount of linen including hand towels and bath towels. The Maintenance Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	

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F 584	Continued From page 16 at 8:42 AM, the total supply of clean towels was checked in the laundry room. There was a total of 17 bath towels and approximately 30 wash cloths on the shelf. There were no hand towels. The [NJ Exec O] stated there were a lot of towels in the dirty laundry bins from the evening/night before and some were currently being washed and the rest would be washed and distributed in the afternoon. During an observation with the [U.S. FOIA] on 05/30/24 at 8:46 AM, the clean linen cart on the [NJ Exec O]-hall was checked and there was a total of three wash cloths on the cart. There were no hand towels or bath towels on the cart. On 05/30/24 at 8:48 AM the [U.S. FOIA] and surveyor went room to room in the [NJ Exec O]-hall making observations and asked residents who were awake and available about the supply/availability of towels. Residents' comments included: -On 05/30/24 at 8:50 AM, R75 stated, "We are short of towels ... I am [NJ Exec Order 26.4b1] There are times I cannot get towels; I will keep and reuse a towel." -On 05/30/24 at 8:51 AM, R33 stated there were no towels in [NJ Exec O] room. -On 05/30/24 at 8:52 AM, R7 stated there were no towels in [redacted] room. -On 05/30/24 at 8:53 AM, R15 stated staff had not brought any towels into the room. -On 05/30/24 at 8:57 AM, R94 stated [NJ Exec O] thought there might be towels in the bathroom; however, observation revealed there were no towels in the bathroom. -On 05/30/24 at 8:58 AM, R74 stated [NJ Exe] did not get towels delivered to [redacted] room today and [NJ Exe] had been using the same towel for three days. R74 stated [NJ Exe] had one towel in [NJ Exe] room and kept using it because [NJ Exe] could not get clean towels.	F 584		

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F 584	Continued From page 17 Observation of the supply of towels on the clean linen cart for the [redacted]-hall on 05/30/24 at 9:02 AM revealed there were no towels on the cart. The [redacted] verified this. Observation of the supply of towels on the clean linen cart for the [redacted]-hall on 05/30/24 at 9:05 AM revealed there was one bath towel and one wash cloth on the cart. The [redacted] verified this. Observation of the supply of towels on the clean linen cart for the [redacted]-hall on 05/30/24 at 9:10 AM revealed there were no towels on the cart. The [redacted] verified this. 6. During an interview on 05/30/24 at 10:42 AM, the [redacted] stated he was not sure if residents could have towels in their rooms. The [redacted] stated he had been in his position about [redacted]. During an interview on 05/30/24 at 1:19 PM, the [redacted] stated he had not been aware of a problem with the availability of towels until today. NJAC 8:39-4.1(a) NJAC 8:39-27.2(j)	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		7/19/24

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F 600	Continued From page 18 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 24 reviewed for NJ Ex Order 26 was free from NJ Exec Order 26.4b1 by a staff member of 26 sampled residents. This had the potential to affect resident safety at the facility. Findings include: Review of R24's "Admission Record,"" dated NJ Exec Order 26.4b1 and located in the electronic medical record (EMR) under the "Admissions" tab, indicated the resident was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including NJ Exec Order 26.4b1 [redacted]. Review of R24's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 and located in the EMR under the "MDS" tab, indicated a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident had NJ Exec Order 26.4b1. The assessment indicated the resident was receiving both scheduled and NJ Exec Order 26.4b1 medications and the resident experienced NJ Exec Order 26.4b1 that interfered with NJ Exec day-to-day activities. Review of R24's "Order Summary Report," dated	F 600	1)How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The nurse in question was immediately suspended pending investigation. NJ Exec Order 26.4b1 visited Resident 24 for support. Social Services monitored Resident 24 for any signs of NJ Exec Order 26.4 and provided support as needed. Abuse Prohibition and Sensitivity Education was implemented for facility staff. Notified the DOH, Ombudsman, and MD. Resident 24□s Care Plan was reviewed with immediate interventions. 2)How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognized that all Residents have the potential to be affected. 3)What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Director of Nursing or Designee will	

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F 600	Continued From page 19 and found in the EMR under the "Orders" tab, indicated orders for the resident to receive U.S. FOIA (b)(6) (mg) by times a day for (original order date) and (a NJ Exec Order 26.4b1 management of NJ Exec Order 26.4b1 (original order date . Review of R24's "Medication Administration Record (MAR)," dated and found in the EMR under the "Orders" tab, indicated the resident reported levels between out of and that was receiving the above routine medication as ordered. Review of R24's "Pain Care Plan," dated and found in the EMR under the "Care Plan" tab, indicated the resident had the potential to and related to diagnoses of NJ Exec Order 26.4b1 The care plan indicated staff were to respond immediately to any complaint of and to administer the resident's medications as ordered. Review of R24's Care Plan," dated and found in the EMR under the "Care Plan" tab, indicated the resident was at risk of NJ Exec Order 26.4b1 . Review of R24's "Incident Report," dated and provided by the facility, indicated the resident informed a nurse on that on NJ Exec Order 26.4b1 Registered Nurse (RN) 1 used the words when she was administering the resident	F 600	educate all staff on Abuse prevention. 4)How the facility will monitor its corrective actions to ensure that 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 the systemic change The Director of Nursing or Designee will perform weekly audits for three weeks and then monthly audits for three months by interviewing random alert and oriented residents ensuring they were not abused. The Director of Nursing or Designee will present the findings of the audits and review trends and needed follow up in two facility Monthly Quality Assurance Performance Improvement Meeting.	

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F 600	Continued From page 20 her medications. The facility's investigation into the above alleged incident, dated [redacted] and provided by the facility, revealed the allegation was reported timely and a thorough investigation was initiated into the allegation. According to an undated statement received by Licensed Practical Nurse (LPN) 5 during the investigation, LPN5 indicated she was present at the time of the alleged incident since RN1 was orienting her to the facility at the time and the two staff members were passing medications to the resident together. LPN5 confirmed she heard RN1 reference R24 with the term "[redacted]" and stated the resident responded to RN1 by stating [redacted] wished RN1 had [redacted]. LPN5 stated RN1 told R24 that "NJ Exec Order 26.4b1." LPN5 indicated she later apologized to R24 for RN1's earlier statement. During an interview with the [redacted] on 05/29/24 at 10:52 AM, the U.S. FOIA (b)(6) indicated RN1 had been suspended immediately after the allegation and an investigation had been initiated into the alleged [redacted]. The [redacted] indicated RN1 quit related to the incident and was no longer employed with the facility. Review of the facility's policy titled, "Abuse, Neglect and Exploitation Policy," dated 07/23, read, in pertinent part, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures to prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property;" and "Verbal Abuse: means the use of	F 600		

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(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 600	Continued From page 21 oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability."	F 600		
F 644 SS=D	NJAC 8:39-4.1(a)5 Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure a [NJ Exec Order 26.4b1] and Resident Review) was revised for one of two residents (Resident (R) 16) reviewed for [NJ Exec Order 26.4b1] after the resident was newly diagnosed with a [NJ Exec Order 26.4b1] I) of 26 sampled	F 644	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The [NJ Exec Order 26.4b1] was completed for R16 and uploaded as part of the	7/19/24

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 644	Continued From page 22 residents. This failure created the potential for residents to receive inadequate [redacted] services. Findings include: Review of R16's "Admission Record," located in the electronic medical record (EMR) under the "Admission" tab, indicated the resident was admitted to the facility on [redacted] with diagnoses including [redacted] was added to the resident's diagnoses list on [redacted] after the resident's original admission to the facility. Review of R16's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] and located in the EMR under the "MDS" tab, indicated a "Brief Interview for Mental Status (BIMS)" score of [redacted] which indicated the resident had [redacted]. The assessment indicated the resident was receiving [redacted] medication on a routine basis. The assessment indicated the resident frequently exhibited signs of [redacted]. Review of R16's '[redacted] document," dated [redacted] and found in the EMR under the "Miscellaneous" tab, revealed the [redacted] incorrectly indicated the resident did not suffer from [redacted]. During an interview with the [redacted] on 05/29/24 at 2:23 PM, the [redacted] confirmed R16's [redacted] assessment dated [redacted] was	F 644	electronic medical record. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Social Service or Designee will audit the charts of current residents with a diagnosis of a major mental illness (MMI) to ensure a PASARR Level II was completed and included as part of the electronic medical record. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Social Service Staff, Nursing Administration, and Nursing Staff will be educated by the Administrtor or designee that any resident who has a Major Mental Illness (MMI) is required to have a PASARR Level II completed and part of the resident□s electronic medical record. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change The Social Service Director or designee will perform monthly audits for six months of residents with a Major Mental Illness (MMI) to ensure the PASARR Level II is in	

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F 644	Continued From page 23 incorrect. The NJ Exec Order 26.4b1 stated her expectation was NJ Exec Order 26.4b1 assessments were to be correct and were expected to be updated timely with any change in a resident's health status. Review of the facility's policy titled, "Resident Assessment - Coordination with PASARR Program Policy," dated 2023, read, in pertinent part, "This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate for their needs;" and "a. PASARR Level 1 - initial pre-screening that is completed prior to admission: i. Negative Level 1 Screen - permits admission to proceed and ends unless a possible serious mental disorder or intellectual disability arises later;" and "Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level 2 resident review." NJAC 8:39-40.3(d)	F 644	place and included as part of the resident electronic medical record. The Director of Social Service or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		7/19/24

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F 657	Continued From page 24 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure that two of 26 sampled residents (Residents (R) 9 and R100) care plans were revised to reflect the residents care needs. R9's care plan was not revised to reflect the physician ordered emergency [redacted] dressing supplies to be maintained at the resident's bedside. Additionally, R100 was not allowed to participate in the scheduled care plan meetings. Findings include: 1. Review of R9's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on [redacted] with diagnoses that included [redacted]	F 657	1)How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 9□s care plan was updated to reflect physicians□ order for [redacted] and tape. Resident 100 had a Care Plan meeting with the IDT on [redacted]. Resident was present for the meeting. 2)How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 657	Continued From page 25 NJ Exec Order 26.4b1 Review of R9's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 and located in the resident's EMR "MDS" tab revealed the resident had a Brief Interview for Mental Status (BIMS) score NJ Exec Order 2 which indicated the resident had NJ Exec Orde The section for special treatments and procedures revealed the resident was assessed to receive NJ Exec Order 26.4b Review of R9's quarterly "MDS" with an ARD of NJ Exec Order 26.4b and located in the resident's EMR "MDS" tab revealed under special treatment and procedures the resident was to receive NJ Exec Order 26.4b Review of R9's "Physicians' Orders" for the month of NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4b1 and located in the resident's EMR "Orders" tab, revealed the resident had a NJ Exec Order 26.4b1 The orders included to ensure the following supplies were maintained at the resident' s bedside NJ Exec Order 26.4b1 . Review of R9's "Care Plan" for NJ Exec Order 26 with a revision date of NJ Exec Order 26.4b and located in the resident's EMR "Care Plans" tab, revealed the resident's care plan was not revised to reflect the physician order for the NJ Exec Order 26.4b1 During an interview on 05/30/24 at 12:45 PM, LPN, Unit Manager (LPN) 1 reviewed the physician's orders and stated the resident's care plan should have reflected the physician's orders. LPN1 also stated that the care plans were usually revised during the care plan meetings. However,	F 657	The facility recognized that all Residents have the potential to be affected. 3)What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Nursing Administration and Nursing Staff will be educated by the DON or Designee that the care plan of residents with dialysis need to include the need for hemostats, gauze, and tape at the bedside. The Social Service Staff and all the interdisciplinary team will be educated by the DON or Designee that all residents must have a quarterly Care Plan meeting and that the resident should be present for that meeting when it is conducted. 4)How the facility will monitor its corrective actions to ensure that 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 the systemic change The Director of Nursing or Designee will perform weekly audits for three weeks and monthly audits for three months to ensure the Care Plans of dialysis residents include the need to have hemostats, gauze, and tape at the bedside. The Director of Nursing or Designee will present the findings of the audits and review trends and needed follow up in two facility Monthly Quality Assurance Performance Improvement	

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F 657	Continued From page 26 any floor nurse could revise a resident's care plan, as necessary. During an interview on 05/30/24 at 1:08 PM, the NJ Exec Order 26.4b1 stated the baseline care plan was generated by the floor nurse; then the unit manager was responsible for generating the comprehensive care plan. The NJ Exec Order 26 stated each member of the Interdisciplinary Team (IDT) was responsible for the section for their department and then U.S. FOIA (b)(6) reviewed the MDS in its entirety to make sure everything had been completed. 2. Review of R100's undated "Admission Record," dated U.S. FOIA (b)(6) and found in the electronic medical record (EMR) under the "Admissions" tab, indicated the resident was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including NJ Exec Order 26.4b1 [redacted]). Review of R100's quarterly MDS with an ARD of NJ Exec Order 26.4b1 and located in the EMR under the "MDS" tab, indicated a BIMS score of NJ Exec Order 26.4b [redacted] which indicated the resident had NJ Exec Orde [redacted]. Review of R100's Comprehensive Care Plan, dated NJ Exec Order 26.4b1 and located in the EMR under the "Care Plan" tab. The care plan had not been updated since it was initially entered on U.S. FOIA (b)(6) Review of R100's comprehensive EMR was reviewed and indicated nothing to show a quarterly care planning meeting, or any other care planning meeting had been held by the IDT or	F 657	Meeting. The Social Service Director or Designee will perform weekly audits for three weeks and monthly audits for three months to ensure residents are receiving quarterly care plan meetings. The Director of Nursing or Designee will present the findings of the audits and review trends and needed follow up in two facility Monthly Quality Assurance Performance Improvement Meeting.	

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F 657	Continued From page 27	F 657		

that R100 had been invited or was included in such a meeting since her initial care plan had been implemented.

During an interview on 05/28/24 at 10:49 AM, R100 stated NJ Exec did not remember participating in a care planning meeting with the IDT, and indicated NJ Exec would like to participate in such a meeting since NJ Exec had questions related to NJ Exec medications/treatments.

During an interview on 05/29/24 at 3:40 PM, the U.S. FOIA (b)(6) confirmed IDT care planning meetings had not been happening at least quarterly like they were supposed to. She stated she was only in the building twice weekly on Mondays and Fridays, and she was trying to schedule and complete care planning meetings for residents when she was able. She confirmed R100 had not had an IDT care planning meeting since right after her admission at the end of NJ Exec Order 26.4b1.

During an interview on 05/30/24 at 6:34 PM, the U.S. FOIA (b)(6) confirmed his expectation was an IDT care planning meeting was to occur for each resident in the facility at least quarterly and residents and/or their representative were expected to be invited to each meeting.

Review of the facility's policy titled, "Comprehensive Care Plan Policy," dated 2023, read, in pertinent part, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the

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F 657	Continued From page 28 resident's comprehensive assessment;" and "5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set) Assessment;" and "The physician, other practitioner, or professional will inform the resident and/or the resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options." NJAC 8:39-11.2(e),(f),(h)	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one of one resident reviewed for activities (Resident (R) 74) was provided with a meaningful activity program of 26 sampled residents. An assessment of R74's activity preferences was lacking; the care plan was not specific to R74's interests, and R74 was not provided with sufficient activities to prevent boredom.	F 679	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The activity assessment for R74 was re-done to capture preferred activities and interests. The activity care plan for R74 was	7/19/24

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F 679	Continued From page 29 Findings include: Review of the undated "Admission Record," provided by the facility, revealed R74 was admitted to the facility on [redacted]. During an interview on 05/27/24 at 11:55 AM, R74 stated [redacted] was a [redacted] and liked to [redacted] R74 stated NJ Exec Order 26.4b1 activities; however, there were not any people at the facility to NJ Exec Order 26.4b1 with. R74 stated [redacted] stayed in [redacted] room with the TV on all the time and [redacted] had no activity beyond TV. R74 stated [redacted] was [redacted] and NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 and asked, "What am I supposed NJ Exec Order 26.4b1 R74 stated [redacted] completed [redacted] own activities of daily living and was able to walk NJ Exec Order 26.4b1 Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] in the electronic medical record (EMR) under the "MDS" tab, revealed R74 was NJ Ex Order 26.4b1 with a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated R74 had [redacted]. Review of R74's activity preferences revealed it was very important to have books, newspapers, and magazines to read, very important to have music to listen to, very important to keep up with the news, and very important to go outside and get fresh air. Review of the "Care Plan," dated [redacted] in the EMR under the "Care Plan" tab, revealed a problem of, "I am [redacted] on staff for activities, NJ Exec Order 26.4b1 r/t [related to] NJ Exec Order 26.4b1 due to a [redacted] NJ Exec Order 26.4b1]." The goal	F 679	updated to include specific preferred activities including NJ Ex Order 26.4b1 [redacted]. The care plan was also updated to indicate books, magazines, music, and outdoor time would be offered to R74 daily by activity staff members. Cards and Games have been added to the calendar for every Tuesday and Thursday where residents with interests in games such checkers, chess, and others will be invited. Recreation staff have been educated to invite R74 to all activities of interest reflected oh his updated assessment and care plan 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential to be affected by this deficient practice. All activity assessments will be reviewed by Activity Director of designee to ensure specific activity preferences (based on specific residents) are identified within the assessment and updated accordingly. All resident activity care plans will be reviewed by Activity Director or designee to ensure specific activity preferences are identified within the care plan and updated accordingly.	

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F 679	Continued From page 30 was, "I will maintain involvement in [NJ Exec Order 26.4b1 redacted], and social activities as desired through review date." Interventions were: -"All staff to converse with me while providing care." -Assure that the activities I am attending are compatible with [NJ Exec Order 26.4b1 redacted]; compatible with known interests and preferences; adapted as needed (such as large print, holders if I lack hand strength, task segmentation), and compatible with individual needs and abilities; and age appropriate. -Encourage ongoing family involvement. Invite my family to attend special events, activities, and meals. -Establish and record my prior level of activity involvement and interests by talking with me, caregivers, and family on admission and as necessary. -Introduce me to residents with similar backgrounds, and interests and encourage/facilitate interaction. -Invite me to schedule activities. -Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression, and responsibility. -Provide with activities calendar. Notify resident of any changes to the calendar of activities. -Review my activity needs with the family/representative. -Thank me for attendance at the activity function." Review of the Care Plan failed to identify R74's activity preferences and failed to establish goals related to activity participation. Review of the quarterly "MDS" with an ARD of [NJ Exec Order 26.4b1 redacted] in the EMR under the "MDS" tab revealed R74 was [NJ Exec Order 26.4b1 redacted] in	F 679	3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur An Activity Calendar planning committee meeting will be held monthly at a designated time for residents to be invited to and to provide input on activities of preference they would like to see more of or changed. All activity staff members will be educated on the presence of specific activity preferences being in the resident assessment and care plan and to invite or provide residents with appropriate activities that are in line with their preferences. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change Activity Director or designee will randomly audit both group and individual programming weekly for three months and then monthly for three months to ensure residents are participating in and being provided with activities of preference. The results of the audits will be presented and reviewed for trends and follow up	

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F 679	Continued From page 31 [redacted] with a BIMS score of [redacted] out of 15. Review of the quarterly "Recreation Assessment and Documentation," dated [redacted] in the EMR under the "Assessment" tab, revealed R74's preferences included NJ Exec Order 26.4b1 and one to one visit. No specific activity preferences were documented. The heading of games was blank; a preference for [redacted] were blank/not checked. The Summary/Comments read in full, "Resident prefers to stay in [redacted] room and watch tv. Has social interactions with other residents." Review of "Activity Progress Notes" from [redacted] through current, revealed a total of two notes that read as follows: -The "Activity Progress Note," dated [redacted] in the EMR under the "Progress Notes" tab, read in full, "A Recreation Annual/Significant Change Assessment has been completed." -The "Activity Progress Note," dated [redacted] in the EMR under the "Progress Notes" tab, read in full, "A Recreation Quarterly Assessment has been completed." Observations during the survey revealed R74 remained in [redacted] room, lying on the bed with the TV on: [redacted] at 12:05 PM, at 1:28 PM; on [redacted] at 8:55 AM, at 11:13 AM, and at 4:22 PM; on [redacted] at 8:34 AM, at 10:01 AM, and at 3:05 PM. During an interview on 05/28/24 at 4:31 PM, the U.S. FOIA (b)(6) stated R74 did not come to activities and she did not complete one to one visits with [redacted] in [redacted] room. During an interview on 05/29/24 at 10:01 AM,	F 679	needed during the two facility Quarterly Quality Improvement Committee Meetings	

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(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 679	Continued From page 32 Certified Nurse Assistant (CNA) 3 stated R74 stayed in [NJ Exec] room and stayed in bed. CNA3 stated R74 was NJ Exec Order 26.4b1 and could go to activities without assistance. During an interview on 05/30/24 at 11:39 AM, the NJ Exec Order 26.4b1 stated he had been employed since NJ Exec Order 26.4b1. The [NJ Exec] stated R74 did not like to come out of [NJ Exec] room and stayed in [NJ Exec] room and watched TV. The [NJ Exec] stated R74 was invited to activities; however, most of the time R74 declined to attend. The [NJ Exec] stated [NJ Exec] visited with R74 about sports; however, R74 was not on a one-to-one program. The [NJ Exec] stated [NJ Exec] was not aware of R74's interest in NJ Exec Order 26.4b1. The [U.S. FC] verified the Recreation Assessment and Documentation," dated NJ Exec Order 26.4b1 failed to identify any activity preferences for R74. The [NJ Exec] also verified the "Care Plan," dated NJ Exec Order 26.4b1, did not describe R74's interests. The [NJ Exec D] stated the care plan should have included specific activity interests. Review of the facility's policy titled, "Activities," dated 01/24 and provided by the facility, revealed, "It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility sponsored group, individual, and independent activities will be designed to meet the interests of each resident, ...Each resident's interests and needs will be assessed on a routine basis. The assessment shall include ...resident's interest, preferences and needed adaptions ..." NJAC 8:39-7.3	F 679		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		7/19/24

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 690	Continued From page 33 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the 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 interview, record review, and facility	F 690	1)How the corrective action will be	

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F 690	Continued From page 34 policy review, the facility failed to change an U.S. FOIA (b)(6) every month as ordered for one of three residents (Resident (R) 26) reviewed for NJ Exec Order 26.4b1 out of 26 sampled residents. Failure to provide NJ Exec Order 26 as ordered can result in a resident developing a NJ Exec Order 26.4b1. Findings include: Review of R26's undated "Medical Diagnosis" sheet, located under the "Med Diag [Medical Diagnosis]" tab of the electronic medical record (EMR), revealed R26 was admitted to the facility on NJ Exec Order 26.4b and had diagnoses which included NJ Exec Order 26.4b1 Review of R26's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1, which indicated R26 was NJ Exec Order 26.4b1. The "MDS" also indicated R26 had an NJ Exec Order 26.4b1 . Review of R26's current comprehensive "Care Plan," located under the "Care Plan" tab of the EMR, revealed the following "Focus," with a creation date of NJ Exec Order 26.4b1, "[R26's first name] has a NJ Exec Order 26.4b1 ...dx [diagnosis] NJ Exec Order 26.4b1 " Review of the care plan interventions revealed there was not an intervention which specified when or how often R26's NJ Exec Order 26.4b1 was to be changed by staff.	F 690	accomplished for those residents found to have been affected by the deficient practice. Resident 26□s NJ Exec Orde was changed on and the order was updated to include supplemental documentation. 2)How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognized that all Residents have the potential to be affected. 3)What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Nursing Administration and Nursing Staff will be educated by the DON or designee on the importance of Foley catheter changes and that any resident with a Foley catheter needs an order with supplemental documentation to capture the Cather change in the EMR. 4)How the facility will monitor its corrective actions to ensure that 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 the systemic change The Director of Nursing or Designee will perform weekly audits for three weeks and monthly audits for three months of residents with Foley Catheters to ensure there is an order for changes and	

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F 690	Continued From page 35 Review of R26's "Physician's Orders," located under the "Orders" tab in the EMR, revealed an order, dated [redacted] which specified, the [redacted] was to be changed every [redacted] starting on the 24th and ending on the 24th each month for [redacted]. Review of R26's monthly "Treatment Administration Records (TARs)," dated [redacted] provided by the facility, revealed the resident's [redacted] was documented as being [redacted] on [redacted]. There was no documentation that R26's [redacted] was [redacted] between [redacted]. R26's monthly TARs for [redacted], [redacted] and [redacted] did not include the physician's order to change the resident's [redacted] each [redacted]. During an interview on 05/27/24 at 11:48 AM, R26 confirmed he had a [redacted] in place. R26 stated [redacted] should have been [redacted], but it had not been changed for two months. R26 stated he needed [redacted] changed because [redacted] did not want to get a [redacted] because they were [redacted]. During an interview on 05/29/24 at 10:55 AM, Licensed Practical Nurse (LPN) 4 stated she changed R26's [redacted] on [redacted] but was unsure when the resident's [redacted] was previously changed. During an interview on 05/29/24 at 11:10 AM, LPN1, who was a nurse supervisor, confirmed R26 had a physician's order for [redacted] to be changed every [redacted] and as needed. LPN1 reviewed R26's medical record and stated the	F 690	documentation of the change is included in the order. The Director of Nursing will present the findings of the audit and review trends and needed follow up in two facility Monthly Quality Assurance Performance Improvement Meeting.	

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F 690	Continued From page 36 resident's NJ Exec Order 26.4b1 TAR reflected [redacted] was changed on NJ Exec Order 26.4b1, but she was unable to locate documentation that showed the resident's NJ Exec Order 26.4b1 was changed between NJ Exec Order 26.4b1 During an interview on 05/29/24 at 5:55 PM, the facility's NJ Exec Order 26.4b1 reviewed R26's medical record. The NJ Exec Order 26.4b1 stated the staff documented on R26's NJ Exec Order 26.4b1 treatment record that NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) stated when staff entered the resident's NJ Exec Order 26.4b1 order they erroneously selected "Order Type: Other Orders (no documentation required)" so the new order to change the resident's [redacted] monthly on the U.S. FOIA (b) of each month did not show up on the resident's monthly TARs for [redacted] The U.S. FOIA (b)(6) [redacted] stated there was no documentation between NJ Exec Order 26.4b1 that reflected the staff had changed the R26's NJ Exec Order 26.4b [redacted] as ordered. Review of the facility's policy titled, "Catheter Care," dated 11/27/23, indicated, "It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use." NJAC 8:39-19.4(a) NJAC 8:39-33.2(c)5	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		7/19/24

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F 698	Continued From page 37 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, record review, and interview the facility failed to ensure that one of one resident (Resident (R) 9) reviewed for [redacted] of 26 sampled residents had emergency NJ Ex Order 26.4b1 at the bedside according to the physician orders. The failure has the potential to delayed response to NJ Exec Order 26.4b1 [redacted] from the [redacted] port. Findings include: Review of R9's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on [redacted] with diagnoses that included NJ Exec Order 26.4b1 [redacted] Review of R9's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the resident's EMR "MDS" tab revealed the section for special treatments and procedures identified the resident was assessed to receive [redacted] Review of R9's quarterly "MDS" with an ARD of [redacted] located in the resident's EMR "MDS" tab revealed special treatment and procedures identified the resident was to receive [redacted] Review of R9's "Physicians' Orders" for the month of [redacted] and located in the resident's EMR "Orders" tab, revealed the resident was receive [redacted] on Monday, Wednesday,	F 698	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. [redacted] were placed by the [redacted] of Resident 9 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognized that all Residents have the potential to be affected. 3)What measures will be put into place or systematic changes to ensure that the deficient practice would not recur. The Nursing Administration and Nursing staff will be educated by the DON or designee that residents with Dialysis access need an emergency supply of hemostats, gauze and tape at bedside. 4)How the facility will monitor its corrective actions to ensure that 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 the systemic change. The Director of Nursing or Designee will	

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F 698	Continued From page 38 and Friday. The orders also directed the staff to monitor the resident's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) for of NJ Exec Order 26.4b1 And ensure were always kept at the resident's bedside. Observation on 05/30/24 at 11:59 AM revealed there were no NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 observed at resident's bedside according to the physician's order. During an interview on 05/30/24 at 12:05 PM, R9 stated the nurse brought NJ Exec Order 26.4b1 when performing NJ Exec Order 26.4b1 but no supplies were kept at the bedside. During an interview on 05/30/24 at 12:20 PM, Licensed Practical Nurse (LPN) 2 stated was not aware of the physician's orders for NJ Exec Order 26.4b1 , and tape to be maintained at the resident's bedside. During an interview on 05/30/24 at 12:45 PM, Unit Manager, LPN1 stated that she was not aware of the physician's orders to maintain the emergency NJ Ex Order 26.4b1 at the resident's beside in the event the NJ Exec Order 26.4b1 from the U.S. FOIA (b)(6) port.	F 698	perform weekly audits for three weeks and monthly audits for three months to ensure supplies are bedside. The Director of Nursing or designee will present the findings of the audits and review trends and needed follow up in two facility Monthly Quality Assurance Performance Improvement Meeting	
F 700 SS=D	NJAC 8:39-2.9 Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed	F 700		7/19/24

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F 700	Continued From page 39 rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure one of six residents (Resident (R) 105) reviewed for accidents had appropriate physicians' orders, was provided informed consent, and was appropriately assessed for [redacted] use of [redacted] of 26 sampled residents. This failure had the potential to affect resident safety at the facility. Findings include: Review of R105's "Admission Record," dated [redacted] and located in the electronic medical record (EMR) under the "Admissions" tab, indicated the resident was admitted to the facility on [redacted] with diagnoses including [redacted]	F 700	1)How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. An assessment for [redacted] was done for Resident 105. [redacted] care plan was updated and Informed consent was obtained. 2)How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognized that all Residents have the potential to be affected. 3)What measures will be put into place or systematic changes to ensure that the deficient practice would not recur	

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F 700	Continued From page 40 Review of R105's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] and located in the EMR under the "MDS" tab, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. The assessment indicated the resident required [redacted] from staff to [redacted] or [redacted] in [redacted] bed and to [redacted] in and out of [redacted] bed. The assessment indicated [redacted] were not in use for the resident. Review of R105's "Order Summary Report," dated [redacted] and located in the EMR under the "Orders" tab, indicated no orders for the resident's use of [redacted] Review of R105's undated "Activities of Daily Living Care Plan," located in the EMR under the "Care Plan" tab, indicated the resident had an activities of daily living (ADL) self-care [redacted] related to [redacted] of [redacted]. Interventions included the use of [redacted] to assist with [redacted] and [redacted] in bed. Review of R105's comprehensive EMR was reviewed and indicated nothing to show an assessment related to the resident's use of [redacted] had been done since [redacted] admission to the facility. R105 was observed in [redacted] room in bed with [redacted] in the [redacted] at the head of [redacted] bed on [redacted] at 10:40 AM, on [redacted] at 4:17 PM, on [redacted] at 8:25 AM, at 12:43 PM, and at 4:13 PM, and on [redacted] at 8:46 AM.	F 700	The Nursing Administration and Nursing Staff will be educated by the DON or designee that on admission all residents should be assessed for the need for siderails and if they are appropriate for siderails and order must be obtained, the care plan updated, and informed consent obtained prior to the resident using the siderails. 4)How the facility will monitor its corrective actions to ensure that 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 the systemic change The Director of Nursing of Designee will perform weekly audits for three weeks then monthly audits for three months of all new admissions to ensure they assessments are done and if appropriate that there is an order, the care plan is updated, and the informed consent is obtained. The Director of Nursing or designee will present the findings of the audits and review trends and needed follow up in two facility Monthly Quality Assurance Performance Improvement Meeting.	

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F 700	Continued From page 41 During an interview on 05/30/24 at 9:08 AM, the U.S. FOIA (b)(6) confirmed the use of R105's [redacted] and confirmed no information could be found in the resident's record to show physician's orders had been obtained for the use of the resident's [redacted], an assessment had been completed for the use of the [redacted] or informed consent had been obtained for the use of the [redacted] She stated her expectation was all these things should have been in place for the resident prior to the use of [redacted] During an interview on 05/30/24 at 9:31 AM, the US FOIA (b)(6)) stated it was part of the facility's admission process to assess, receive orders, and complete the assessment for any resident's use of [redacted] and all of those things were expected to have been in place for R105 prior to [redacted] use of [redacted]. Review of the facility's policy titled, "Proper Use of Bed Rails Policy," dated 2023, read, in pertinent part, "It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, facility ensures correct installation, use, and maintenance of the rails;" and "As part of the resident's comprehensive assessment, the following will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs: a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms, b. Size and weight, c. Sleep habits, d. Medications, e, Acute medical or surgical interventions, f. Underlying medical conditions, g. Existence of delirium, h. Ability to	F 700		

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F 700	Continued From page 42 toilet self safely, i. Cognition, j. Communication, k. Mobility (in and out of bed), l. Risk of falling; 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs; 3. The resident assessment must also include the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails includes: a. Accident hazards (e.g. falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard), b. Barrier to residents from safely getting out of bed, c. Physical restraint (e.g. hinders residents from independently getting out of bed or performing routine activities), d. Decline in resident function, such as muscle functioning/balance, e. Skin integrity issues, f. Decline in other areas of activities of daily living such as using the bathroom, continence, eating, hydration, walking and mobility, g. Other potential negative psychosocial outcomes such as an undignified self-image, altered self-esteem, feelings of isolation, or agitation/anxiety;" and "Informed consent: 6. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion;" and "8. Upon obtaining informed consent, the facility will obtain a physician's order for the use of the specific bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail." NJAC 27.1(a)	F 700		

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		7/19/24

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 756	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure one of five residents reviewed for unnecessary medications (Resident (R58)) had a documented response to the US FOIA (b)(6) recommendations. Specifically, the US FOIA (b)(6) made recommendations for NJ Exec Order 26.4b1 of an NJ Exec Order 26.4b1 for R58 due to an NJ Exec Order 26.4b1 The US FOIA (b)(6) failed to document that the identified NJ Exec Order 26.4b1 had been reviewed and what, if any, action was taken to address it, or the rationale to make no changes to the medication. Findings include: Review of the undated "Admission Record," provided by the facility, revealed R58 was admitted to the facility on U.S. FOIA (b)(6) and had a diagnosis of NJ Exec Order 26.4b1. Review of the "Order Summary," dated NJ Exec Order 26.4b1 in the electronic medical record (EMR) under the "Orders" tab, revealed a prescription for NJ Exec Order 26.4b NJ Exec Order 26.4b1), NJ Exec Order 26.4b1 Review of the "Consultant Pharmacist's Medication Regimen Review," report from U.S. FOIA (b)(6), the US FOIA (b)(6) made recommendations to NJ Exec Order 26.4b1 R58's dose of on . The report read, "Resident is on daily. The maximum recommended dose of > NJ Exe years old is . The resident is old.	F 756	1)How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The physician for Resident 58 stated he reviewed the Pharmacist□s recommendations for Resident 58□s NJ Exec Order 26.4b and NJ Exe did not want to initiate a NJ Exec Order 26.4b1. NJ Exec stated the U.S. FOIA (b)(6) agrees that resident 58 is NJ Exec Order 26 on the dose NJ Exec O is currently on. Pharmacy recommendations were reviewed by MD, Signed, and uploaded into Resident 58□s chart. 2)How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all Residents have the potential to be affected. 3)What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Nursing Administration and Nursing Staff will be educated by the DON or Designee that all pharmacy recommendations need to be relayed to the MD with a documented answer. The document should then be uploaded into the resident□s charts under Misc. 4)How the facility will monitor its corrective actions to ensure that the deficient	

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F 756	Continued From page 45 Recommend reevaluating the resident and consider a lower [redacted] dose ...If resident continues on this dose, please document risk vs [versus] benefit ..." There was no written response from the US FOIA (b)(6) and the dose of [redacted] remained the same. Review of the "Consultant Pharmacist's Medication Regimen Review," report from NJ Exec Order 26.4b1 , revealed the US FOIA (b)(6) made the recommendation to decrease NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . Each time the dose remained unchanged. There were notes on the reports that documented [redacted] was involved and risks outweighed benefits although specifics were not identified; however, there was no documentation by the US FOIA (b)(6) either agreeing to the recommendations or disagreeing with the rationale. During an interview on 05/30/24 at 3:12 PM, the US FOIA (b)(6) stated the notes on the "Consultant Pharmacist's Medication Regimen Review," report from NJ Exec Order 26.4b1 , were written by the nurses based on talking with the US FOIA (b)(6) The US FOIA (b)(6) verified there was no direct response documented by the US FOIA (b)(6) with the date of review or signature. During an interview on 05/30/24 at 5:05 PM, the U.S. FOIA (b)(6)) stated he had been in his NJ Exec Order 26.4b1 did not know where the reports with the US FOIA (b)(6) review and signature were located. The U.S. FOIA (b) stated the US FOIA (b)(6) was supposed to respond in writing to the U.S. FOIA (b)(6) recommendations and there was a specific form on which the US FOIA (b)(6)	F 756	practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change The Director of Nursing of Designee will perform weekly audits for three weeks then monthly audits for three months of pharmacy reviews to ensure they are being addressed and uploaded into the resident□s charts. The Director of nursing or designed will present the findings of the audit and review trends and needed follow up in two facility Monthly Quality Assurance Performance Improvement Meeting.	

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F 756	Continued From page 46 should document whether he agreed, disagreed and the rationale if he disagreed with the recommendations. During an interview on 05/30/24 at 5:23 PM, the US FOIA (b)(6) stated he reviewed the US FOIA (b)(6) recommendations monthly and signed the form indicating he did not want to initiate a dose reduction of R58's NJ Exec Order 26.4. The US FOIA (b)(6) stated, the resident's [redacted] did not want a dose reduction completed because R58 was NJ Exec Order on the current medication. The US FOIA (b)(6) stated this should have been documented on the forms; however, he did not know where the forms were maintained in the facility. Review of the facility's policy titled, "Addressing Medication Regimen Review Irregularities," dated 04/15/24 and provided by the facility, revealed "It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event ... The Pharmacist must report any irregularities to the attending physician ... and the reports must be acted upon ...The attending physician must document in the resident medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record ..." NJAC 8:39-29.3	F 756		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		7/19/24

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F 803	Continued From page 47 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility menu review, and facility policy review, the facility failed to ensure menus were prepared in advance which included a specific vegetable that was to be served for 39 of 56 lunch and supper meals on the facility's four-week menu cycle. This had the potential to affect 114 of 116 residents who consumed food prepared in the facility's kitchen. Findings include:	F 803	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Food Service Director will remove Vegetable of the Day from the daily menu. A specific vegetable to be served at lunch and dinner will be put on the menu. The [redacted] spoke to R77 about [redacted]	

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F 803	Continued From page 48 1. Review of R77's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4b], located in the electronic medical record (EMR) under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of [NJ Exec Order 26.4b1], which indicated R77 was [NJ Exec Order 26.4b1]. During an interview on 05/27/24 at 11:05 AM, R77 voiced a concern that the facility's menu frequently listed "Vegetable of the Day" instead of having a specific planned vegetable that was to be served at lunch and supper. R77 stated the same vegetables were served over and over at meals. R77 stated peas and carrots were often served at lunch and supper. During an interview on 05/29/24 at 12:40 PM, R77 stated carrots or peas were served four or more times a week at meals as the Vegetable of the Day." Observation on 05/29/24 at 1:13 PM revealed R77 was served [NJ Exec] lunch meal in [NJ Exec] room. Review of the resident's tray slip that was served with this meal revealed "Vegetable of the Day" was the only vegetable listed on [NJ Exec] menu. Observation of the food served on R77's meal tray revealed he was served carrots as the vegetable for this meal. 2. Review of the facility planned four-week cycle menus, which were provided by the facility and signed by the facility's Registered Dietitian, revealed "Vegetable of the Day" was the only vegetable planned on 21 of 28 planned lunch menus and on 18 of 28 planned supper menus. Review of the planned lunch menu for 05/29/24	F 803	concerns and preferences and addressed on his specific menu [U.S. FOIA (b)(6)] will speak to R77 to determine what vegetables [NJ Ex] would like to see more of on the menu for lunch and dinner. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential to be affected by this deficient practice. The facility will schedule an organized meeting between the Food Service Director and the Registered Dietitian, with alert and oriented residents to discuss what vegetables they would like to see served during lunch and dinner. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Food Service Director and Registered Dietitian will revise the facility menus for lunch and dinner to include new vegetable options that will be signed off on by the Registered Dietician for nutritional adequacy. The Food Service Director and Registered Dietitian will educate Dietary staff members on the new menu contents and	

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F 803	Continued From page 49 listed "Vegetable of the Day" as the planned vegetable. During an interview on 05/29/24 at 11:40 AM, Dietary Aide (DA) 1 stated she also cooked meals at the facility. DA1 stated when "Vegetable of the Day" was on the planned menu, the cook decided what vegetable to prepare and serve for that meal based on the vegetables available in the facility. DA1 stated Dietary Cook (DC) 1 prepared the lunch meal for 05/29/24. During an interview on 05/29/24 at 11:45 AM, DC1 stated she prepared the lunch meal for 05/29/24 and she decided to prepare diced carrots for this meal because she knew they were not served yesterday (05/28/24). DC1 stated she would inform the evening cook regarding the vegetable she served to residents at lunch, so residents would not be served the same vegetable at supper. DC1 also stated she would inform the cook who was scheduled to work the following day, so the same vegetable would not be served to residents on two consecutive days. DC1 stated that it was possible for the same vegetable to be served to the residents every other day. DC1 explained that the "Vegetable of the Day" was implemented on the menus about 15 months ago by the prior U.S. FOIA (b)(6) [redacted]. During an interview on 05/29/24 at 11:50 AM, the facility's U.S. FOIA (b)(6) [redacted] stated she was aware the "Vegetable of the Day" was planned on the facility's four-week cycle menus at many meals. The [redacted] stated she signed and approved the facility's menus for nutritional adequacy. When the [redacted] was asked how she approved the menus for nutritional adequacy when a vegetable	F 803	the importance of variety and nutritional adequacy, 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change Food Service Director or designee will randomly audit meals weekly for three months and then monthly for three months for both lunch and dinner to ensure that the vegetable listed on the new menu is being served as intended to the residents. The Food Service Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	

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F 803	Continued From page 50 was not planned to be served for many of the lunch and supper meals, she confirmed that she could not ensure the menus were nutritionally adequate without knowing what vegetables were going to be served at meals. The [U.S. FOIA] stated the "Vegetable of the Day" was put on the menu by the prior [U.S. FOIA] about a year and a half ago and the cooks decided what vegetable to prepare and serve when "Vegetable of the Day" was on the menu. The [U.S. FO] agreed residents could be served the same vegetable too often since a specific vegetable was not planned on the menu for many lunch and supper meals. Review of the facility's policy titled, "Menus and Adequate Nutrition," dated 03/23, indicated, "Policy: The purpose of this policy is to assure menus are developed and prepared to meet resident choices including their nutritional, religious, cultural and ethnic needs, while using established guidelines ...1. The facility will ensure that menus meet the nutritional needs of residents in accordance with established nutritional guidelines. a. The facility maintains access to current national guidelines (i.e. American Diabetes Association, Academy of Nutrition and Dietetics, USDA [United States Department of Agriculture] Dietary Guidelines for Americans). b. Standard meal planning guides used for menu planning and food purchasing will be adjusted to consider individual needs ...2. Menus shall be planned at least two weeks in advance for timely approval and ordering of food ...7. The facility's dietitian or other clinically qualified nutrition professional will review all menus for nutritional adequacy and approve the menus." Review of the facility's policy titled, "Standardized	F 803		

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F 803	Continued From page 51 Menus," dated 03/23, indicated, "The facility shall provide nourishing, palatable meals to meet the nutritional needs of the residents based on the Recommended Daily Allowances (RDA) of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, standardized cycle menus are prepared in advance and utilized ...8. Menus will be planned to include 100% of RDA's ...11. Menus will be updated periodically to mitigate the risk of menu fatigue ..." NJAC 8:39-17.2(b) NJAC 8:39-17.4(a)	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, test tray review, record review, review of Resident Council Minutes, and facility policy review, the facility failed to serve food that was palatable and at appetizing temperature for 13 of 13 residents (Resident (R) 26, R67, R81, R10, R86, R100, R105, R83, R84, R30, R45, R25, and R9) reviewed for food palatability out of 26 sampled residents. This failure had the potential to affect all 114 of 116 residents who consumed food	F 804	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Registered Dietitian or designee will met with residents R26, R67, R81, R10, R86, R100, R105, R84, R30, R45, R25, and R9 to review food preferences and food concerns.	7/19/24

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F 804	Continued From page 52 prepared from the facility's kitchen. Findings include: 1. Review of R26's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4b], located in the electronic medical record (EMR) under the "MDS" tab, revealed a "Brief Interview Mental Status (BIMS)" score of [NJ Exec Order 26.4b1], which indicated R26 was [NJ Exec Order 26.4b1]. During an interview on 05/27/24 at 11:48 AM, R26 stated at times meals were [NJ Exec Order 26.4b1]." R26 specified breakfast was not good and was not always hot when served. During an interview on 05/29/24 at 11:13 AM, R26 stated [NJ Exec] breakfast was not hot when served during the morning of 05/29/24. 2. Review of R67's annual "MDS" with an ARD of [U.S. FOIA (b)(6)], located in the EMR under the "MDS" tab, revealed a "BIMS" score of [U.S. FOIA (b)(6)], which indicated R67 was [U.S. FOIA (b)(6)]. During an interview on 05/27/24 at 11:30 AM, R67 stated [NJ Exec] did not always like the food served at the facility. R67 specified [NJ Exec] food and coffee were not hot when served at meals. During an interview on 05/29/24 at 10:58 AM, R67 stated [NJ Exec] breakfast on 05/29/24 was not hot when served. R67 specified the scrambled eggs at breakfast were only slightly warm and [NJ Exec] coffee was very weak and only warm. R67 again stated [NJ Exec] would like [NJ Exec] food and coffee to be hotter when served at meals.	F 804	The Food Service Director, through the grievance process, documented and addressed the above residents specific concerns. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential to be affected by this deficient practice 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The facility Administrator or designee will educate staff on and will implement the All Hands-on Deck Program during meals where assigned staff will assist the CNAs with the delivery of meals to residents and assist in making sure any missing items and concerns are addressed timely. The Food Service Director will educate the Dietary staff to utilize hot plates during each meal service. The Director of Nursing or designee will educate nursing staff on timely distribution of trays when trucks arrive to the wings. 4) How the facility will monitor its corrective actions to ensure that the	

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F 804	Continued From page 53 3. Review of R81's quarterly "MDS" with an ARD of [redacted], located in the EMR under the "MDS" tab, revealed a "BIMS" score of [redacted] which indicated R81 was [redacted]. During an interview on 05/27/24 at 10:50 AM, R81 stated the food [redacted] was served at meals was not hot. R81 also stated the coffee served at meals was not hot and did not taste good. During an observation and interview on 05/28/24 at 9:13 AM, R81 was in [redacted] room eating [redacted] breakfast meal. R81 stated the scrambled eggs, hot cereal, and coffee that [redacted] was served at this breakfast meal were cold. 4. Review of R10's quarterly "MDS" with an ARD of [redacted], located in the EMR under the "MDS" tab, revealed a "BIMS" score of [redacted] which indicated R10 was [redacted]. During an interview on 05/30/24 at 9:21 AM, R10 stated the food served at the facility was "so/so" and food served at meals was not hot especially at breakfast. R10 stated [redacted] coffee was served cold at breakfast and [redacted] preferred hot coffee. 5. Review of R86's "Admission Record," dated [redacted] and found in the EMR under the "Admissions" tab, indicated the resident was admitted to the facility on [redacted] with diagnoses [redacted]. Review of R86's quarterly "MDS" assessment with an ARD Date of [redacted] and located in the EMR under the "MDS" tab, revealed a BIMS score of [redacted] which indicated the resident	F 804	deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change The Food Service Director or Designee will perform random Meal Tray Evaluation audits, using a specific tool, with alert and oriented residents weekly for three weeks and monthly for three months to evaluate the satisfaction level of the residents with food temperature, food taste, tray accuracy, and preferences being met. The Food Service Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT REHABILITATION AND HEALTHCARE CENTER	**633 STATE ROUTE 28 RARITAN, NJ 08869**

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F 804	Continued From page 54 had [redacted].	F 804		

Review of R86's "Nutritional Care Plan," dated [redacted] and found in the EMR under the "Care Plan" tab, indicated the resident was receiving a [redacted]) and indicated the resident had a history of [redacted] due to [redacted] medical condition.

Review of R86's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" tab, indicated the resident was to receive a [redacted] with [redacted].

During an interview on 05/28/24 at 10:23 AM, R86 stated [redacted] was '[redacted]' with the food in the facility. [redacted] stated the facility had been out of coffee the previous Friday, Saturday, and Sunday. The resident stated [redacted] was often not able to access fresh fruit in the facility and so [redacted] had to bring it in for [redacted] if [redacted] wanted it.

6. Review of R100's "Admission Record," dated [redacted] and found in the EMR under the "Admissions" tab, indicated the resident was admitted to the facility on [redacted] with diagnoses including [redacted]).

Review of R100's quarterly "MDS" assessment with an ARD of [redacted] and found in the EMR under the "MDS" tab, revealed a BIMS score of [redacted] which indicated the resident had [redacted].

Review of R100's "Nutritional Care Plan," dated [redacted] and found in the EMR under the "Care

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 804	Continued From page 55	F 804		

Plan" tab, indicated the resident was receiving a [redacted] and indicated the resident was at risk for [redacted] due to [redacted] history of [redacted] with [redacted], including the placement of a [redacted] in [redacted] to assist [redacted] with [redacted]

Review of R100's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" tab, indicated the resident was to receive a [redacted]

During an interview on 05/28/24 at 10:50 AM, R100 stated, "The food could be better. The only meal I (eat) here is breakfast and otherwise I buy my food. They (the facility) run out of things. Recently they didn't have hotdog buns, so they used sandwich bread.... This has happened a couple of times and so I stopped asking for hotdogs. They run out of coffee (frequently), so I got my own thingy to make coffee (in my room)."

During a follow-up interview on 05/29/24 at 12:36 PM, R100 stated another concern [redacted] had with the food was the facility never indicated what vegetable was being served with meals. [redacted] stated the menu always indicated "Vegetable of the Day" rather than indicating a specific vegetable that was to be served. [redacted] stated most frequently the vegetable served was either carrots or green beans. Meal ticket indicated "Vegetable of the day" and resident confirmed they never knew what vegetable they were going to get, but it was usually carrots or green beans. [redacted] stated [redacted] liked broccoli and cauliflower, but those vegetables were rarely or never served.

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 804	Continued From page 56 7. Review of R105's "Admission Record," dated [redacted] and found in the EMR under the "Admissions" tab, indicated the resident was admitted to the facility on [redacted] with diagnoses including [redacted]. Review of R105's admission "MDS" assessment with an ARD of [redacted] and located in the EMR under the "MDS" tab, indicated a BIMS score of [redacted] which indicated the resident had [redacted]. Review of R105's "[redacted] Care Plan," dated [redacted] and found in the EMR under the "Care Plan" tab, indicated the resident was receiving a [redacted] and indicated the resident was at risk for [redacted] due to [redacted] history of [redacted]. Review of R105's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" tab, indicated orders for the resident to receive a [redacted] no added [redacted] and no [redacted]. During an interview on 05/28/24 at 9:39 AM, R105 stated, "They (staff) tell me they are all out of things (foods and liquids) a lot. They run out of bananas. They run out of coffee." 8. During an interview on 05/27/24 at 11:38 AM, R83 stated the food was not good and [redacted] did not like it. Review of the quarterly "MDS" with an ARD of	F 804		

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT REHABILITATION AND HEALTHCARE CENTER	**633 STATE ROUTE 28 RARITAN, NJ 08869**

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F 804	Continued From page 57 [redacted] in the EMR under the "MDS" tab, revealed a BIMS score of [redacted] which indicated R83 was NJ Exec Order 26.4b1 [redacted] 9. During an observation and interview on 05/28/24 at 8:54 AM, R84 stated the food for breakfast was so bad [redacted] asked for cereal. R84 stated [redacted] was served a pancake, toast, bacon, and eggs. R84's plate of breakfast was observed with NJ Exec Order 26.4b1 of the meal. Review of the quarterly "MDS" with an ARD of [redacted] in the EMR under the "MDS" tab, revealed a BIMS score of [redacted] which indicated R84 was NJ Exec Order 26.4b1 [redacted] 10. During an interview on 05/29/24 at 9:31 AM, a resident who requested to remain anonymous stated the food was not served hot. Review of the annual "MDS" with an ARD of [redacted] in the EMR under the "MDS" tab, revealed the resident who wished to remain anonymous had a BIMS score of [redacted] which indicated the resident was [redacted] [redacted] 11. During the resident council interview on 05/28/24 at 10:00 AM, four of five residents expressed concerns about the food: -R30 stated the food was cold at times. -R45 stated the cold food was served warm. R25 agreed with R45's statement. -R45 stated yesterday at lunch [redacted] chocolate ice cream was completely melted and liquid when it was served. -R25, R9, and R45 stated they did not like the	F 804		

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 804	Continued From page 58 food. R25 stated "The food sucks." -R25 stated the food was bland and R9 agreed. Review of "Resident Council Minutes" from 03/23 through 04/24 revealed concerns with palatability as follows: -"Resident Council Minutes," dated 03/28/23, revealed "Residents concerned over milk appearing spoiled." -"Resident Council Minutes," dated 05/29/23, revealed "Resident stated the coffee is sometimes cold." -"Resident Council Minutes," dated 09/26/23, revealed "Residents stated they wanted to see oatmeal offered more and if their food was cold, they wanted it heated up." 12. During an observation on 05/29/24, in response to resident complaints about food, a test tray was requested to be sent on the last meal delivery cart to the facility's [NJ Exec D.] hallway for the breakfast meal. Observation revealed, before the test tray left the kitchen at 8:44 AM, temperature monitoring of food being served from the kitchen's tray line revealed the food was at acceptable levels, of greater than 135 degrees Fahrenheit (F). The meal trays were placed on an open cart with no heating element. The meal cart with the test tray was observed to arrive on the [NJ Exec D.]-hallway at 8:46 AM. Staff were observed to complete the resident meal pass at 9:15 AM when staff served and set up a resident's breakfast meal in her room on the [NJ Exec D.]-hallway. At this time, the foods and beverages on the test tray were sampled in the presence of the facility's [U.S. FOIA (b)(6)] and Dietary Aide (DA) 1. The [U.S. FOIA] and DA1 verified the temperatures taken of the foods and	F 804		

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F 804	Continued From page 59 beverages on the test tray. DA1 also tasted foods and beverages served on the requested test tray. Observation and tasting of the food on the test tray revealed the following: -The scrambled eggs served on the test tray tasted slightly warm. The temperature of the scrambled eggs was measured at 118.2 degrees F. DA1 tasted the scrambled eggs and agreed they tasted slightly warm. -The oatmeal served on the test tray tasted slightly warm. The temperature of the oatmeal was measured at 117.5 degrees F. DA1 tasted the oatmeal and agreed it tasted slightly warm. -The toast served on the test tray was barely warm and tasted spongy. The temperature of the toast was measured at 98.9 degrees F. DA1 tasted the tasted the toast and agreed it was barely warm and tasted spongy. -The bacon served on the test tray tasted slightly warm. DA1 tasted the bacon and agreed it tasted barely warm. -The coffee served on the test tray was warm and tasted weak. The temperature of the coffee was measured at 121 degrees F. DA1 tasted the coffee and agreed it was warm and tasted weak. During an interview on 05/29/24 at 9:30 AM the [redacted] stated she was aware during prior Resident Council meetings the residents' voiced concerns regarding food not always being served hot at meals. Review of the facility's policy titled, "Food Preparation Guidelines," dated 03/23, indicated,	F 804		

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F 804	Continued From page 60 "It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. Definitions: 'Food attractiveness' refers to the appearance of the food when served to residents. 'Food palatability' refers to the taste and/or flavor of the food. 'Proper (safe and appetizing) temperature' means both appetizing to the resident and minimizing the risk for scalding and burns ...3. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include ...c. Serving hot foods/drinks hot and cold foods/drinks cold." NJAC 8:39-17.4(a)2(e)	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility served known food allergies and food dislikes to three of four residents (Resident (R) 102, R77, and R81) reviewed for [redacted] and food choices out of 26 sampled residents. Findings include:	F 806	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Registered Dietitian met with R102. The resident agreed to have fresh fruit removed from [redacted] ticket in the system and	7/19/24

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	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 806	Continued From page 61 1. Review of R102's undated "Medical Diagnosis" sheet, located under the "Med Diag [Medical Diagnosis]" tab of the electronic medical record (EMR), revealed R102 was admitted to the facility on [redacted] and had an [redacted] to [redacted]. Review of R102's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted], located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] which indicated R102 was [redacted]. Review of R102's care plan, with an initiation date of [redacted], located under the "Care Plan" tab of the EMR, contained the following "Focus" which specified, "I have a [redacted] or a potential [redacted] r/t [related to] [redacted]." A care plan intervention specified, "[redacted]: [redacted] During an interview on 05/30/24 at 12:08 PM, R102 stated [redacted] had an [redacted] which included [redacted] and [redacted]. R102 explained the kitchen staff were aware of this [redacted] and it was noted on [redacted] meal tray slip, but [redacted] continued to receive [redacted] on [redacted] meal trays. R102 specified since [redacted] admission to the facility (on [redacted]) [redacted] was served [redacted] seven times at meals, and [redacted] had discussed this [redacted] with the facility's [redacted] on multiple occasions. R102 stated [redacted] most recently was served [redacted] during [redacted] breakfast meal on [redacted]. R102 stated [redacted] again informed the facility's [redacted] on [redacted] that she received [redacted] on [redacted] tray and the [redacted] again noted this [redacted] on [redacted] meal tray slip.	F 806	replace it with [redacted] preference of bananas. R102 is now given select menus to complete every week to specify what food [redacted] would like to receive. The [redacted] met with R77. Pancakes and mashed potatoes were removed from [redacted] ticket in the system. R77 is now given select menus to complete every week to specify what food [redacted] would like to receive. The [redacted] met with R81. Pancakes were removed from [redacted] ticket in the system. R81 is now given select menus to complete every week to specify what food [redacted] would like to receive. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The Registered Dietitian reviewed all residents with known food allergies and dislikes and removed each item from the individual tray tickets in the system. For the same residents alternatives were discussed and identified and added to the ticket in the system. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur Weekly select menus for alert residents will be implemented to include breakfast	

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F 806	Continued From page 62 Observation on 05/30/24 at 12:50 PM revealed R102 was served [redacted] lunch meal in her room. Review of R102's tray slip that was served with her meal tray revealed the following information, NJ Exec Order 26.4b1 [redacted] " During an interview on 05/30/24 at 2:20 PM, the U.S. FOIA (b)(6) [redacted]) confirmed R102 had a known [redacted] to NJ Exec Order 26.4b1 was listed as a [redacted] on R102's meal tray slip. The [redacted] stated when the kitchen staff prepared R102's meals, they were to review R102's tray slip for [redacted] and food preferences and should not serve the resident any type of [redacted] During an interview on 05/30/24 at 3:35 PM, the facility's [redacted] confirmed R102 had an [redacted] to [redacted] The [redacted] explained she was aware R102 was served [redacted] at multiple meals since being admitted to the facility with the most recent occurrence being on U.S. FOIA (b)(6) when [redacted] was served [redacted] on [redacted] breakfast meal tray. The [redacted] stated R102's [redacted] to [redacted] was noted on [redacted] meal tray slip multiple times and staff were instructed to carefully read the resident's meal tray slip when preparing [redacted] meal trays to prevent [redacted] from being served [redacted] again. 2. Review of R77's undated "Medical Diagnosis" sheet, located under the "Med Diag" tab of the EMR, revealed R77 was admitted to the facility on [redacted] and had diagnoses which included NJ Exec Order 26.4b1 [redacted]. Review of R77's quarterly "MDS" with an "ARD" of [redacted], located in the EMR under the "MDS" tab, revealed a "BIMS" score of NJ Exec Order 26.4b1 which indicated R77 was NJ Exec Order 26.4b1.	F 806	and not just lunch and dinner like previous. Process implemented by Food Service Director and Dietitian to have any allergies and dislikes removed from tray tickets in the system, so it does not appear on the ticket and replace it with agreed alternatives The Registered Dietitian or designee will educate dietary staff on the dangers of food allergies and the need to respect the resident rights of food preferences. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change The Registered Dietitian will randomly audit meals for three weeks and then monthly for three months at different meals to ensure allergies and food preferences are being followed. The Dietitian or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	

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F 806	Continued From page 63 Review of R77's care plan, most recently reviewed on 03/28/24, located under in the EMR under the "Care Plan" tab, contained a "Focus" which specified, "The resident has a [redacted] or potentia[redacted] r/t: [redacted]." A care plan approach specified, "Honor food preferences within [redacted] Review of R77's current physician's orders located in the EMR under the "Orders" tab, revealed the following diet order '[redacted]' During an interview on 05/27/24 at 11:05 AM, R77 stated [redacted] was not always served food that [redacted] selected on [redacted] menus. R77 specified that [redacted] did not like pancakes and this food dislike was noted on [redacted] meal tray slip, but [redacted] continued to receive pancakes at breakfast. During an interview on 05/29/24 at 12:40 PM, R77 stated he was served pancakes again during the breakfast meal on 05/28/24. The resident saved [redacted] meal tray slip served with [redacted] breakfast meal of 05/28/24 and review of the tray slip revealed it specified '[redacted]' Observation on 05/29/24 at 1:13 PM revealed R77 was served [redacted] lunch meal in [redacted] room. Observation of the resident's meal revealed [redacted] was served mashed potatoes. Review of the resident's tray slip served with this meal revealed mashed potatoes was crossed through on the menu. During an interview on 05/29/24 at 1:13 PM, R77	F 806		

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F 806	Continued From page 64 stated [redacted] did not want to be served mashed potatoes on [redacted] lunch meal tray, so [redacted] crossed through them on [redacted] menu, but [redacted] received it anyway. During an interview on 05/30/24 at 2:20 PM, the [redacted] stated R77 should not have been served [redacted] at breakfast on [redacted] and should not have been served mashed potatoes at lunch on [redacted] 3. Review of R81's undated "Medical Diagnosis" sheet, located under the "Med Diag" tab of the EMR, revealed R81 was admitted to the facility on [redacted] and had diagnoses which included type [redacted] Review of R81's quarterly "MDS" with an "ARD" of [redacted], located in the EMR under the "MDS" tab, revealed a "BIMS" score of [redacted], which indicated R81 was [redacted] Review of R81's care plan, most recently reviewed on [redacted] located under in the EMR under the "Care Plan" tab, contained a "Focus" which specified, "The resident has a [redacted] or [redacted] r/t: [redacted]." A care plan approach specified, "Honor food preferences within [redacted] Review of R81's current physician's orders located in the EMR under the "Orders" tab revealed the following diet order "[redacted] "	F 806		

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F 806	Continued From page 65 During an interview on 05/27/24 at 10:50 AM, R81 stated [redacted] food preferences were not honored at meals because [redacted] was served food that [redacted] had previously informed staff that [redacted] disliked. Observations on 05/28/24 at 9:13 AM revealed R81 was eating [redacted] breakfast meal in [redacted] room. Observation of foods served on the resident's meal tray revealed [redacted] was served pancakes. Review of the meal tray slip served with R81's breakfast meal tray revealed it specified "no pancakes." During an interview on 05/28/24 at 9:13 AM, R81 stated that [redacted] did not like [redacted] and had informed staff a number of times that [redacted] did not want to be served [redacted], but continued to receive them at meals and [redacted] does not eat them. Observations on 05/29/24 at 9:02 AM revealed staff were serving R81's breakfast meal tray. Observations of foods served on the resident's tray, with the [redacted] present, revealed R81 was served toast. Review of the meal tray slip served with R81's breakfast meal revealed toast was listed as a disliked food. During an interview on 05/29/24 at 9:02 AM, R81 stated [redacted] received toast on [redacted] meal tray, and [redacted] would not eat it. During an interview on 05/29/24 at 9:02 AM, the [redacted] confirmed [redacted] and [redacted] were listed as dislikes on R81's meal tray slip, and the resident should not have been served these foods at meals. Review of the facility's policy titled, "Food	F 806		

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F 806	Continued From page 66 Preparation Guidelines," dated 03/23, indicated, "Policy: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status ...5. Staff shall accommodate resident allergies, intolerances, and preferences, providing appropriate alternatives when needed ...9. Resident preferences and allergies shall be obtained during the resident assessment process and added to the resident's dietary tray card."	F 806		
F 809 SS=E	NJAC 8:39-17.4(a)(e) Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:	F 809		7/19/24

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F 809	Continued From page 67 Based on observation, interview, record review, and review of the facility's meal service times the facility served meals later than scheduled to residents who resided on four of five facility hallways which included five residents (Resident (R) 10, R57, R211, R30, and R25) of 26 sampled residents. This had the potential to affect 114 of 116 residents who consumed meals that were prepared from the kitchen. Findings include: Review of the facility's undated "Meal service times" schedule, provided by the US FOIA (b)(6) on 05/29/24, revealed meals were scheduled to be served at the following times: -Breakfast: Wing-5 (500 Hallway): 7:40 AM to 7:55 AM; Wing-1 (100 Hallway): 7:55 AM to 8:05 AM; Wing-2 (200 Hallway): 8:05 AM to 8:15 AM; Wing-3 (300 Hallway): 8:15 AM to 8:25 AM; Wing-4 (400 Hallway): 8:25 AM to 8:35 AM. -Lunch: Wing-5 (500 Hallway): 11:55 AM to 12:05 PM; Wing-1 (100 Hallway): 12:05 PM to 12:15 PM; Wing-2 (200 Hallway): 12:15 PM to 12:25 PM; Wing-3 (300 Hallway): 12:25 PM to 12:35 PM; Wing-4 (400 Hallway): 12:35 PM to 12:45 PM. 1. Review of R10's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b, located in the electronic medical record (EMR) under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1, which indicated R10 had NJ Exec Order 26.4b1. The assessment also indicated R10 resided on the facility's NJ Exec O Hallway (Wing NJ Ex).	F 809	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Food Service Director met with residents R10, R57, R211, R30, and R25 to address their concerns. The Food Service Director through the grievance process, documented and addressed the residents□ specific concerns. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential to be affected by this deficient practice. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The facility will implement the All Hands-on Deck Program during meals where assigned staff will assist the CNA□s with the delivery of meals to residents and assist in making sure any missing items and concerns are addressed timely. 4) How the facility will monitor its corrective actions to ensure that the	

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F 809	Continued From page 68 Observation on 05/27/24 at 12:52 PM revealed R10 was seated at a table in the [NJ Exec Order 26.4b] dining room. R10 had not been served [NJ Exec] lunch meal tray. Continuous observations on 05/27/24 from 12:55 PM to 1:21 PM revealed R10 remained seated at the dining room table and was not served [NJ Exec] lunch meal. During an interview on 05/27/24 at 1:21 PM, R10 stated NJ Exec Order 26.4b1 " and stated that [NJ Exec] was [NJ Exec Order 26.] Observation on 05/27/24 at 1:32 PM revealed staff served R10 [NJ Exec] lunch meal and he began to eat [NJ Exec] meal independently. On 05/27/24 at 1:44 PM, R10 finished [NJ Exec] lunch meal and was observed to eat 100 percent of the foods and beverages served on [NJ Exec] meal tray. Observation on 05/28/24 at 9:03 AM revealed staff served R10 [NJ Exec] breakfast meal in the [NJ Exec Order 26.4b] dining room. During an interview on 05/30/24 at 9:21 AM, R10 stated that [NJ Exec] ate [NJ Exec] meals in the [redacted] dining room and [NJ Exec] breakfast and lunch meals were frequently served late. R10 specified [NJ Exec] breakfast meal was not served until after 9:00 AM and [NJ Exec] lunch meal was frequently not served until after 1:00 PM. 2. During observation of lunch on 05/27/24, residents residing on the [NJ Exec] -hall were served their meals up to an hour after the posted meal service time. On 05/27/24 as of 1:03 PM, no meal trays were delivered to the [NJ Exec] -hall. On 05/27/24 at 1:21 PM the first meal cart arrived at the [NJ Exec] hall.	F 809	deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change The Food Service Director or Designee will perform random audits weekly for three months and monthly for three months during different meals to ensure the meals are being delivered to the wings and dining room at the scheduled times. The Food Service Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Assurance Performance Improvement Meetings.	

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F 809	Continued From page 69 During an interview on 05/27/24 at 1:23 PM, R57 (who resided on the [redacted]-hall) stated [redacted] waited a long time for [redacted] lunch today in the [redacted] dining area. R57 was served at 1:16 PM when [redacted] went over to the cart in the dining room and asked for [redacted] tray. During an observation on 05/27/24 at 1:31 PM, R211 was standing at the entrance to [redacted] room on the [redacted]-hall. R211 asked a staff member wheeling the meal cart down the hall where [redacted] lunch tray was. R211 stated, NJ Exec Order 26.4b1," stating [redacted] had been waiting too long for lunch. On 05/27/24 at 1:44 PM, the last tray was served to residents on the [redacted]-unit. 3. Observations during the 05/29/24 breakfast meal of meal delivery, carts leaving the kitchen or arriving on the resident hallways revealed the following resident meals were delivered later than scheduled: a. Observation on 05/29/24 at 8:15 AM revealed Wing-[redacted]'s meal delivery cart, which contained prepared resident meal trays, left the kitchen. Breakfast meals for residents who resided on Wing [redacted] were scheduled to be served between 7:55 AM and 8:05 AM. b. Observation on 05/29/24 at 8:28 AM revealed Wing-[redacted]'s meal delivery cart, which contained prepared resident meal trays, left the kitchen. Breakfast meals for residents who resided on Wing [redacted] were scheduled to be served between 8:05 AM and 8:15 AM. c. Observation on 05/29/24 at 8:35 AM revealed	F 809		

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F 809	Continued From page 70 Wing[redacted]s first meal delivery cart, which contained prepared resident meal trays, left the kitchen. Breakfast meals for residents who resided on Wing-[redacted] were scheduled to be served between 8:15 AM and 8:25 AM. -Observation on 05/29/24 at 8:44 AM revealed Wing[redacted] second meal delivery cart, which contained prepared resident meal trays, left the kitchen. Breakfast meals for residents who resided on Wing[redacted] were scheduled to be served between 8:15 AM and 8:25 AM. Observation on 05/29/24 at 9:15 AM revealed the last resident was served a breakfast meal on the [redacted] Hallway which was confirmed by the [redacted] d. Observation on 05/29/24 at 8:54 AM revealed Wing[redacted] first meal delivery cart was delivered to the hallway. This cart was observed to contain 14 resident meal trays. Breakfast meals for residents who resided on Wing[redacted] were scheduled to be served between 8:25 AM and 8:35 AM. Observation on 05/29/24 at 8:59 AM revealed Wing[redacted] second meal delivery cart was delivered to the hallway. The cart was observed to contain 15 resident meal trays. Breakfast meals for residents who resided on Wing[redacted] were scheduled to be served between 8:25 AM and 8:35 AM. During an interview on 05/29/24 at 9:30 AM, the [redacted] confirmed resident breakfast meals were served later than scheduled on [redacted]. The [redacted] stated the dietary staff started the breakfast tray line later than scheduled which resulted in meal trays being delivered to the hallways late. The [redacted] stated staff were expected to serve resident meals on time.	F 809		

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F 809	Continued From page 71 During an interview on 05/29/24 at 11:45 AM, Dietary Cook (DC) 1 stated resident breakfast meals were served later than scheduled on 05/29/24 because the kitchen's breakfast tray line started late. DC1 explained the breakfast tray line started late because the morning dietary staff had to perform some duties the evening dietary staff failed to complete on [redacted] which included pouring the juices for the [redacted] breakfast meal and making [redacted]. DC1 also stated resident meals were served later than scheduled at times because of staffing issues. 4. During an interview on 05/29/24 at 8:32 AM, R57 stated he waited too long for meals; the meals were served late. Review of the annual "MDS" with an ARD of [redacted] in the EMR under the "MDS" tab, revealed R57 had a BIMS score of [redacted] which indicated he had [redacted]. 5. During an interview on 05/29/24 at 9:31 AM, a resident requesting to remain anonymous stated [redacted] was served lunch on [redacted] Review of the annual "MDS" with an ARD of [redacted] in the EMR under the "MDS" tab, revealed the resident who wished to remain anonymous had a BIMS score of [redacted] which indicated. 6. During the Resident Group interview on 05/28/24 at 10:00 AM, three of five residents who attended the meeting (R30, R10, and R25) stated their meals were frequently served late. Review of "Resident Council Minutes," dated 03/21/24 and provided by the facility, revealed	F 809		

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F 809	Continued From page 72 "Nursing not passing trays timely sometimes." During an interview on 05/29/24 at 3:38 PM, Registered Nurse (RN) 2 stated there had been a delay in receiving the evening meal from the dietary department all week, stating it was late arriving at the unit. During an interview on 05/30/24 at 5:27 PM, the U.S. FOIA (b)(6)) stated the facility had received complaints about late meals, stating food was important and residents expected things to be right. NJAC 8:39-17.2(f) NJAC 8:39-17.4(d)	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources 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.	F 812		7/19/24

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F 812	Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure food and beverages stored in one of one kitchen were dated and did not have expired manufacturer's use by dates. This had the potential to affect 114 of 116 residents who consumed food prepared in the facility's kitchen. Findings include: 1. Observation on 05/27/24 from 9:20 AM to 10:00 AM, during the initial kitchen inspection, with the[U.S. FOIA (b)(6)] present, revealed the following: a. Observation of food and beverages stored in the kitchen's walk-in refrigerator revealed an opened one-gallon container of Russian dressing with an expired manufacturer's use by date of 09/25/23, four five-pound containers of cottage cheese with expired manufacturer's use by dates of 05/15/24, one five-pound container of cottage cheese with an expired manufacturer's use by date of 05/24/24, and 10 undated and thawed four-ounce cartons of nutritional shakes. During an interview on 05/27/24 at 9:30 AM, the [NJ Exec] confirmed the container of Russian dressing, and five containers of cottage cheese had expired manufacturer's use by dates and the 10 cartons of thawed nutritional shakes were not dated. The [U.S. FOIA] stated the cooks and herself were responsible for checking the manufacturer's expiration and use by dates on stored food and were to discard any food with an expired expiration/use by date.	F 812	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Director of Dietary removed the expired Russian Dressing, the expired containers of cottage cheese, and the undated nutritional shakes from the walk-in refrigerator and discarded them. The Director of Dietary removed the expired hot dog buns, the undated packages of hot dog buns, the undated loaves of bread, and the undated package of [NJ Exec Order 26.4b1] and discarded them. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential to be affected by this deficient practice. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur All dietary staff will be in-serviced by the Director of Dietary on the policy of proper storage, labeling and dating of food items and health shakes, which includes when to discard food items and health shakes.	

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F 812	Continued From page 74 During an interview on 05/29/24 at 9:30 AM, the [redacted] stated she checked with the supplier of the thawed and undated four-ounce supplemental nutrition shakes observed in the kitchen's walk-in refrigerator on 05/27/24. The [redacted] stated the supplier informed her the supplemental shakes should be dated when removed from freezer storage and placed in refrigeration storage to thaw and the shakes should be used within 14 days after being thawed. b. Observation of bread products stored on bread racks in the kitchen's dry storage room revealed six packages of hot dog buns had expired manufacturer's use by dates of 05/25/24, one package of hot dog buns with a handwritten date of 05/09/24 on the package, 15 undated packages of hot dog buns, 30 undated loaves of sliced bread, and one undated package of [redacted] bread. During an interview on 05/27/24 at 9:40 AM, the [redacted] confirmed the six packages of hot dog buns had expired manufacturer's use by dates of 05/25/24 and the undated bread products that were stored on the bread racks in the kitchen's dry storage area. The [redacted] stated staff were expected to date bread products when received and to discard bread products with expired use by dates. Review of the facility's policy titled, "Date Marking for Food Safety," dated 03/23, indicated, "The facility adheres to a date marking system to ensure the safety of ready-to-eat time/temperature control for safety food ...2. The food shall be clearly marked to indicate the date or the day by which the food shall be consumed or discarded. 3. The individual opening or	F 812	All dietary staff will be in-serviced by the Director of Dietary on the use of the labeling guns and single use food labels and when to use them. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change The Director of Dietary and Licensed Nursing Home Administrator or Designee will use an audit tool to conduct weekly audits for three months and then monthly for three months on the storage, labeling and dating of food items and health shakes in the refrigerators, freezers, and dry storage area. The results of these audits will be reviewed by the Director of Dietary or designee during the two Quarterly Quality Assurance Improvement Committee Meetings for any trends and improvements needed	

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F 812	Continued From page 75 preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. 5. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday.) 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. 7. The Dietary Manager (DM), or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed." NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT REHABILITATION AND HEALTHCARE CENTER	**633 STATE ROUTE 28 RARITAN, NJ 08869**

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F 880	Continued From page 76 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 77 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and facility policy review, the facility failed to ensure proper infection control for one of two residents (Resident (R) 107) reviewed for NJ Exec Order 26.4b1 of 26 sampled residents. R107's [redacted] were not changed weekly to ensure sanitary administration of the resident's [redacted] Findings include: Review of R107's "Admission Record," dated [redacted] and located in the electronic medical record (EMR) under the "Admissions" tab, indicated the resident was admitted to the facility on [redacted] with diagnoses including [redacted]. Review of R107's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] and located in the EMR under the "MDS" tab, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. The assessment did not indicate the resident was receiving [redacted] at the	F 880	1)How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 107□s NJ Exec Order 26.4b1 were immediately [redacted] and dated. 2)How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognized that all Residents have the potential to be affected. 3)What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Nursing Administration and Nursing Staff will be educated by the DON or Designee that residents on Oxygen need their tubing and humidifier changed weekly as ordered for infection control. 4) How the facility will monitor its	

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F 880	Continued From page 78 time of the assessment. Review of R107's "Order Summary Report," dated [redacted] and located in the EMR under the "Orders" tab, indicated orders for the resident to receive [redacted] at [redacted] via [redacted]. The order indicated the resident's [redacted] were to be [redacted] weekly on Sunday nights. Review of R107's "Treatment Administration Record (TAR)," dated [redacted] and located in the EMR under the "Orders" tab, indicated the resident was receiving [redacted] as ordered. The record did not indicate anything to show the resident's [redacted] or [redacted] had been changed since admission. Review of R107's undated '[redacted] Care Plan," located in the EMR under the "Care Plan" tab, indicated the resident required [redacted] related to her diagnosis of [redacted]. During an observation, R107 was in her room in bed with her [redacted] as ordered on [redacted] at 8:49 AM and at 4:25 PM, on [redacted] at 8:29 AM, at 12:47 PM, and at 4:07 PM, and on [redacted] at 8:53 AM. The resident's [redacted] was dated as most recently changed on [redacted]. During an interview on 05/30/24 at 9:04 AM, the [redacted]) observed R107 with the surveyor and confirmed the resident's [redacted] and [redacted] had not been changed timely. She stated her expectation was [redacted] and other	F 880	corrective actions to ensure that 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 the systemic change The Director of Nursing or Designee will perform an audit weekly for three weeks then monthly for three months to ensure the oxygen tubing and humidifier were changed and dated. The Director of Nursing or Designee will present the findings of the audits and review trends and needed follow up in two facility Monthly Quality Assurance Performance Improvement Meeting.	

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F 880	Continued From page 79 equipment such as NJ Exec Order 26.4b1 for [redacted] were expected to be [redacted] at least weekly on Sunday nights. During an interview on 05/30/24 at 9:29 AM, the U.S. FOIA (b)(6) [redacted]) confirmed his expectation was nursing staff was to change out each resident's [redacted] weekly on Sunday night. Review of the facility's policy titles, "Oxygen Administration Policy," dated 2024, read, in pertinent part, "Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences;" and "5. Staff shall perform hand hygiene and don gloves when administering oxygen when in contact with oxygen equipment. Other infection control measures include b. Change oxygen tubing and mask/cannula weekly and as needed as needed if it becomes soiled or contaminated, c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer." NJAC 8:39-19.4	F 880		

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
315140 Y1	A. Building B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT REHABILITATION AND HEALTHCARE CENTER	633 STATE ROUTE 28 RARITAN, NJ 08869

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 F0584	Correction	ID Prefix F0806	Correction	ID Prefix	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.60(d)(4)(5)	Completed	Reg. #	Completed
LSC	07/19/2024	LSC	07/19/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/30/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

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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 05/28/24. 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 the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/28/24 and was found not to be in compliance with 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. Waterfront Rehabilitation and Healthcare Center was constructed in 1964 with an addition at an unknown time. The facility is one story with concrete slab flooring, steel stud bearing walls, flat fiberglass and steel studs roofing. The addition has fire rated wood sheathing as the roofing deck. The steel joists lack protective coatings and are deemed unprotected materials. The facility is a type II (000) non-combustible, unprotected construction type. The facility has a 60 KW (kilowatt) natural gas standby generator. The facility has 115 occupied beds. The facility has eight smoke zones.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211		7/1/24

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

Electronically Signed | 06/18/2024

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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K 211	Continued From page 1 exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews with facility staff, the facility failed to ensure that one set of egress doors and one exit discharge path to the public way were maintained in accordance with NFPA 101 (2012 edition) sections 7.1.6.2. and 7.2.1.5.3. This deficient practice had the potential to affect 25 residents. Findings include: An observation of a set of main dining room doors on the egress side on 05/28/24 at 8:50 AM revealed a lock had been added that held both egress doors closed with a latch and key. The doors could not be opened from the egress side of the doors unless a key was used. Ten minutes later, the U.S. FOIA (b)(6) was located as he was the only person that had the key to unlock the dining room door. An interview with the U.S. FOIA (b)(6) at the time of the observation indicated he was not sure why there was a lock on the door and stated the door had the lock since before he took over the job of U.S. FOIA (b)(6). An observation on 05/28/24 at 11:15 AM of the exterior sidewalk that leads one from the NJ Exec Order 26:4 units near the laundry area revealed the sidewalk was sunken to a depth of four inches, was six feet long and measured the entire width of the	K 211	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The added lock on the main dining room door was removed. This now allows for egress through that door from within the dining room. The external sunken sidewalk going from wing three to wing four was repaired so that the pavement was level. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All other facility dining rooms and common rooms were evaluated to ensure there were no further obstructions to egress or added locks on additional doors. No further issues were identified. The entire external walkway outside of the building was evaluated to ensure there were no further areas of sunken sidewalk. No further issues were identified	

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K 211	Continued From page 2 sidewalk. The sidewalk had been repaired previously, however, the repaired area had also sunken into the ground and was now four inches deeper than the original sidewalk. An interview with the U.S. FOIA (b)(6) at the time of the observation verified the condition of the sidewalk. NJAC 8:39-31.2(e)	K 211	3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur Maintenance staff will be educated by the Maintenance Director that added locks to doors is not permitted to allow for proper egress in all areas of the facility. Maintenance staff will be educated by the Maintenance Director that pavement and walkways throughout the facility grounds must be level and must be repaired if sunken down or in any disrepair. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change. Maintenance Director or Designee will audit dining rooms and common rooms within the facility weekly for three months then monthly for three months to ensure there are no added locks on doors and that egresses are not obstructed. Maintenance Director or designee will audit external pavement and walkways weekly for three months then monthly for three months to ensure there are no sunken pavement or disrepair. The findings of the above audits will be reviewed by the Maintenance Director or Designee for any trends or follow up	

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K 211	Continued From page 3	K 211	needed during the two upcoming Quarterly Quality Assurance Performance Improvement meetings.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to ensure that emergency egress illumination was installed and maintained in accordance with NFPA 101 (2012 edition) sections 7.8.1.1. and 7.8.1.4. The deficient practice had the potential to affect 12 residents. Findings include: An observation of the exit discharge light near bedroom 203 on 05/28/24 at 10:35 AM revealed that one of the two lights provided was burned out and/or not illuminating. An interview with the NJ Exec Order 26.4b1 at the time of the observation verified that one of two lights was burned out. An observation of the kitchen exit discharge light on 05/28/24 at 1:30 PM revealed a light was present above the exit door, however, only one bulb was provided.	K 281	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The burnt-out bulb in the exit discharge light by room 203 was replaced. A functioning bulb was installed into the exit discharge light by the kitchen that was missing a bulb. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The Maintenance department reviewed the other exit discharge lights throughout the facility. There were no other missing or burnt-out bulbs.	7/1/24

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K 281	Continued From page 4 An interview with the U.S. FOIA (b)(6) at the time of the observation verified the condition of the light or one bulb present. NJAC 8:39-31.2(e)	K 281	3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Maintenance Director will educate the maintenance staff on exit discharge lights needing functioning bulbs and lights and that any burnt out or missing bulbs need to be replaced. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change. The Maintenance Director or designee will audit the facility exit discharge lights for missing or burnt-out bulbs weekly for three months and then monthly for three months. The Maintenance Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the	K 341		7/1/24

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K 341	Continued From page 5 building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and review of fire safety contractor reports, the facility failed to ensure that the alarm system was installed according to NFPA 101 (2012 edition) 19.3.4.1 to 9.6.1.1. to NFPA 72 (2010 edition) to 17.14.4 and 17.14.6 for 15 of 20 manual pull stations throughout the facility. These deficient practices had the potential affect all 115 residents. Findings include: Observations of manual pull stations throughout the facility on 05/28/24 from 12:40 PM to 1:05 PM revealed 15 of 20 pull stations were positioned too high or not within five feet of an exit and therefore not in accordance with NFPA 72 as follows:. An observation of the front door pull station on 05/28/24 at 12:40 PM to measure 55 inches from the floor to the handle of the pull station as measured by the NJ Exec Order 26.4b1 [redacted] An observation of the dining room exit pull station	K 341	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The 15 Fire Alarm Manual Pull Stations that were too high was lowered by a qualified vendor (County Fire on 6/20/2024 and 6/21/2024) to within 48 inches of height to meet NFPA guidelines. The two Fire Alarm Manual Pull Stations that were too far from an exit was moved by a qualified vendor (County Fire on 6/20/2024 and 6/21/2024) to be within five feet of an exit. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential of being affected by this deficient practice.	

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K 341	Continued From page 6 on 05/28/24 at 12:41 PM measured 55 inches from the floor to the handle of the pull station as measured by the U.S. FOIA (b)(6) [redacted] An observation on 05/28/24 at 12:43 PM revealed a pull station near the maintenance room exit measured 55 inches from the floor to the handle of the pull station as measured by the U.S. FOIA (b)(6) [redacted] An observation on 05/28/24 at 12:44 PM revealed a pull station at the main atrium near bedroom 418 measured 55 inches from the floor to the handle of the pull station as measured by the U.S. FOIA (b)(6) [redacted]. An observation on 05/28/24 at 12:45 PM revealed a pull station near the exit at bedroom 402 measured 55 inches from the floor to the handle of the pull station as measured by the NJ Exec Order 26.4b1 [redacted] An observation on 05/28/24 at 12:46 AM revealed a pull station near the exit at bedroom 417 measured 55 inches from the floor to the handle of the pull station as measured by the NJ Exec Order 26.4b1 [redacted] In addition, this pull station was approximately 18 feet from the exit door as measured by the NJ Exec Order 26.4b1 [redacted] An observation on 05/28/24 at 12:48 PM revealed a pull station near the exit at unit three nursing station on the 500 unit measured 55 inches from the floor to the handle of the pull station as measured by the NJ Exec Order 26.4b1 [redacted]	K 341	The Maintenance Director reviewed the remaining five pull stations and they met the requirements of being within 48 inches of height and within five feet of an exit. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Maintenance Director will educate the maintenance staff on the NFPA guidelines that all Fire Alarm Manual Pull Stations must be within 48 inches of height from the ground and within five feet of distance to an exit. The Maintenance Director will educate the US FOIA (b)(6) [redacted]) to include the height and distance of the manual pull stations in their scheduled inspection and reports. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change The Maintenance Director or designee will audit the facility Fire Alarm Manual Pull Stations weekly for three months then monthly for three months to ensure they are within 48 inches from the ground and within five feet of an exit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

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K 341	Continued From page 7 An observation on 05/28/23 at 12:50 PM revealed a pull station near bedroom 302 and the exit measured 55 inches from the floor to the handle of the pull station as measured by the [redacted] An observation on 05/28/25 at 12:52 PM revealed a pull station at the unit two nursing station measured 55 inches from the floor to the handle of the pull station as measured by the [redacted] An observation on 05/28/23 at 12:51 PM revealed a pull station at bedroom 117 measured 55 inches from the floor to the handle of the pull station as measured by the NJ Exec Order 26.4b1 [redacted] An observation on 05/28/24 at12:53 PM revealed a pull station near the Dayroom Lounge measured 52 inches from the floor to the handle on the pull station as measured by the [redacted] An observation on 05/28/24 at 12:55 PM revealed a pull station near the sprinkler room on unit 1 nursing station measured 52 inches from the floor to the handle on the pull station as measured by the U.S. FOIA (b)(6) [redacted]. In addition, the pull station was noted to be 14 feet from the exit door as measured by the [redacted] An observation on 05/28/24 at 12:58 PM revealed a pull station near the library measured 55 inches from the floor to the handle on the pull station as measured by the U.S. FOIA (b)(6) [redacted].	K 341	The Maintenance Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	

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K 341	Continued From page 8 An observation on 05/28/24 at 12:59 PM revealed a pull station near the exit in the kitchen measured 57 inches from the floor to the handle on the pull station as measured by the U.S. FOIA (b)(6) [redacted] An observation on 05/28/24 at 1:05 PM revealed a pull station at the exit in the boiler room measured 58 inches from the floor to the handle on the pull station as measured by the U.S. FOIA (b)(6) [redacted]. A review of the report titled "Report Cover Page" dated 09/08/23 and annual at 03/14/24 revealed no reference to problems with pull station height and pull stations farther than 60 inches from an exit. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 341		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to complete smoke detection sensitivity testing for 57 out of 57 photo electric smoke detectors in accordance with	K 345	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	7/1/24

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	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

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K 345	Continued From page 9 NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 115 residents who resided at the facility. Findings include: A review of the facility's fire safety records titled, "Report of Cover Page," dated 09/08/23 and annual date of 03/14/24 revealed no reference to a smoke detection sensitivity test in the past two years. Observations of the facility smoke detectors revealed on 05/28/24 from 8:50 AM to 11:00 AM and to 1:05 PM smoke detectors were in common areas and corridors as well as at smoke walls. During an interview on 05/28/24 at 3:30 PM, the U.S. FOIA (b)(6) indicated he did not have a recent report on smoke detection sensitivity. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	The facility had sensitivity testing performed on the 57 photo electric smoke detectors within the facility by the vendor Survivor Fire on 6/14/2024. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential to be affected by this deficient practice. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Regional Maintenance Director will educate the facility US FOIA (b)(6) that an annual sensitivity test must be performed on all electric smoke detectors in accordance with NFPA. The Maintenance Director will schedule the next annual sensitivity testing with the vendor Survivor Fire. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change The Maintenance Director or designee will	

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	315140	A. BUILDING 01 B. WING	05/30/2024

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K 345	Continued From page 10	K 345	audit the facility Maintenance Inspection Book monthly for six months to ensure the Annual Smoke Detector Sensitivity Report is up to date and present in the book. The results of these audits will be reviewed by the Maintenance Director or designee during the two Quarterly Quality Assurance Improvement Committee Meetings for any trends and improvements needed	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview with staff, the facility failed to ensure that three sprinklers showing damage in the	K 353	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient	7/1/24

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K 353	Continued From page 11 kitchen were maintained/replaced as required in accordance with NFPA 25 (2011 edition) section 5.2.1.1.1 and 5.2.1.1.2. The deficient practice had the potential to affect eight residents in the dining room at the time of the observation. Findings include: An observation of the kitchen sprinkler head in the dishwashing room on 05/28/24 at 9:10 AM revealed a rusted sprinkler pendent head hanging directly down. An observation of two sprinkler pendent heads pointing directly downward near the main stove area of the kitchen on 05/28/24 at 9:10 AM revealed rusting and debris and grease on numerous sections of each sprinkler head. Interviews with the US FOIA (b)(6) at the time of each observation verified the condition of the sprinkler heads. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	practice. The three identified rusty and soiled sprinkler heads in the locations of the dish machine room and in the kitchen above the stove were replaced by the vendor Survivor Fire on June 12, 2024. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. A quarterly inspection was completed by the vendor Survivor Fire on June 12, 2024, where all facility sprinkler heads were checked and there were no further sprinkler heads that needed to be repaired or replaced. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Maintenance Director will educate the maintenance staff that any sprinkler head in the facility that shows signs of rust or debris needs to be reported and evaluated for repair or replacement. The Maintenance Director will ensure the quarterly Sprinkler Inspections are done timely and assesses the condition of each sprinkler head in the facility. 4) How the facility will monitor its corrective actions to ensure that the	

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	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

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K 353	Continued From page 12	K 353	deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change The Maintenance Director or designee will audit the facility sprinkler heads in different areas of the building weekly for three months and then monthly for three months to identify any sprinkler heads that are rusty or have debris to evaluate for repair or replacement. The Maintenance Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	
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 observation and interview with facility	K 372	1) How the corrective action will be	7/1/24

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K 372	Continued From page 13 staff, the facility failed to ensure that four of six smoke barrier/fire barrier walls observed were maintained in accordance with NFPA 101 (2012 edition) section 8.5.2.1. The deficient practice has the potential to affect all 115 residents. Findings include: An observation of the smoke barrier wall at bedroom 415 on 05/28/24 at 12:05 PM revealed a large opening around the diameter of a two-inch sprinkler pipe running through the wall. In addition, large gaps were observed around the top section of the duct work penetrating the wall. A beige colored foam sealant was used for additional gaps or holes. Observations on 05/28/24 at 12:08 PM revealed the smoke barrier wall at bedroom 316 to have a hole at the I-beam. The wall also had been sealed previously with foam of a beige color. Observations on 05/28/24 at 12:10 PM revealed the smoke barrier wall at bedroom 215 to have large openings at the duct work running through the wall at a large gap. In addition, a large gap was found at the entire diameter of a two-inch sprinkler pipe running through the wall. Beige foam was used to fill in the additional gaps in the wall. Observations of the smoke barrier wall at bedroom 113 on 05/28/24 at 12:15 PM revealed two holes the size of golf balls near bedroom 114, one large gap around the entire diameter of a two-inch sprinkler pipe, large gaps at the I-beam located at the wall, and a beige foam used throughout the wall to fill in gaps.	K 372	accomplished for those residents found to have been affected by the deficient practice. The holes in the smoke barrier / fire barrier walls at the locations of rooms 415, 315, 215, and 113 were repaired by facility maintenance with fire rated foam material by Friday June 21, 2024. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. There is a total of six smoke barrier / fire barrier walls in the facility. The other two smoke barrier / fire barrier walls were inspected and determined to be intact with no holes or penetration. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur Maintenance Director will educate maintenance staff that all smoke barrier / fire barrier walls must be intact and not have any presence of holes or penetration. Maintenance Director will establish a documented Preventative Maintenance Program specific to the six-smoke barrier / fire barrier walls where monthly inspection of these walls will take place to ensure there are no holes or penetration in the walls. If there are repairs will be	

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K 372	Continued From page 14 Interviews with the U.S. FOIA (b)(6) at the time of each observation verified the condition of the wall. In addition, he added that he did not have a record of the beige foam fire rating and did not know who put the foam in the walls. NJAC 8:39-31.1(c), 31.2(e)	K 372	made with the appropriate fire rated foam material. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change Maintenance Director or designee will audit the six-smoke barrier / fire barrier walls weekly for three months and then monthly for three months to ensure the walls are intact with no holes or penetration. The Maintenance Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meeting.	
K 908 SS=E	Gas and Vacuum Piped Systems - Inspection and CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	K 908	1) How the corrective action will be	7/19/24

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	315140	A. BUILDING 01 B. WING _____	05/30/2024

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K 908	Continued From page 15 review, the facility failed to ensure that the medical gas system had been inspected in accordance with NFPA 99 (2012 edition) section 5.1.14.2.3.1. This deficient practice had the potential to affect all seven residents on the 500 unit. Findings include: An observation of the central medical gas system and shut off valve in the main corridor revealed the facility system supplied residents on the 500 wing. A review of facility inspection records revealed the facility has no maintenance records of the system being tested and or maintained nor did the facility have any information available describing the model or specifics of the system. An interview with the NJ Exec Order 26.4b1 [redacted] indicated there was no documentation that the system had ever been maintained. NJAC 8:39-31.2(e) NFPA 99	K 908	accomplished for those residents found to have been affected by the deficient practice The facility has contracted with the vendor NJ Ex Order 26.4b1 and have developed a plan and has scheduled the annual inspection of the central and medical gas system and shut off valve located on Wing 5. The annual inspection was completed on July 10, 2024 by NJ Ex Order 26.4b1 [redacted] 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that the patients located on Wing 5 have the potential to be affected by this deficient practice. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Maintenance Director will educate the maintenance staff that the central and medical gas system and the shut off valve located on Wing 5 must be inspected annually by the facility vendor. The Maintenance Director will maintain the proper scheduling of these annual inspections with the facility vendor. 4) How the facility will monitor its	

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	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 908	Continued From page 16	K 908	corrective actions to ensure that 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 the systemic change The Maintenance Director or designee will audit the facility Maintenance Inspection Book monthly for six months to ensure the annual inspection of the central medical gas system and shut off valve located on Wing 5 is completed, up to date, and present in the book. The Maintenance Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		7/1/24

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	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

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K 918	Continued From page 17 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview with staff, the facility failed to ensure that standby emergency generator testing and maintenance was in accordance with NFPA 110 (2010 edition) section 8.4.1. The deficient practice had the potential to affect all 115 residents. Findings include: An observation on 05/28/24 of the natural gas generator located near the laundry room in the back section of the building revealed the device was labeled as 60 Kilowatt (KW). A review of the maintenance and testing reports conducted by the facility revealed no weekly inspections and no monthly load tests from May of 2023 to 01/24/24.	K 918	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Current Maintenance Director started employment with facility in [NJ Ex Order 26.4b1] [redacted] Since then, there is a documented process in place for performing weekly generator inspections and at least monthly generator load tests. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential of being affected by this	

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	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

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K 918	Continued From page 18 An interview with the U.S. FOIA (b)(6) on 05/28/24 at 4:30 PM revealed he does a monthly load test but has no reports prior to starting employment with the facility in NJ Exec Order 26.4b1. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	deficient practice. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur The Maintenance Director will educate the maintenance staff on the required process and schedule of the department performing weekly generator inspections and monthly generator load tests. The Maintenance Director has implemented and currently maintains a weekly schedule where a generator inspection and a generator load test is performed every Wednesday. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change The Maintenance Director or designee will audit the generator logbook monthly for six months to ensure weekly generator inspections and the at least monthly generator load tests are completed and present in the generator logbook. The Maintenance Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT REHABILITATION AND HEALTHCARE CENTER	**633 STATE ROUTE 28** **RARITAN, NJ 08869**

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K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on review of in-service records and interview with staff, the facility failed to ensure that the personnel handling compressed oxygen were provided continuing education of safe handling practices in accordance with NFPA 99 (2012 edition) section 11.5.2.1.1. This deficient practice had the potential to affect all 115 residents. Findings include: A review of in-service information on 05/28/24 revealed the facility lacked documentation that staff handling compressed oxygen cylinders were provided continuing education of safe handling practices. The facility also provides transfilling services for small oxygen cylinders and a transfilling room in the 500 wing. An interview with the U.S. FOIA (b)(6) on 05/28/24 at 4:30 PM stated he did not have the continuing education training for the safe handling practices of compressed oxygen. NJAC 8:39-31.2(e)	K 926	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. A safe oxygen handling education was conducted with all current facility staff members who handle oxygen cylinders and the transfilling oxygen. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have the potential to be affected by this deficient practice. 3) What measures will be put into place or systematic changes to ensure that the deficient practice would not recur All new hires to the facility will be	7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**05/30/2024**

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WATERFRONT REHABILITATION AND HEALTHCARE CENTER	**633 STATE ROUTE 28** **RARITAN, NJ 08869**

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K 926	Continued From page 20 NFPA 99	K 926	educated by the Maintenance Director or designee on safe oxygen handling of cylinders and the transfilling oxygen as part of general orientation. The Maintenance Director or designee will perform and maintain quarterly facility wide education on safe oxygen handling of cylinders and transfilling oxygen with staff members who handle oxygen cylinders and the transfilling oxygen. 4) How the facility will monitor its corrective actions to ensure that 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 the systemic change The Maintenance Director or designee will audit the completed safe oxygen handling education monthly for six months to ensure all staff members who handle the oxygen cylinders and the transfilling oxygen have been educated. The Maintenance Director or designee will present the findings of the audits and review trends and needed follow up in the two facility Quarterly Quality Assurance Performance Improvement Meetings.	

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
315140 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT REHABILITATION AND HEALTHCARE CENTER	633 STATE ROUTE 28 RARITAN, NJ 08869

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 K0211	07/01/2024	LSC K0281	07/01/2024	LSC K0341	07/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	07/01/2024	LSC K0353	07/01/2024	LSC K0372	07/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0908	07/19/2024	LSC K0918	07/01/2024	LSC K0926	07/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO